Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
May 26, 30, 31, Oct. 17, 18 and 19, 2011; Jan. 24, 2012	2011_061129_0001	Complaint # H-00630, H-00614, H-00615 and H-00603

Licensee/Titulaire
REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive, Suite 700, Mississauga, ON, L5R-4H1

Long-Term Care Home/Foyer de soins de longue durée
THE WILLOWGROVE
1217 Old Mohawk Road, ANCASTER, ON, L9K-1P6

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

Phyllis Hiltz-Bontje (129)

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with: the Administrator, Directors of Care (2), Assistant Director of Resident Care, Physiotherapist, Hairdresser and the resident's family members.

During the course of the inspection, the inspector: reviewed clinical records, policies and procedure documents and the Falls Prevention program.

The following Inspection Protocols were used in part or in whole during this inspection: Falls Prevention

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

[2] WN
[2] VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

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 subsections:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings:

1. The licensee did not ensure that staff collaborate with each other in the development and implementation of the plan of care for an identified resident in relation to: s.6.(4)(b)
a) Physiotherapy staff did not collaborate with nursing staff in the development of a plan to reduce falls for this resident. Physiotherapy assessed the resident and recommended care to reduce falls. The Physiotherapist confirmed that this recommendation was not shared with nursing and there were no care directions developed for staff providing care related to this recommendation.

2. The licensee did not ensure that staff and others collaborate with each other in the assessment of the resident so that their assessments are integrated and complement each other in relation to: s.6.(4)(a)
a) Assessment information collected by nursing with respect to: self transfers, potential falls risk factors such as hypotension, use of medication, as well as behaviors being demonstrated by the resident that have the potential to increase falls were not shared with physiotherapy staff. This was confirmed by the Physiotherapist.
b) Nursing and Physiotherapy assessments are inconsistent with respect to the resident abilities.
c) The resident experienced multiple falls over a three month period following which nursing staff completed post falls assessments for the resident but did not communicate this information to physiotherapy staff. The Physiotherapy staff

confirmed that a referral was not received and they were not aware that the resident was experiencing multiple falls and as a result the increase in falls experienced by the resident was not a factor in the physiotherapy assessment of the resident.

3. The licensee did not ensure that the care set out in the plan of care was based on assessments conducted in relation to transfers and falls for resident an identified resident. s.6.(2)
Care set out in the plan of care does not include care related to the following assessment information collected by the Nursing and Physiotherapy staff:
-The resident will transfer independently, will not consistently call for assistance when transferring and does not always wear appropriate footwear, increasing the risk for falls.
-The resident is often observed to be ambulating without the use of a wheeled walker, increasing the risk for falls
-The potential increased risks for falling associated with medications the resident is taking for other conditions.
-Other conditions the resident has that may increase the risk of falling such as: memory/recall issues, visual problems, occasional incontinence, agitated behavior, loss of balance, leg edema and decreased muscle coordination, do not have corresponding care directions to staff, with the goal to reducing falls and minimizing injury from falls.

4. The licensee did not ensure the resident was reassessed and the plan of care reviewed and revised when the resident care needs changed in relation to: s.6.(10)(b)
The resident experienced multiple falls over a three month period and the care for the resident was not reviewed or revised through this period of time.
a) The care directions for nursing staff were developed and were not altered when the resident experienced multiple falls. The Director of Care confirmed that a resident who was experiencing multiple falls would mean that there was a change in the resident's condition.
b) Care directions for physiotherapy staff were developed and were not altered when the resident experienced multiple falls. The Physiotherapist confirmed that a resident who continues to fall would represent a change in the resident's condition.
c) Documentation in the clinical record indicates that there were no discussions about falls for this resident during a scheduled care conference and there were no changes to the resident's plan of care in relation to increased episodes of falling.

Inspector ID #:	129

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 with sections 6(2), 6(4)(a), 6(4)(b) and 6(10)(b), to be implemented voluntarily.

WN #2: 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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings:

1. The licensee did not ensure that the homes policies and protocols included in the Falls Prevention Management Program in accordance with O. Reg. 79/10 s. 48 are complied with respect to the following: r.8.(1)(b)

a) Staff did not comply with directions in the home's Falls Prevention and Management Program which directs staff to:
- Complete a fall debrief form after every fall and submit this document to the Falls Coordinator. Staff in the home did not complete the fall debrief document after each fall experienced by the resident. This was confirmed by the Director of Care.
- Meet monthly to review falls in the home. Staff in the home did not meet to review the circumstances for the falls experienced by this resident. This was confirmed by the Physiotherapist who is a member of the home's falls committee.

b) Staff in the home did not comply with the home's policy #NUR-V-66 [Falls-Resident] which directs staff to:
- Complete a Morse Scale if the residents condition changes, to review and determine strategies to improve the safety of the resident. The identified resident experienced multiple falls and staff in the home did not reassess the resident, review the circumstances with respect to fall or determine strategies to improve safety for this resident in accordance with the policy.
- To review the residents medications checking for side effects, drug interactions, dosages and paradoxical effects in relation to falls. The resident was receiving regularly scheduled and [as necessary] medications that may effect falls. Staff did not review these medications for the effects they maybe having in relation to increasing falls for this resident.
- That in the event of a fall staff are to record the actions taken in response to the fall, notify the physician, document the specific information around the notification, document in the progress notes the resident's condition for 48 hours following all falls as well as file an incident report for tracking and trending of falls and file the same in the resident's clinical record. Staff did not document actions taken for one of the identified falls, did not document the notification of the physician for five of the falls experienced by this resident and did not document the resident's condition for 48 hours following six of the falls experienced by this resident.

Inspector ID #:	129

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 related to ensuring that the homes policies and protocols, including those contained in the falls prevention and management program are complied with, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). July 2, 2012