Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 15, 2015 | 2015_284545_0012 | O-000387-14, O-001287-14, O-001349-14 | Critical Incident System |

### Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

CENTRE D'ACCUEIL CHAMPLAIN
275 PERRIER STREET VANIER ON K1L 5C6

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

ANGELE ALBERT-RITCHIE (545)

### 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): June 2, 3 and 4, 2015**

**During the course of the inspection, the inspector(s) spoke with the Administrator, two Resident Care Managers, RAI Coordinator, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Care Worksers (PSW), a family member, and Residents.**

**The inspector also conducted a tour of two resident care areas, observed Residents' rooms, observed Resident common areas, reviewed resident health records, the home's Fall Prevention Program, and observed delivery of Resident care and services.**

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

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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 did not ensure that 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, is complied with, in that the home failed to ensure compliance with the following program:

• Falls Prevention Program, March 2014, including the Falls Prevention Program: Resident Assessment for Falls Tool (RAFT), AP & OP No: 315.08, September 2013

As per O.Reg 79/10, s. 48 (1) 2, every licensee of a long-term care home shall ensure that the following interdisciplinary programs is developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury, and s. 48 (2) whereby each program must, in addition to meeting the requirements set out in section 30, (a) provide for screening protocols; and (b) provide for assessment and reassessment instruments.

The home's Falls Prevention Program: Resident Assessment for Falls Tool (RAPF), items 2 and 3, under section Operational Procedure, indicates that the registered staff will:

Item 2: Host a post fall meeting (Huddle) and complete the Huddle form on the shift when the fall occurred. In the event of an unwitnessed fall, head injury will be assessed and neuro vital signs will be taken.

Item 3: Complete the RAFT when the condition or circumstances of the resident require: upon admission, where there is an injury from falling requiring hospitalization and if the resident has more than 2 falls in a 1 week (7 days) period

During an interview with the Resident Care Manager #S101 on June 4, 2015, she indicated that the "Huddle form" was the home's paper format of the post-fall assessment tool and that the registered staff were expected to complete one each time a Resident had a fall, witnessed or unwitnessed.

Critical Incident Reports for three Residents were reviewed by the Inspector. All three critical incidents related to a fall causing injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health

condition.

Related to Intake #O-000387-14, for Resident #001:

Resident #001 was admitted to the home on a specific date in August 2012 with multiple medical conditions, including Alzheimer's Disease. The Resident was assessed with an unstable gait and was provided with a walker for ambulation on the unit, although was known to forgetting to use it.

A completed Falls Risk assessment (RAFT) was reviewed by the Inspector; it indicated that Resident #001 was at moderate risk (score of 9) for falls due to unstable gait, requiring supervision when using a mobility aid, requiring to void at least twice per night. The RAFT was not dated or signed.

A review of Resident #001's most recent Falls Prevention Resident Assessment Protocol (RAP) was conducted by the Inspector. The following fall triggers were identified: wandering, use of antidepressants, possibility of hypotension due to use of psychotropic medications, unstable gait, and previous falls in past 180 days (2 falls without injury).

Upon review of the Resident's health record, two incidents were noted where a post-fall assessment (Huddle form) was not completed as per the home's policy:

• Fall #1 - a specific date in April 2014: Resident #001 was found on the floor in the corridor in front of his/her room, screaming "Help", a head injury (laceration and hematoma) was observed with moderate amount of bleeding, the site was opened, and soft to touch. The Resident was alert, incoherent and confused. The Resident was transferred to the hospital via ambulance for sutures. Cognitive impairment (delirium/confusion) was identified as a factor. Notes indicated that the Resident was placed in a Broda chair with a temporary restraint upon return from hospital for closer monitoring. The notes indicated that the Resident was observed walking on the unit without the use of his/her walker on four different dates between return from the hospital and a second fall (described below). Notes indicated that the Resident refused to use the walker, made attempts to sit on the seat of the walker without putting the brakes. A note indicated that the Resident was at high risk for falls.

• Fall #2 - 8 days after Fall #1: Resident #001 was found in bed, complaining of pain to the right arm, blood on the bed sheets and on his/her pyjama top was observed, as well as bruising. The Resident was changed due to bladder incontinence, the nurse in charge

was notified and after assessment, dressings were applied. Cognitive impairment was identified as a factor. The Resident complained of pain, pain medication, including narcotic was administered regularly to manage pain. Two and three days post injury, notes indicated that the Resident was complaining of pain; an x-ray was done 4 days post injury. Resident #001 was no longer walking due to pain. The results of the x-ray showed a fracture, the Resident was transferred to hospital via ambulance for surgery, 6 days post injury.

During an interview with RN #S103 on June 03, 2015, she indicated that a post-fall assessment was done each time a Resident fell, added that the assessment helped the staff understand why the Resident fell, and the information was used to update the plan of care in adding strategies to prevent further falls. The RN indicated Resident #001 fell often last year because he/she would forget to use the walker, but that presently as the Resident was wheelchair bound, he/she no longer fell.

During an interview with RPN #S108 on June 4, 2015, she indicated that each time a Resident fell, a head to toe assessment was conducted, the doctor was advised, and an incident report and Post-Fall assessment was completed. She indicated she did not remember the incidents of falls in April 2014, but remembered that Resident #001 was at high risk for falls, and because of those falls causing injury the Resident no longer ambulated with a walker, was now wheelchair bound, and exhibited fear of falling. RPN #S108 was unable to provide documented post-fall assessments for the fall that occurred on a specific date in April 2014 and the unwitnessed incident with injury of a specific date in April 2014 which resulted in a fracture.

The RPN was unable to find documented post-fall assessments for falls that occurred on two separate dates in April 2014. [s. 8. (1) (a),s. 8. (1) (b)]

2. Related to Intake #O-001287-14, for Resident #002:

Resident #002 was admitted to the home on a specific date in May 2014 with dementia and other health conditions. The Resident was assessed with an unstable gait (October 2014) and used a walker for ambulation on the unit, requiring extensive assistance of one person.

A Falls Risk assessment (RAFT) completed upon admission was reviewed by the Inspector; it indicated that Resident #002 was at moderate risk (score of 4) for falls due to use of psychotropic medications, cognitive loss and non-compliance related to

requesting assistance, following instructions or decreased ability to pay attention to his/her environment.

Upon review of the Resident's health record, four (4) falls were noted within a 9 day period, where a post-fall assessment (Huddle form) was not completed as per the home's policy:

• Fall #1 - a specific date in October 2014: Resident #002 was found on the floor on his/her back between the bed and the bathroom. The Resident was trying to get to the bathroom and fell out of bed. Cognitive loss and unstable gait were identified in the note as factors, as well as a need of assistance when using the walker. Following head to toe assessment, no injury was noted.

• Fall #2 - 2 days after fall #1: Resident #002 was found on the floor on his/her back near the nursing station. The Resident was trying to sit in a chair and missed. Cognitive loss and unstable gait were identified in the note as factors, as well as a need for assistance when using the walker. Following head to toe assessment, no injury was noted. On the same date the Resident was started on antibiotics to treat a lung infection.

• Fall #3 - 5 days after fall #2: Resident #002 was found by another resident, on his/her knees by the bed. The Resident was confused and unable to explain what happened. The Resident was lifted back to bed by 3 staff using a mechanical lift. The Resident was encouraged to call for assistance using the call bed. Following head to toe assessment, no injury was noted.

• Fall #4 - 3 days after fall #3: Resident #002 was found on the floor on his/her left side in the room, after staff heard a loud noise and screaming. The Resident's legs were bent, complained of severe pain and having difficulty moving. The Resident was transferred to hospital via ambulance as the nurse suspected a fracture. The Resident returned from the hospital the next day with a fracture, returned to the hospital 3 days later with severe pain. The Resident passed away in hospital from lung and cardiac conditions as per a physician's note, 6 days post-fall.

On June 3, 2015 during an interview with PSW #S105, she indicated that she remembered that Resident #002 was at risk for falls, that he/she had a walker but often didn't use it, added that the Resident had several falls until he/she passed away, after one of the falls.

During an interview with RPN #S104 on June 3, 2015 she indicated that she was responsible in completing a post-fall assessment using the post-fall assessment form each time a Resident fell, added that if a Resident fell three times in one day, 3 post-fall assessments would be completed. She further indicated that a copy of the completed post-assessment falls forms was sent to the Administrator, both Resident Care Managers and the RAI Coordinator and the original was kept in the Resident's paper chart. The RPN indicated that Resident #002 was at risk for falls because he/she was taking psychotropic medications and that he/she required monitoring especially when he/she went to the bathroom, added that the Resident was able to transfer in and out of bed on his/her own when was admitted in May 2014. The RPN further indicated that a fall mat would probably not have been used because they were rarely used on this specific unit due to many residents wandering in other resident's room and they could become a tripping hazard.

The RPN was unable to find documented post-fall assessments for falls that occurred on 4 different dates in October 2014, or a documented Resident Assessment for Falls Tool (RAFT) showing reassessment of fall risks for Resident #002, as per the home's policy.

On June 3, 2015, during an interview with Resident Care Manager #S102, she indicated that after 3 falls, a post-fall assessment should have been conducted. She indicated that Resident #002 had a pulmonary infection and was treated with antibiotics, added that the falls were due to an acute health condition. The Resident Care Manager indicated that the Resident was not known to falls prior to having falls in October 2014, and was identified as being at Moderate Risk for Falls. [s. 8. (1) (a),s. 8. (1) (b)]

3. Related to Intake #O-001349-14, for Resident #003:

Resident #003 was admitted to the home on a specific date in January 2013. The Resident was diagnosed with several medical conditions including dementia. The Resident was taking an anticoagulant medication daily. On a specific date in October 2014, the Resident was assessed with an unstable gait, used a walker, required assistance for transfers, and was identified with one fall in the last 31 to 180 days.

Upon review of the Resident's health record, three (3) falls were noted within a 3 day period, a Resident Assessment for Falls Tool (RAFT) to reassess Resident #003's risk for falls was not found, as per the home's policy:

• Fall #1 - a specific date in November 2014: Resident #003 was found on the floor, after

breakfast. The Resident was attempting to place a cup of coffee on the seat of his/her 4-wheel walker, and when the cup spilled over the Resident slipped and fell. No injury was noted and the resident was encouraged to finish his/her meal at the Dining Room.

• Fall #2 - on same day as Fall #1, approximately 1 hour later: Resident #003 was found lying on his/her right side on the floor in front of the television in the small lounge closest to the Resident's bedroom. The Resident was anxious, requesting assistance from staff. The Resident was transferred to the Lazy-Boy chair, and upon assessment a head injury was observed: a bump on the right side of head, ice was applied and vital signs done. The Resident was alert. The following day, the Resident was started on antibiotics to treat an infection.

• Fall #3 - 3 days after Falls #1 and #2: Resident #003 was found on the floor in his/her bedroom with both legs bent backward and his/her head lying on the side of the bed. The Resident was transferred to bed by three staff, alert but unable to respond to questions coherently. Following head to toe assessment, no injury was noted. The following day, a note indicated that the Resident was complaining of hip pain, was very unstable on his/her feet with difficulty in weight-bearing. The Resident was transferred to hospital on that same day, and again the following day for further investigation. The Resident was diagnosed with a traumatic brain injury and a fracture.

On June 4, 2015 during an interview with RPN #S108, she indicated that Resident #003 was not identified at risk for falls prior to falling three times in November 2014 who added that the Resident walked with a walker. The RPN indicated that when the Resident fell the first time in November 2014, it occurred because his/her cup of coffee had spilled and it caused the Resident to lose his/her balance and fall. RPN #S108 indicated that at that time the Resident required minimal assistance with his/her ADL, but after the third fall in November 2014, due to a stroke, the Resident's condition changed significantly, and now no longer walks, requires a 2-person transfer and is wheelchair bound. The RPN further indicated that the Resident started to spend most of his/her time in bed, except for meals.

The RPN was unable to find a documented Resident Assessment for Falls Tool (RAFT) showing reassessment of fall risks for Resident #003, as per the home's policy, following three falls in November 20, 2014.

During an interview with the Resident Care Manager #S101 on June 4, 2015 she indicated that she was aware that the registered staff had not been compliant with the

home's Fall Prevention policy, such as completing a post-fall assessment after each fall and completing a Fall Risk Assessment if the resident had more than 2 falls in a week (7 days) period. She indicated that the home had initiated recently (May 2015) a new tracking system for falls and closer monitoring. [s. 8. (1) (a),s. 8. (1) (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 all staff comply with the home's Falls Prevention Program, to be implemented voluntarily.***

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**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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, when an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Resident #001:
Resident #001 was admitted to the home on a specific date in August 2012 with multiple medical conditions, including Alzheimer's Disease. The Resident was assessed with an unstable gait and was provided with a walker for ambulation on the unit, although was known to forgetting to use it.

Upon review of the Resident's health record, it was noted that on a specific date in April

2014, Resident #001 was found on the floor in the corridor in front of his/her bedroom, screaming "Help", a head injury (laceration and hematoma) was observed with moderate amount of bleeding, the site was opened, and soft to touch. The Resident was alert, incoherent and confused. The Resident was transferred to the hospital via ambulance for sutures. Cognitive impairment (delirium/confusion) was identified as a factor. Notes indicated that the Resident was weak, unstable on his/her feet, had decreased appetite when the Resident returned from hospital on the day of the incident.

No Critical Incident Report (CIR) was submitted to Director as per regulations.

Resident #003:
Resident #003 was admitted to the home on a specific date in January 2013. The Resident was diagnosed with several medical conditions including dementia and stroke with hemiplegia. The Resident was taking an anticoagulant medication daily. On a specific date in October 2014, the Resident was assessed with an unstable gait, used a walker independently, and required assistance of one person for transfers.

Upon review of the Resident's health record, it was noted that a specific date in November 2014, Resident #003 was found on the floor in his/her bedroom with both legs bent backward and his/her head lying on the side of the bed. The Resident was transferred to bed by three staff, alert but unable to respond to questions coherently. Following head to toe assessment, no injury was noted. The following day, a note indicated that the Resident was complaining of hip pain, was very unstable on his/her feet with difficulty in weight-bearing. The Resident was transferred to hospital on that same day, and again the following day for further investigation. The Resident was diagnosed with a traumatic brain injury and a fracture. Post incident, the Resident was put on bedrest to decrease inflammation, and within 3 days post fall, the Resident was wearing an incontinent product for bladder incontinence, was unable to feed self due to inability to bring his/her right hand to his/her mouth, and inability to move his/her right leg on own.

A Critical Incident Report (CIR) was submitted to the Director 5 days after Resident #003 was taken to a hospital for a fall that had occurred the day before, and that resulted in a significant change in the resident's health condition.

During an interview with Resident Care Manager #S101 on June 8, 2015 she indicated that it was the responsibility of the management team to notify the Director when an incident that caused an injury to a resident for which the resident was taken to a hospital

and that results in a significant change in the resident’s health condition. The Resident Care Manager confirmed that the Director was not informed, when Resident #001 was taken to hospital on a specific date in April 2014 following a fall which resulted in a head injury. In regards to Resident #003, the Resident Care Manager confirmed that the Director was not immediately informed, when Resident #003 sustained a fall on a specific date in November 2014. She indicated that the Resident was transferred to the hospital one day post-fall for investigation and returned the following day with a significant change in her health condition with a diagnosis of traumatic brain injury and a fracture. The Resident Care Manager confirmed that there had been a delay in notifying the Director. [s. 107. (3) 4.]

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**Issued on this 16th day of June, 2015**

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

**Original report signed by the inspector.**