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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 18, 2019	2019_695156_0007	019951-19	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Halton
1151 Bronte Road OAKVILLE ON L6M 3L1

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

Creek Way Village
5200 Corporate Drive BURLINGTON ON L7L 7G7

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

CAROL POLCZ (156)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 4, 5, 6, 12, 18, 19, 20, 21, 25, 26, 27, 28, 29, December 3, 4, 5, 2019.

This inspection was completed simultaneously with complaint inspection 2019_695156_0006 / 020131-19, 022007-19.

PLEASE NOTE: A Written Notification (WN) and Compliance Order related to LTCHA, 2007, O. Reg. 79/10, s. 8 (1) b) and WN, Voluntary Plan of Correction (VPC) related to O. Reg. 79/10, s. 27 (a) from this inspection are identified in concurrent inspection #2019_695156_0006 (Log #0020131-19/022007-19).

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Senior Nursing Manager, Assistant Director of Care #2, Acting Manager of Resident Care, social worker, Registered Dietitian (RD), physician, Occupational Therapist (OT), maintenance staff, registered staff (registered nurses and registered practical nurses), personal support workers (PSW's), residents and family members.

During the course of the inspection, the inspector(s) completed observations of the provision of care, medication administration, dining services, resident programs and the homes environment. Inspector(s) reviewed resident clinical records including resident plans of care, policies and procedures, internal investigation notes, quality and improvement systems, and staff training records.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

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. (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 :

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

The plan of care in place for resident #002 at the time of the fall on October 2019 indicated that the resident was to have the a specific safety device in place. Progress notes several days prior to the fall stated that a referral was made to Occupational Therapy (OT) as the safety device was malfunctioning and removed. Progress notes written by OT staff #119 the following day identified that no other safety devices were available and it would be replaced as soon as one became available. Interview with OT staff #119 confirmed that the safety device was not in place at the time of the fall and that care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

On an identified date in September 2019, resident #002 sustained a witnessed fall.
A review of the clinical record indicated that after the fall, there were changes in the resident’s condition; however, the written plan of care did not include reassessment of the resident related to the identified changes in condition.
As confirmed with the Acting Manager of Resident Care, the resident was not reassessed and the plan of care reviewed and revised when the resident's care needs changed with respect to these care areas. [s. 6. (10) (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 the care set out in the plan of care is provided to the resident as specified in the plan and to 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 the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The home submitted Critical Incident (CI) #M623-000015-19 to the Director, which identified that on an identified day, resident #002 had an unwitnessed fall.

The home's policy number 19-01-01 Falls prevention and management defined a fall as any unintentional change in position where the resident ends up on the floor, ground or other lower level; and included witness and unwitnessed falls whether there was an injury or not.

It was confirmed with ADOC #2 that this incident was considered to be a fall and that registered staff #118 failed to document any actions taken with respect to resident #002 including assessments, reassessments, interventions and the resident's responses to interventions. [s. 30. (2)]

2.On an identified date in September 2019, resident #002 sustained a witnessed fall. The resident was assessed by the physician and an x-ray was ordered. Review of the plan of care did not include a documented assessment after the fall, by registered staff. As confirmed with the Acting Senior Nursing Manager, the assessment was not documented. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: 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 :

1. The licensee failed to ensure that when a resident had fallen, the resident had been assessed and a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home submitted Critical Incident (CI) #M623-000015-19 to the Director, which identified that on an identified day, resident #002 had an unwitnessed fall.

The home's policy number 19-01-01 Falls prevention and management defined a fall as any unintentional change in position where the resident ends up on the floor, ground or other lower level; and included witness and unwitnessed falls whether there was an injury or not.

Review of the plan of care did not include a documented assessment after the fall, by registered staff. It was confirmed with ADOC #2 that this incident was considered to be a fall and a post fall assessment was not completed using a clinically appropriate assessment instrument that was specifically designed for falls at this time. [s. 49. (2)]

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 had fallen, the resident has been assessed and a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

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Issued on this 14th day of January, 2020

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

Original report signed by the inspector.