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
Feb 12, 2020	2020_643111_0005	022954-19, 023381-19, 024096-19, 000443-20	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Bay Ridges
900 Sandy Beach Road PICKERING ON L1W 1Z4

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

LYNDA BROWN (111)

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 30, February 3, 4, 5 and 7, 2020.

The following critical incidents were inspected concurrently during this inspection: -Log #023381-19, Log #022954-19 and Log #000443-20 for an incident that caused an injury that resulted in a transfer to hospital and a significant change in condition.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Associate Director of Care (ADOC) and falls lead, the RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

During the course of the inspection, the inspector reviewed resident health records, observed residents and resident rooms, reviewed falls prevention committee meeting minutes and reviewed the home's falls prevention management policies.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. (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 :

The licensee has failed to ensure that when the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care.

A critical incident report (CIR) was submitted to the Director for an incident that caused an injury to a resident for which the resident was transferred to hospital and resulted in a significant change in condition. The CIR indicated on a specified date and time, resident #002 had an unwitnessed fall in a specified area. The RPN suspected an injury to a specified area and the resident was transferred to hospital for assessment and was diagnosed with an injury to a specified area.

Review of the health care record for resident #002 indicated prior to the last fall with injury, the resident was ambulatory with the use of a mobility aid and required two staff assistance with all transfers.

Review of the progress notes for resident #002 indicated the resident had sustained a number of falls on specified dates and times. All of the falls occurred in a specified area and occurred as a result of the resident attempting to self-transfer. After the second last fall, an alarming device was to be implemented. There were no new interventions identified to prevent a recurrence, until the last fall when the resident sustained an injury to a specified area.

During an interview with PSW #107, they indicated resident #002 used a mobility aid for mobility, required two staff assistance and the use of a mechanical device with all transfers. The PSW indicated the resident was at risk for falls and had a number of fall prevention interventions in place. The PSW indicated no awareness of any alarming device in place prior the resident's last fall that resulted in an injury.

During an interview with RPN #104, they identified a number of falls prevention interventions that were readily available in a specified area, on each unit. The RPN identified additional interventions to be considered for residents at risk for falls. The RPN indicated they were working and responded when resident #002 sustained the last fall with an injury, on a specified date. The RPN indicated they found the resident in a specified area complaining of pain to a specified area, after the resident had attempted to self-transfer. The RPN indicated no awareness of an alarming device being in place at that time.

During an interview with RPN #108, they indicated resident #00 was at risk for falls, would attempt to self-transfer and they had recommended the use of a restraining device with the family but was never implemented. The RPN indicated after the last fall, the resident had a number of falls prevention interventions implemented. The RPN confirmed they were working when the resident sustained the fall that resulted in an injury to a specified area and had no awareness of an alarming device in place at the time of the fall.

During an interview with the ADOC, they confirmed they were the lead for the falls prevention team. The ADOC indicated the team was interdisciplinary and met weekly to discuss falls that had occurred that week, contributing factors, interventions to be put in place for falls prevention or injury reduction and the meetings were documented. The ADOC identified a number of falls prevention equipment that was available for falls prevention and injury reduction. The ADOC indicated at the falls prevention meeting after the residents second last fall, they determined resident #002 was to have an alarming device implemented on a specified date. The ADOC also confirmed that the other falls prevention interventions were not implemented until after the resident sustained the last fall that resulted in an injury to a specified area.

The licensee had failed to ensure that when resident #002 was being reassessed related to falls, the plan of care was revised because care set out in the plan has not been effective and different approaches were considered in the revision of the plan of care.

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 the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care, 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 :

The licensee has failed to ensure that a resident was protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A critical incident report (CIR) was submitted to the Director for a fall incident that resulted in an injury for which the resident was transferred to hospital and resulted in a significant change in condition. The CIR indicated on a specified date and time, resident #006 had sustained a fall in a specified area. The resident was transferred to hospital the following day and diagnosed with an injury to a specified area.

Observation of resident #006 on various dates and times by Inspector #111, indicated the resident was utilizing a specified mobility aid.

Review of the home's investigation by Inspector #111 indicated on a specified date and time, resident #006 was abused by resident #007 in a specified area resulting in a fall. PSW #113, PSW #114 and RPN #115 all confirmed that resident #006 had sustained a second fall, the same shift. RPN #115 confirmed the second fall was not documented, there was no post fall assessment completed and the physician and SDM was not notified when the resident had a significant change in mobility. RPN #116 confirmed the resident was previously independently mobile prior to the fall and indicated on their shift, the resident required the use of a mobility aid, a mechanical device for transfers and remained in bed for a specified period of time, which was unusual. The RPN confirmed they did not complete a full assessment of the resident despite a significant change in their mobility status.

During an interview with PSW #113, they indicated they were very familiar with resident #006 and prior to the fall on a specified date, the resident walked independently. The PSW confirmed they were working on the specified date, when the resident sustained an un-witnessed fall in a specified area. The PSW indicated PSW #114 and RPN #115 were present and responded to the fall. The PSW indicated no awareness of a second fall occurring and confirmed the resident had a significant change in mobility status post

During an interview with RPN #116, they indicated they were very familiar with resident #006 and prior to the fall on a specified date, the resident was independently mobile. The RPN indicated when a resident sustained a fall, the resident was to be assessed by completing a head to toe assessment, completing range of motion (ROM) and vitals to ensure the resident is not in any pain or has any injury. The RPN confirmed they were working the shift after the resident sustained a fall. The RPN confirmed no awareness the resident had sustained two falls on the previous shift. The RPN confirmed the resident had a significant change in mobility status and had increased responsive behaviours. The RPN confirmed the resident remained in bed the entire shift which was unusual. The RPN confirmed they did not complete a full assessment of the resident, despite the significant change in their mobility status.

The Inspector was unable to speak to PSW #114 or RPN #115.

Observation of the video footage for the specified date and time, in the specified area confirmed what the staff interviews and investigation indicated.

After reviewing the home’s investigation, reviewing the video footage and interviews with staff, resident #006 sustained a fall on a specified date and time, in a specified area as a result of abuse by resident #007. The resident was then transferred manually post fall by PSW #113 and RPN #115. The resident remained in the specified area for a specified time. During a specified period of time, the resident had sustained a second fall and there was no documented evidence of the fall, or to indicate the resident was assessed for pain or injury or who was notified of the second fall. The resident also was noted to have a significant change in mobility status. RPN #115 confirmed they did not report the second fall.

During an interview with the DOC, they indicated when a resident sustains an unwitnessed fall, the staff are to notify the nurse, the nurse is to complete a full assessment to determine any injuries and including ROM. The DOC indicated if there is a suspected injury, then 911 was to be notified, the family and the physician and the resident sent to hospital for assessment. The DOC indicated if the resident has no injury noted, the staff are to use a mechanical device to transfer the resident. The DOC indicated the falls that occurred on a specified date, involving resident #006 did not have those steps taken until the following day and the resident was diagnosed with an injury to a specified area.

The licensee failed to ensure that resident #006 was protected from abuse by resident #007 and neglect by the staff.

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 a resident was protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A critical incident report (CIR) was submitted to the Director for a fall incident that resulted in an injury for which the resident was transferred to hospital and resulted in a significant change in condition. The CIR indicated on a specified date and time, resident #006 had sustained a fall in a specified area. The resident was transferred to hospital the following day and diagnosed with an injury to a specified area. The CIR identified PSW #113, RPN #112 and RPN #115 being present or discovering the incident.

During an interview with PSW #113, they confirmed they were working when resident #006 sustained an un-witnessed fall in a specified area. The PSW indicated PSW #114 and RPN #115 were present and responded to the fall. The PSW indicated the resident was manually transferred post fall, without the use of a mechanical device, as required by the home's policy.

During an interview with RPN #116, they indicated they were working the following shift when resident #006 sustained a fall and had a significant change in mobility. The RPN confirmed no awareness the resident had sustained two falls on the previous shift.

The Inspector was unable to speak to PSW #114, RPN #115 or the student nurse.

Review of the home’s investigation, review of the health care record of resident #006 and review of the video footage of a specified area, on the specified date and time, determined that resident #006 had sustained an un-witnessed fall as a result of abuse by resident #007. The resident had been manually transferred post fall by PSW #113 and RPN #115.

During an interview with the DOC, they confirmed that after the un-witnessed fall of resident #006 that occurred on a specified date, time and location, the resident had been manually transferred post-fall by PSW #113 and RPN #115 without the use of the mechanical aid, as required by the home's policy.

The licensee had failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #006, post fall.

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: 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 the resident has fallen, the resident had been assessed and, if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A critical incident report (CIR) was submitted to the Director for a fall incident that resulted in an injury for which the resident was transferred to hospital and resulted in a significant change in condition. The CIR indicated on a specified date and time, resident #006 had sustained a fall in a specified area, was transferred to hospital the following day and diagnosed with an injury to a specified area.

The licensee has a clinically appropriate assessment tool that is completed by the staff after a resident has fallen. The tool includes a head to toe assessment, completing range of motion (ROM) and vitals to ensure the resident is not in any pain or has any injury. There was no assessment conducted for the second fall that occurred on the same day.

During an interview with PSW #113, they confirmed they were working on a specified

date when resident #006 had sustained a fall in a specified area. The PSW confirmed the resident had a significant change in mobility status post fall. The PSW denied awareness of the resident sustaining a second fall.

During an interview with RPN #116, they confirmed they were working the following shift that resident #006 had a sustained a fall. The RPN confirmed the resident had a significant change in mobility status, had remained in bed for most of the their shift which was unusual and had increased responsive behaviours. The RPN confirmed no awareness the resident had sustained more than one fall on the previous shift. The RPN confirmed they did not complete a full assessment of the resident despite the resident having a significant change in their mobility status.

The Inspector was unable to speak to PSW #114 or RPN #115.

After reviewing the home’s investigation, reviewing the video footage and interviews with staff, indicated that resident #006 sustained a fall on a specified date and time, in a specified area, after being abused by resident #007. A short time later, the resident had sustained a second fall due to changes in mobility status after the first fall and there was no documented evidence of the second fall, or to indicate the resident was assessed for pain or injury post fall.

Observation of the video footage confirmed what the investigation indicated.

During an interview with the DOC, they indicated when a resident sustained an un-witnessed fall, the nurse was to complete and document a full assessment of the resident, including ROM to determine if any pain or injuries. The DOC confirmed there was no documented evidence of a post fall assessment completed for resident #006, using a clinically appropriate assessment tool as per the home's policy, for the second fall that occurred on the same specified shift. The DOC confirmed the resident was determined the following day, to be found with an injury to a specified area and required transfer to hospital.

The licensee had failed to ensure that when resident #006 had fallen, a post-fall assessment had been conducted, using a clinically appropriate assessment instrument that is specifically designed for falls.

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

Issued on this 18th day of February, 2020

[redacted]

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

Original report signed by the inspector.