Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 2, 2020	2020_838760_0022	001523-20, 002081-20	Critical Incident System

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

JACK SHI (760)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 23, 24, 25, 2020.

The following intakes were completed in this critical incident inspection:

Log #001523-20, CIS report #2174-000001-20 was related to falls prevention;
Log #002081-20, CIS report #2174-000002-20 was related to falls prevention and responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Quality Assurance Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Worker (PSW), Environmental Services Manager (ESM) and the resident.

During the course of the inspection, the inspector reviewed records, conducted interviews and observations.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the falls policy under the licensee's fall prevention program were complied with, for residents #002 and #004.

Ontario Regulations 79/10, s. 49 (2) requires that when a resident has fallen, the resident is assessed and a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Specifically, staff did not comply with the home’s policy and procedure "Resident Falls", effective January 2013. The policy indicates that a post falls assessment is to be completed after a resident sustains a fall.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to resident #002’s fall, after having a significant change in status. Resident #002 sustained a fall resulting in a significant change in status. A review of the assessments completed in the resident’s chart did not produce a completed post falls assessment after resident #002’s fall. Quality Assurance RN #104 confirmed that resident #002 sustained a fall and that the RN should have completed a post falls assessment but did not do so in this incident.

Sources: Resident #002’s progress notes, assessments on Med-E-Care; Policy title: Resident falls, Policy # CS-12, Effective date: January 2013; Interviews with RN #103, Quality Assurance RN #104, and other staff. [s. 8. (1) (a),s. 8. (1) (b)]

2. The progress notes indicated resident #004 sustained a fall. RPN #100 followed up and found that the resident had a change in their condition. A review of the assessments completed in the resident’s chart did not produce a completed post falls assessment after their fall. RPN #100 stated it was agency RN #109 who would have needed to complete the required assessments after the resident’s fall. DOC #102 confirmed that a post fall assessment was not completed after the resident’s fall and one should have been completed.

Sources: Resident #004’s progress notes, assessments on Med-E-Care; Policy title: Resident falls, Policy # CS-12, Effective date: January 2013; Interviews with RPN #100, Quality Assurance RN #104, DOC #102 and other staff. [s. 8. (1) (a),s. 8. (1) (b)]

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system; is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect resident #002 from physical abuse, after resident #002 sustained a fall with an injury after an altercation with resident #003.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident.”

The progress notes indicated that RN #103 witnessed resident #002 and resident #003 arguing and before the RN could intervene, resident #003 had an altercation with resident #002, resulting in resident #002 sustaining a fall afterwards with a diagnosed injury. The administrator confirmed the events that occurred.

Sources: Resident #002’s progress notes; Interviews with RPN #100, RN #103, Administrator #106 and other staff. [s. 19. (1)]

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 to protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 2nd day of October, 2020

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

Original report signed by the inspector.