Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 6, 2019	2019_684604_0025	024808-18	Complaint

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

Long-Term Care Home/Foyer de soins de longue durée

The Willows Estate Nursing Home
13837 Yonge Street AURORA ON L4G 3G8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 21, 22, 23, 24, 28, and 29, 2019.

During this inspection intake log #024808-18, related to an incident resulting in injury was inspected.

During the course of the inspection, the inspector(s) spoke with the Complainant, Administrator, Previous Director of Care (PDOC), Charge Registered Nurses (CRN), Registered Nurse (RN), Registered Practical Nurses (RPN), Minimum Data Set Coordinator (MDSC), Personal Support Workers (PSW), Nursing Administrative Services Manager (NASM), Falls Program Lead (FPL), Physiotherapist (PT), and Physiotherapist Assistant.

During the course of the inspection, the inspectors conducted observations of staff and resident interactions, provision of care, conducted reviews of health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee had failed to ensure that the resident was reassessed, and the plan of care was reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective.

On an identified date, the Ministry of Long-Term Care (MLTC) ACTIONline received a complaint stating the resident had multiple identified incidents with injury.

On an identified date, the MLTC ACTIONline received a second complaint stating the resident was found in an identified location and the home needed to care for the resident better. The family had staff monitor the resident and the Personal Support Worker (PSW) informed the family of the residents' injuries.

An interview was carried out with complainant #100 who indicated resident #003 had sustained multiple identified incidents in the home and the home had no interventions in place. The complainant further stated their main concern was related to identified incident and the resident sustained an injury.

A review of resident #003's e-notes was carried out for an identified period of time, related to the resident's identified incidents and noted the resident had an identified amount of incidents within an identified period of time.

Review of resident #003's e-Assessments was carried out for identified dates which indicated resident #003 had a history of an identified incident due to their health status.

A review of resident #003's plans of care was carried out for an identified time period which consisted of an identified problem statement related to their care needs with identified interventions. The record review of the plans of care for an identified period, identified that there was no revisions to the plans of care after resident #003 had further incidents during this time period.

In separate interviews with Physiotherapist (PT) #112 and Charge Registered Nurse (CRN) #109 indicated resident #003 was at risk for an identified incident due to their past health history. The PT and CRN reviewed resident #003's plans of care and acknowledged the plans of care was not reassessed, reviewed and revised when the care set out in the plan had not been effective as resident #003 kept sustaining an identified incident.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident was reassessed, and the plan of care was reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

On an identified date, the Ministry of Long-Term Care (MLTC) ACTIONline received a complaint stating the resident multiple identified incidents with injury.

On an identified date, the MLTC ACTIONline received a second complaint stating the resident was found in an identified location and the home needed to care for the resident better. The family had staff monitor the resident and the Personal Support Worker (PSW) informed the family of the residents' injuries.

A review of resident #003's e-care e-notes indicated the resident had an incident in the home. A review of residents e-Assessments indicated a Post Fall Assessment (PFA) was not completed for identified dates when the resident #003 sustained an identified incident.

The home's policy tilted "Resident Falls", #CS-12.1, with an effective date as January 2013, procedure #13 states a post-fall assessment shall be initiated as soon as possible after the resident has been assessed and is safe and comfortable. Procedure #14 states the post-fall assessment shall be completed within 24hrs of the fall and provided to the DOC for review.

In separate interviews carried out with CRN #109 and PT #012 indicated a PFA was to be completed after each incident. The CRN and PT reviewed resident #003's e-Assessments and acknowledged a PFA was not completed on identified dates when the resident had an identified incident.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls., to be implemented voluntarily.

Issued on this 7th day of November, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.