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

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

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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
Jan 27, 2020	2020_685648_0001	019620-19, 024025-19	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of York
17250 Yonge Street NEWMARKET ON L3Y 6Z1

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

York Region Newmarket Health Centre
194 Eagle Street NEWMARKET ON L3Y 1J6

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

JOVAIRIA AWAN (648)

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): January 15, 16, 17, and 20, 2020.

The following Critical Incident System (CIS) reports were inspected upon:
Log #024025-19 related to an injury and change in resident status.
Log #019620-19 related to a fall resulting in a change in resident status.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Practical Nurse's (RPN's), Personal Support Worker (PSW's), and residents.

During the course of the inspection, the inspector made observations of staff and resident interactions, provision of care, and completed reviews of resident health records.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care is provided to the resident as specified in the plan.

Resident #001 was identified in Critical Incident System (CIS) report submitted to the Ministry of Long Term Care (MLTC) the resident was admitted to hospital for a significant change in health related to an identified injury. Review of the CIS identified PSW noticed a change while providing the resident care. Resident #001 was subsequently assessed with no indications of injury identified at the time of the incident. Resident #001 was transferred to hospital on where an injury was identified, and returned to the home. The resident was discharged from the home after an identified period following this incident.

Review of resident #001's progress notes indicated PSW #106 identified a change while providing resident #001 care and reported it to RN #102. PSW #106 continued the provision care following assessment by RN #102. Review of resident #002's written plan of care including the care plan and kardex report identified resident #001 was to receive care in an identified manner for personal care.

Review of resident #001's personal care documentation identified documentation by various PSW staff to have provided care in to the resident which was not according to their identified needs as noted in their their plan of care.

Interview with PSW #106 revealed they were unaware of the homes expectation of when and how often to review a residents' kardex or care plan for residents in their care. PSW #106 reported they do not get time during their shifts to review a residents kardex or care

plan but expressed awareness that a residents plan of care was expected to be followed for all care needs of a resident in the home. PSW #106 was unable to identify when they had last reviewed resident #001's plan of care. PSW #106 confirmed they provided routine care to resident #001, and stated they recalled the instance of care where they noticed a changed during provision of care, prior to resident #001's change. PSW #106 stated they had provided personal care to the resident in an identified manner. Resident #001's plan of care was reviewed with PSW #106 identifying the manner in which they were to receive personal care. PSW #106 confirmed resident #001 was not provided care as specified in the residents plan of care as reviewed during the interview.

Interviews with RN#102 (identified as staff who assessed resident #001, following PSW #106 report of a change during care), and RPN #103. revealed that resident #001 routinely received care in an identified manner from direct care staff such as PSW's. RN #102 confirmed they found PSW #106 in resident #001's room during the provision of personal care of the resident, and no additional staff were noted present with PSW #106 at the time. Review of resident #002's written plan of care including the care plan and kardex report with RN #102 and RPN #103 identified resident #001 was to receive care in a specified manner for personal care. RN #102 and RPN #103 confirmed that review of the written plan of care conflicted with what they were aware of based on staff reports regarding the manner in which resident #001 received care from PSW staff and acknowledged that staff did not provide care to resident #001 as specified in the plan.

Interview with the homes DOC revealed that PSW #106 reported they had been providing care to resident #001 during at the time of the reported change. The DOC reported they had reviewed resident #001's plan of care during the homes investigation and confirmed that resident #001 was identified to require care in a specified manner. Review of the homes records related to resident #001 and staff interviews were reviewed with the DOC, demonstrating the home failed to ensure that care was provided to resident #001 as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that care set out in the plan of care is provided to the resident as specified in the plan.

Resident #002 was identified in a CIS submitted to the MLTC, related to a fall resulting in an identified injury. The CIS identified resident #002 was found by PSW staff in their home area. The resident indicated they were reaching out and slipped. Previous falls history identified a fall where the resident was identified to have attempted to self-transfer. The CIS was updated o, stating that the residents' plan of care was updated to

include identified interventions to manage their risk of falls.

Review of resident #002's clinical records identified indicated nursing staff completed a an assessment reiterating PSW staff identified resident #002 to have sustained a fall. The resident reported to staff that they had been reaching then slipped. Progress notes identified that the resident required an identified intervention which needed to be applied, and directed to refer to the care plan and kardex for interventions. Review of resident #002's written plan of care including the kardex, did not identify the intervention or that it had been implemented following the fall on noted in the CIS. Review of resident #002's written plan of care identified it had been revised to reflect this intervention on a later date following an subsequent fall.

Observations of resident #002 were completed during the inspection period and did not identify the documented intervention in place for the resident.

Interviews were completed with PSW #100 and PSW #104.

PSW #100 stated they were unaware of resident #002's falls prevention strategies as they had not reviewed the residents kardex. PSW #100 stated resident did not have have the identified intervention in place for falls prevention.

PSW #104 was identified as staff responding to resident #002's unwitnessed fall on as reported in the CIS. PSW #104 indicated that resident #002 was known to attempt self transfer which put them at risk of falls.

Resident #002's plan of care was reviewed with PSW's #100 and 104 who confirmed that the identified intervention for falls prevention was not in place for the resident as specified in the plan of care.

Interview with RPN #101 and #103 identified direct care staff, including PSW's, were required to reference a residents Kardex to direct appropriate care to a resident in the home. Resident #002's records as noted above were reviewed with RPN #101 and #103. RPN #101 and #103 confirmed resident #002 did not have the identified intervention for falls prevention at the time of this inspection contradicting the intervention as outlined in the residents' plan of care.

Interview with the homes DOC confirmed direct care staff including nursing and PSW's are expected to follow a residents plan of care. Staff interviews, observations, and

resident #002's care records were reviewed with the homes DOC. The DOC acknowledged that resident #002's did not receive the identified intervention for falls prevention as specified in their plan of care. [s. 6. (7)]

3. The licensee failed to ensure that when a resident is reassessed and the plan of care is reviewed and revised, that different approaches are considered in the revision of the plan of care.

Resident #002 was identified in a CIS submitted to the MLTC, related to a fall resulting in an identified injury. The CIS identified resident #002 was found by PSW staff in their home area. The resident indicated they were reaching out and slipped. Previous falls history identified a fall where the resident was identified to have attempted to self-transfer. The CIS was updated o, stating that the residents' plan of care was updated to include identified interventions to manage their risk of falls.

Review of resident #002's written plan of care dated for a previous review period, identified the resident's falls history and interventions identified to manage and prevent future falls for resident #002.

Review of resident #002's clinical records prior to the fall reported in the CIS, identified a physiotherapy assessment, where the resident was identified to be at high risk of falls. Progress notes documented by physiotherapy and nursing, identified the resident sustained an identified injury while attempting to self transfer which resulted in the resident sustaining a fall.

Review of resident #002's written plan of care for the following review period, identified the resident sustained a previous fall. The interventions identified to manage and prevent future falls for resident #002 remained unchanged and the same as the plan of care from the previous review period.

Review of resident #002's progress notes identified their unwitnessed fall. The progress note indicated nursing staffs assessment and reiterated that PSW staff identified resident to have sustained unwitnessed fall. The resident reported to staff that they had been reaching and then slipped. The progress notes related to this fall stated resident #002 required an identified intervention which needed to be applied and that the care plan and kardex was to be referred to for this interventions. Review of resident #002's written plan of care including the kardex did not identify this identified intervention had been implemented following the fall reported in the CIS.

During interviews with staff, PSW #100 stated they were unaware of resident #002's falls prevention strategies as they had not reviewed the residents kardex.

PSW #104, identified as staff responding to resident #002's unwitnessed fall as reported in the CIS, reported that resident #002 was known to attempt self transfer which put them at risk of falls. PSW #104 was unaware of residents #002's falls prevention strategies or whether alternative strategies had been considered.

Interview with RPN #101 identified the homes falls program included review of residents who have sustained a suspected fall included interdisciplinary assessment, identification of risks, and consideration of alternative approaches to prevent further falls - all of which would be documented in the plan of care for effective communication to direct care staff. RPN #101 stated that a residents written plan of care was expected to include a date of the most recent fall, review of existing interventions, and revision of the interventions based on what contributed to the fall. Resident #002's records as noted above were reviewed with RPN #101. The RPN #101 acknowleged the residents plan of care did not identify risk factors, and that the plan of care had not been revised to reflect alternative strategies had been considered during the review of resident #002's falls risk following their falls history and the fall reported in this CIS.

Interview with the homes DOC revealed that interdisciplinary staff are expected to review a residents plan of care following a fall, and revise to include identification of risk factors contributing to a residents fall, and consideration of new or alternative strategies. The homes process to evaluate the efficacy of falls prevention strategies included a monthly review of residents identified at high risk of falls and whether their interventions are effective in preventing falls. Front line staff interviews, resident #002's written plan of care, and observations of the resident were reviewed with the homes DOC. The DOC acknowledged that resident #002's plan of care did not identify risk factors such as self-transferring and confirmed the home was unable to demonstrate different approaches to falls prevention had been considered, or trialed with resident #002, in the revision of the plan of care during the periods of review identified following the residents falls history. [s. 6. (11) (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 that care set out in the plan of care is provided to the resident as specified in the plan, and that when a resident is reassessed and the plan of care reviewed and revised, different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that when required inform the Director of of an incident under subsection (1), (3) or (3.1) in writing, to include a description of the individuals involved in the incident, including, the names of any staff members or other persons who were present at or discovered the incident, and names of staff members who responded or are responding to the incident.

The MLTC received a CIS report, related to an injury to a resident for which resident #001 sustained a significant change in the residents health status.

Review of the CIS indicated direct care staff including PSW and nursing staff had identified concerns related to a change in the residents health and significant change. The CIS did not identify the names of staff members who discovered and responded to the incident at the time of it being reported, including PSW #105, RPN #103, and RN#102.

Interview with the homes DOC indicated they were unaware of the reporting requirements under this legislative reference, and confirmed the home did not identify the individuals involved including staff members present at the time of the incident and those who responded to the incident. [s. 107. (4)]

Issued on this 29th day of January, 2020

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

Original report signed by the inspector.