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
Jul 24, 2020	2020_816722_0009	009209-20, 009330-20	Critical Incident System

Licensee/Titulaire de permis

Gem Health Care Group Limited
470 Raglan Street North RENFREW ON K7V 1P5

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

Downsview Long Term Care Centre
3595 Keele Street NORTH YORK ON M3J 1M7

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

COREY GREEN (722)

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): Off-site: May 27-28, 2020; June 1-5, 8-12, and 15-16, 2020.

During this inspection, two critical incidents (log #009330-20 and log #009209-20) involving falls were inspected.

This inspection was conducted concurrently with two complaint inspections: #2020_816722_0008 and #2020_816722_0010.

PLEASE NOTE: A Written Notification related to LTCHA, 2007, c.8, s. 6(7) was identified in this inspection and has been issued in Inspection Report 2020_816722_0008, dated July 24, 2020, which was conducted concurrently with this inspection.

During this inspection, the inspector reviewed resident health records (electronic and hard copy); as well as other administrative documents, including relevant policies and procedures, and resident temperature logs.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and residents' family members.

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

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

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when they assisted residents #006 and #007 up from the floor after they sustained falls without using a mechanical lift.

Two separate fall incidents were reported by ADOC #103 to the Ministry of Long-Term Care (MLTC) via the After Hours Infoline on specified dates. In one report, resident #006 fell and sustained an injury that required hospitalization. In the other, resident #007 fell and died several hours later for unrelated reasons.

Review of the Fall Prevention and Management policy (Policy #NM-II-F005), Effective Date: November 2019, indicated that after a fall incident, the registered staff will examine the resident for injuries prior to moving the resident, check vital signs, apply first aid as required, and use a mechanical lift to move the resident to their bed to proceed to do a further assessment.

(A) Review of the progress notes and post fall assessments in PointClickCare (PCC) for resident #006 indicated that the resident sustained two falls on consecutive specified dates. In both cases, the falls were unwitnessed, the resident was found sitting on the floor in their room, and registered staff assessed the resident and determined that they did not have any apparent injuries. The day after the second fall, it was identified that the resident sustained an injury and they were transferred to the hospital for specified treatment. In both post fall assessments, registered staff documented that the resident was assisted off the floor by two staff, but the manner of transfer was not specified.

Review of the care plan for resident #006 indicated that they required a specified level of assistance for transferring due to a previous identified injury. It also indicated that the resident required a specified device for mobility. The physiotherapy focus area identified that the resident had certain issues with strength and balance, and was at a specified risk for falls.

RPN #129 indicated in an interview that they had attended to resident #006 after the first fall. They confirmed that the resident was assessed and no post fall injuries were identified. They explained that four staff took each extremity and lifted the resident off the floor, and placed them in their bed. RPN #129 was not aware that the Falls Prevention and Management policy in the home required staff to use a mechnical lift to transfer residents from the floor post fall.

RPN #142 indicated in an interview that they had attended to resident #006 after the second fall. They confirmed that the resident was assessed and that they did not identify any post fall injuries. The RPN explained that the resident at the time required a specified level of assistance for transferring, and explained that they and another staff person lifted the resident off the floor, and placed them on another specified surface. RPN #142 was

also not aware that the Fall Prevention and Management policy indicated that residents should always be transferred off the floor with a mechanical lift post fall.

(B) Review of the progress notes and post fall assessment in PCC for resident #007 confirmed that the resident sustained a fall on a specified date and time when they were found on the floor beside their bed. The post fall assessment did not specify how the resident was assisted off the floor post fall.

Review of resident #007's care plan identified that the resident required a specified level of assistance with transferring and mobility in the home.

RPN #113 was interviewed and indicated that they discovered resident #007 on the floor beside their bed. They indicated that they completed the post fall assessment, and did not identify any injuries as a result of the fall. The RPN said that they, and another staff person that they could not recall, assisted the resident off the floor and onto another surface. RPN #113 indicated that they were not aware that a mechanical lift was required to assist a resident off the floor after a fall; they understood that the resident could be assisted based on the transfer status specified in their care plan.

RPN #139, the Falls Lead, indicated during an interview that the expectation after a fall was that registered staff needed to assess the resident, and that they may transfer the resident off the floor into their bed or wheelchair once it has been determined that they do not have an injury. The RPN indicated that, according to the policy, residents should always be transferred by two staff using a mechanical lift to ensure resident safety.

ADOC #103 also indicated that the staff were expected, for resident safety and according to the home's Fall Prevention and Management policy, to use a mechanical lift and two staff assist to transfer residents from the floor to their bed after a fall for further assessment.

The evidence above shows that safe transferring techniques were not used for residents #006 and #007 when they were lifted off the floor by staff after sustaining falls without the use of a mechanical lift. [s. 36.]

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 #2: 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 has failed to ensure that when resident #007 fell, that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

An incident was reported by ADOC #103 to the MLTC After Hours InfoLine which indicated that resident #007 sustained a fall on a specified date and died several hours later due to unrelated causes.

Review of the progress notes confirmed that the resident sustained the fall and a post fall note entered in PCC by RPN #113 indicated the date and time of the fall, that it occurred in the resident's room, and the resident was seen sitting on the side of their bed holding the side rails. RPN #113 indicated that they observed a previous specified injury, and indicated 'No' for witnessed or unwitnessed. The remaining fields in the post fall progress note were blank, including pain assessment, vital signs, medications that may put the resident at risk for bleeding, signs of stroke, if the Head Injury Routine (HIR) was completed, factors contributing to fall (e.g., mobility device, footwear, etc.), how the resident was transferred from the floor, history of falls, use of restraint, transfer to

hospital, notification of family member, physician notification, immediate actions taken, any referrals made, and revisions to the resident's care plan. The post fall progress note in PCC was incomplete.

Incident reports in the Risk Management module of PCC were also reviewed to determine if assessment findings, factors that contributed to the fall, and immediate actions taken were documented; an incident report was not completed for resident #006's fall.

RPN #113 was interviewed and confirmed that they were working on the shift when the resident fell but were not assigned to the unit where resident #007 resided. They explained that they were passing the resident's room and for specified reasons, entered the room, and observed the resident sitting on the floor beside their bed. RPN #113 indicated that they assessed the resident and took their vital signs at the time of the fall. They indicated that they documented the resident's vital signs in the HIR record, which was confirmed on record review. The RPN acknowledged that they did not complete the post fall assessment as required by the home, and left most fields blank; they stated they were not the assigned nurse for the resident.

In separate interviews with ADOC #103 and RN #139, the home's Falls Lead, they both confirmed that the post fall assessment in PCC should be used to document resident assessments after they sustain a fall, and that the incident report in Risk Management should also be completed. They both acknowledged that the fields in the post fall assessment tool were required and not completed for resident #007 after their fall.

The evidence shows that a post fall assessment was not completed using a clinically appropriate tool, when the post fall assessment tool available in PCC was not completed as required after resident #007 sustained their fall. [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 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, to be implemented voluntarily.

WN #3: 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 that, where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a strategy, the strategy was complied with.

Under O. Reg. 79/10, s. 48.(1) 1., every licensee shall ensure that an interdisciplinary falls prevention and management program was developed and implemented in the home to reduce the incidence of falls and the risk of injury. According to O. Reg. 79/10, s. 49. (1), the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the licensee's Fall Prevention and Management policy (Policy #NM-II-F005), Effective Date: November 2019, which indicated that registered staff must take the following actions in the management of a fall incident:

- Implement the head injury routine (HIR) when the resident was on specified treatment and the fall was unwitnessed;
- Use a mechanical lift to move the resident to his/her bed to proceed to do a further assessment; and
- Notify the family of the incident.

(i) Review of the post fall assessments in the progress notes indicated that resident #006 sustained two falls on consecutive days. In both cases, the post fall assessment indicated that the resident was found by staff on the floor in their room and the fall was unwitnessed. Review of the post fall assessment and resident #006's Medication Administration Record (MAR) indicated that the resident was receiving a specified medication that required a post fall HIR record to be completed.

Resident #006's HIR record was reviewed; it was initiated after the first fall and was completed at specified intervals over a 24-hour period as per the Head Injury policy (Policy #NM-II-H010), Effective Date: November 2019. However, the HIR was not re-initiated after resident #006's second fall the following day and a progress note on a specified date and time indicated that the HIR was no longer in progress.

In separate interviews, ADOC #103 and the Falls Lead, RPN #139, indicated that the expectation according to the Fall Prevention and Management policy was that the HIR should have been initiated again after the second unwitnessed fall for the 24 hour duration as per the Head Injury policy.

(ii) For both falls involving resident #006, the post fall assessments and staff interviews indicated that a mechanical lift was not used to assist the resident off the floor as required under the home's Falls Prevention and Management policy. Similarly, a staff interview supported the finding that a mechanical lift was not used to assist resident #007 off the floor after their fall on a specified date.

ADOC #103 and RN #139, the Falls Lead, both indicated in separate interviews that the home's Fall Prevention and Management policy was not followed when staff failed to use a mechanical lift to assist residents #006 and #007 off the floor after they sustained falls. See detailed findings in this report under O.Reg. 79/10, s. 36.

(iii) The post fall assessment for resident #006's first fall was blank where the name, date and time that the substitute decision maker (SDM) was notified of the fall was to be entered.

During an interview with resident #006's SDM, they indicated that they were notified of the resident's second fall but they were not aware until contacted for this inspection that the resident had also sustained a fall the previous day.

In separate interviews, ADOC #103 and RPN #139, the Falls Lead, both indicated that resident #006's SDM should have been notified of the initial fall as per the home's Falls Prevention and Management policy.

The evidence above supports the finding that the licensee failed to follow their Fall Prevention and Management policy for residents #006 and #007 when the HIR was not re-initiated after resident #006's second fall; the SDM was not notified of resident #006's first fall the previous day; and a mechanical lift was not used by staff to assist residents #006 and #007 off the floor after both falls. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: 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 has failed to make a report in writing to the Director that set out the

details required under O. Reg. 79/10, s. 107.(4), clauses 1. to 5., within 10 days of becoming aware of the incident, for an incident where resident #006 sustained an injury due to a fall that resulted in hospitalization and a significant change in the resident's condition.

An incident was reported by ADOC #103 to the MLTC via the After Hours InfoLine, which indicated that resident #006 had sustained a fall on a specified date; an injury was identified the following day and the resident was sent to hospital for specified treatment. The InfoLine report was reviewed, which indicated the date and time of the incident, the name of the resident involved, that the resident had an unwitnessed fall, that specified testing was done in the home which identified an injury, and the resident was sent to hospital. There were no other details of the incident in the report.

Inspector #722 reviewed the Long-Term Care Home Portal and, as of June 16, 2020, was unable to identify a Critical Incident System (CIS) report for the incident that involved resident #006's injury and hospitalization.

Review of the progress notes and post falls assessments in PCC for resident #006 indicated that the resident had sustained two falls on consecutive days. After both falls, the post fall assessment completed by registered staff indicated that there were no apparent injuries. For specified reasons, the resident was referred to the physician on the day of the second fall, who ordered specified testing. An injury was identified the following day and the resident was sent to the hospital where they received specified treatment.

An assessment by Physiotherapist (PT) #143 was reviewed which was completed the day after the second fall. PT #143 identified signs and symptoms of a specified injury in their assessment. They specified interventions to reduce the risk of further injury while in the home. The identified injury that was diagnosed in the home the day after resident #006's second fall, PT #143's assessment and interventions, and the transfer to hospital for further treatment, supports the finding that resident #006 had an injury that resulted in a significant change in their health condition.

ADOC #103 confirmed during an interview that resident #006 likely acquired the specified injury during one of the falls, had a significant change in their health status, and that a CIS report was never completed for the incident.

The licensee has failed to make a report in writing for an incident where resident #006

sustained an injury due to a fall that resulted in hospitalization and a significant change in their health condition. [s. 107. (4)]

Issued on this 5th day of August, 2020

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

Original report signed by the inspector.