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 5, 2020	2020_816722_0001	021094-19, 021887-19	Critical Incident System

Licensee/Titulaire de permis

Elm Grove Living Centre Inc.
35 Elm Grove Avenue TORONTO ON M6K 2J2

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

Elm Grove Living Centre
35 Elm Grove Avenue TORONTO ON M6K 2J2

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): January 6-9, 2020

During this inspection, the following intakes were inspected:
- Log #021094-19 to follow-up Compliance Order #001 related to staffing in the home from inspection #2019_616722_0020, with a Compliance Due Date of December 20, 2019.
- Log #021887-19 for a critical incident involving a fall resulting in injury.

During this inspection, the inspector reviewed resident health records and relevant administrative documents (e.g., policies and procedures, staff timesheets, personnel files, etc.), and made observations of residents, staff-to-resident interactions, and resident home areas.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant/Acting Director of Care (ADOC), the Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a private caregiver, a family member, and residents.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Falls Prevention
Sufficient Staffing

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)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 213. (1)	CO #001	2019_616722_0020	722

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 2007, c. 8, s. 6 (4).
(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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #001 that set out clear directions to staff and others who provided direct care to the resident related to transfers.

A critical incident system (CIS) report was received by the Ministry of Long-Term Care (MLTC) for resident #001, who sustained an injury that resulted in hospitalization. The resident sustained two separate falls on two specified dates within 48 hours and the specified injury was identified a period of time after the falls.

Resident #001's care plan was reviewed related to the resident's transfer status and over identified periods conflicting transfer methods were specified in the Physiotherapy (PT) and Transfer Focus Areas.

Inspector #722 observed in resident #001’s room that there was an identified type of transfer equipment, as well as a logo above their bed that identified a particular transfer method.

Physiotherapist (PT) #116 was interviewed and indicated that they assessed resident #001 on a specified date, and confirmed that the resident could transfer as indicated in the care plan. The PT confirmed that they assessed the resident on a later specified date, after resident #001 sustained an injury, and indicated that at the time they felt the resident required a higher specified level of support for transferring. The PT indicated that their expectation was that when they updated the care plan with their recommended intervention for transfers, that the direct care staff would implement the intervention as specified in the care plan. They were not aware that the care plan had different transfer methods identified in the Transfer Focus Area.

The resident’s family member, private companion, and PSW #118 were interviewed separately, and they all indicated that the resident had never been transferred with the method specified in the PT Focus Area of the resident's care plan after the resident sustained an injury. PSW #118 also indicated that they had transferred the resident using a specified method that differed from the method specified in the Transfer section of the care plan, as well as the logo posted above the resident's bed, and that they were not aware that the resident's care plan indicated that a different level of support was required.

ADOC #110 and RPN #103, the Falls Prevention Lead, were interviewed separately, and both acknowledged that the plan of care provided conflicting directions to staff related to transfer methods for resident #001. Neither were aware that the resident’s care plan indicated that the resident was to be transferred with the method specified by PT #116 after the resident's identified injury.

The ADOC indicated that the expectation was that residents’ transfer interventions should be determined based on the PT’s assessment, the PT should communicate the transfer status to the registered staff and PSWs, and it should be documented in the Interventions section of the Transfer Focus Area in the care plan. The ADOC acknowledged that resident #001's plan of care was unclear related to transfer status. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different

aspects of care of resident #001 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A CIS report was received by the MLTC for resident #001, who sustained an injury that resulted in hospitalization. The resident sustained two separate falls on two specified dates within 48 hours and the specified injury was identified a period of time after the falls.

Resident #001's care plan was reviewed and conflicting interventions were identified related to the resident's transfer status over specified periods in the Physiotherapy and Transfer Focus Areas. On a specified date, the PT Focus Area of the care plan had been revised to indicate that resident #001 required a higher level of support with transfers, which was different than the transfer method specified in the Transfer Focus Area of the care plan at that time.

The PT assessments were reviewed and indicated that the PT had assessed the resident on two specified dates after their injury was identified, and indicated that the resident required a specified level of support for transfers. Progress notes were reviewed over the same specified period, and there were no entries identified that indicated PT #116 had discussed with registered staff or PSWs the revision to resident #001's care plan related to their transfer status.

Physiotherapist (PT) #116 was interviewed and indicated that they assessed resident #001 on the two specified dates after the specified injury was identified and indicated that at the time they felt the resident required a higher level of support for transferring as specified in the PT Focus Area of the care plan. They could not recall if they had notified the registered staff or PSWs of the new transfer status but indicated that they usually mentioned it to registered staff. The PT indicated that their expectation was that when they updated the PT Focus Area of the care plan with their recommended intervention for transfers, that the direct care staff would implement the intervention as specified in the care plan. They were not aware that the care plan had different transfer methods identified in the Transfer Focus Area.

The resident's family member, private companion, and PSW #118 were interviewed separately, and they all indicated that the resident had never been transferred with the method specified by PT #116. PSW #118 also indicated that they had transferred the resident with a specified level of support that was not identified in either the PT or

Transfer Focus Areas of their care plan, and that they were not aware that the care plan indicated that the resident was to be transferred as specified by the PT.

RPN #103, the home's Falls Prevention Lead, was interviewed and confirmed that the home's PT was responsible for determining residents' transfer status and communicating it to registered staff. They indicated that if the resident required two different transfer methods depending on their condition, two logos should have been posted by the PT above the resident's bed which indicated that both transfer methods may be used. They indicated that the range of support a resident required should be specified in the care plan, but that the Physiotherapy and Transfer Focus Areas of the care plan in the electronic health record should be consistent. RPN #103 acknowledged that there was a breakdown in communication with registered staff when the PT indicated that the resident required an identified method for transfers on two specified dates, and acknowledged that the home needed to implement a process to ensure that the PT was communicating changes in the transfer method to direct care staff.

ADOC #113 was interviewed and acknowledged that there was conflicting information in the Physiotherapy and Transfer Focus Areas of resident #001's care plan. They indicated that the PT was responsible for determining the appropriate transfer status for residents and communicating their recommendation to the registered staff. ADOC #113 indicated that they expected the PT to communicate their recommendation to direct care staff, and to make a note in the progress notes so that it showed up in the 24-hour report. They also expected that the PT should enter their recommended transfer method under Interventions in the Transfer Focus Area of residents' care plans.

ADOC #113 acknowledged that PT #116 had not collaborated with registered staff when they revised their recommended transfer method for resident #001 and, as a result, there were inconsistencies in the resident's plan of care related to their transfer status. [s. 6. (4) (b)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A CIS report was received by the MLTC for resident #001, who sustained an injury that resulted in hospitalization. The resident sustained two separate falls on two specified dates within 48 hours and the specified injury was identified a period of time after the falls.

During observation of resident #001’s room, a logo was identified above the resident’s bed that specified a particular transfer method and specified transfer equipment was identified.

Resident #001’s care plan was reviewed and conflicting interventions were identified related to the resident’s transfer status in the PT and Transfer Focus Areas, as detailed in findings above.

The resident’s family member, private companion, and PSW #118 were interviewed separately, and they all indicated that the resident had never been transferred with the method specified by PT #116 in the PT Focus Area of the care plan, and they were not aware that this method had been recommended by the PT. They all indicated that they had transferred the resident using a method that was not specified anywhere in resident #001's care plan or on the logo posted above the resident's bed. They were all aware that the logo posted above resident #001's bed indicated a specified transfer method, but indicated that on some days the resident tolerated the transfer method they had used. The family member indicated that at times they transferred the resident using a particular method that the inspector identified as presenting actual risk of harm to the resident.

The ADOC and RPN #103, the Falls Prevention Lead, both acknowledged in separate interviews that resident #001 should not have been transferred as described above by the family member, private companion, and staff. They both agreed that, at minimum, the resident required a specified level of support as indicated in the Transfer Focus Area of the care plan and on the logo posted above the resident’s bed. [s. 6. (7)]

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, (i) there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; (ii) staff and others involved in the different aspects of care of the resident collaborate with each other 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; and (iii) the care set out in the plan of care is provided to the resident as specified in the plan, 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:

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 the home’s Falls Management and Prevention Program policy was complied with.

A CIS report was received by the MLTC for resident #001, who sustained an injury that resulted in hospitalization. The resident sustained two separate falls on two specified dates within 48 hours and the specified injury was identified a period of time after the falls.

Under O. Reg. 79/10, s. 48. (1) 1., every licensee of a long-term care home shall ensure that an interdisciplinary falls prevention and management program is developed and

implemented in the home to reduce the incidence of falls and risk of injury. Under O. Reg. 79/10, s. 49. (1), the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate the risk of falls, including the monitoring of residents.

The home's Falls Management and Prevention Program policy, last revised July 2019, was reviewed, and indicated the following:
- Registered nursing staff were to conduct the fall risk assessment in PCC within 24 hours of admission, quarterly, and when a change in health status puts residents at increased risk for falling, such as falls in 72 hours, more than three falls in three months, more than five falls in six months, a significant change in health status, and falls resulting in serious injury.
- Registered nursing staff were to initiate the Head Injury Routine (HIR) for all unwitnessed falls, which was to be completed every half hour for two hours, every one hour for six hours, every four hours for eight hours, and every eight hours for 56 hours.
- Registered staff were to arrange a care conference for residents who fall frequently, as indicated by falls within 72 hours, more than three falls in three months, and more than five falls in six months.

Review of the electronic health record indicated that resident #001 sustained six unwitnessed falls within a specified period of time from admission to the home. The progress notes were reviewed and indicated that after resident #001's first two falls, which occurred within 48 hours of one another, the resident's condition deteriorated and they were diagnosed with an injury a specified period of time after the two falls.

Review of the electronic health record indicated that a falls risk assessment was completed for resident #001 on their admission date, and on a specified date after their injury was identified a specified period of time after the first two falls. There were no other falls risk assessments identified for resident #001 in the electronic health record at the time of inspection.

RPN #103, the Falls Prevention Lead, and ADOC #110, were interviewed separately, and both indicated that the falls risk assessment should have been completed in the electronic health record after the resident sustained the first two falls because they occurred within 72 hours. They also acknowledged that according to the policy, the falls risk assessment should have been repeated after the sixth fall on a later specified date, as the resident had sustained three additional falls within three months.

Review of the progress notes for resident #001 indicated that a Multidisciplinary Care Conference (MDCC) was completed on a specified date, which was identified as the admission care conference. There was no documentation of another MDCC for resident #001 at the time of inspection.

RPN #103 and ADOC #110 confirmed in separate interviews that, according to the home's Falls Prevention and Management Program policy, a care conference should have been arranged for resident #001 after they sustained their first two falls, as the resident had more than two falls in 72 hours, and again after the sixth fall on a specified date, as the resident had sustained more than three falls in three months. They confirmed that no additional MDCCs had been arranged for the resident.

Review of resident #001's health record indicated that the Head Injury Routine (HIR) documentation was not initiated for the second fall that occurred on a specified date, and that the HIR records for the other four falls during the period inspected were not completed as per the policy, due to resident refusing, sleeping, being at meals, or entries were left blank. More detailed descriptions of the missing HIR entries have been included in the finding under O. Reg. 79/10. s. 30. (2) in this report.

The resident sample was expanded to determine the scope of this issue. The progress notes and risk management incident report were reviewed for resident #003 related to falls, which indicated that they sustained an unwitnessed fall without injury on a specified date. The progress notes indicated that the HIR was initiated, but Inspector #722 was unable to locate the HIR record in the health chart, or at the nursing station. ADOC #110 also searched for the HIR record for resident #003's fall and was unable to locate it.

Both RPN #103 and ADOC #110 indicated in separate interviews that the expectation was that the HIR report should be initiated for any unwitnessed fall and completed as per the Falls Management and Prevention Program policy. The ADOC also acknowledged that the HIR was to be completed, even when the resident was attending meals or sleeping, and that certain parts of the HIR could be completed even when the resident refused (e.g., level of alertness, verbal response, etc.).

The information above demonstrated that the licensee did not comply with their Falls Management and Prevention Program policy when the falls risk assessments, MDCC, and HIR records were not completed for resident #001 as per the home's policy, and when the HIR was not initiated for resident #003's unwitnessed fall. [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 where the Act or 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a 24-hour admission care plan was developed for residents #001, #004, and #005 within 24 hours of their admission to the home that included the type and level of assistance required relating to activities of daily living (ADLs).

A CIS report was received by the MLTC for resident #001, who sustained an injury that resulted in hospitalization. The resident sustained two separate falls on two specified dates within 48 hours and the specified injury was identified a period of time after the falls. While reviewing resident #001's health records for this incident, Inspector #722 identified that interventions were not specified on admission to the home in the resident’s care plan related to mobility and transfers.

Review of the electronic health record indicated that resident #001 was admitted to the home on a specified date. Resident #001’s care plan was reviewed and there were no

interventions specified related to mobility, transfer method, or assistance with toileting on admission. Interventions were added to the resident's care plan related to these care areas 19 days after admission to the home.

Resident #001's paper health chart was reviewed, and a New Admission Profile was identified that indicated the admission date; it specified that resident #001 was at risk for falls and identified their mobility at the time of admission. There were no interventions specified for transfers or assistance with toileting. An Admission Care Plan was also identified in the chart for resident #001. It specified the resident's admission date, but there was no date identified when it was initiated. Falls interventions were identified in this document, but there were no interventions specified related to mobility, transfers, or assistance required with toileting.

RPN #103, PSW #118, the resident's family member, and the private companion all indicated in separate interviews that resident #001 was never mobile as specified in the New Admission Profile. They all indicated that during the first month after admission to the home, the resident required a specified level of support by staff or the family member for any mobility outside of the room. This intervention for mobility in the home was never identified in the 24-hour care plan.

The sample was expanded to determine if the 24-hour care plan was developed for residents #004 and #005, who were recently admitted to the home.

Review of the electronic health record indicated that resident #004 was admitted to the home on a specified date. Their care plan was reviewed and interventions for mobility, transfers, and transfer assistance for toileting were initiated 20 days after admission to the home. The New Admission profile was reviewed from the paper chart, which identified the admission date, and did not have any interventions specified for transfers or assistance with toileting. The Admission Care Plan was also reviewed, which identified the date of admission, and it also did not specify interventions for mobility, transfers, or assistance with toileting.

Review of the electronic health record indicated that resident #005 was admitted to the home on a specified date. Their care plan was reviewed and indicated a specified transfer method in the PT Focus Area of the care plan within 24-hours of admission to the home; however, there were no details specified regarding the transfer method (i.e., type, number of staff support, etc.). On a specified date 13 days after admission, a specified type of wheelchair was identified for resident use. At the time of inspection, the

care plan identified physiotherapy treatments, a specific mobility aid for resident use, specified feeding directions, and nutritional requirements; there were no entries for transfers, locomotion, incontinence care, oral care, or any other ADLs. Review of the New Admission Profile in resident #005’s paper chart also did not specify transfer method, assistance required for continence care, or any other ADLs; and the Admission Care Plan document in the paper chart was blank.

ADOC #110 indicated during an interview that the care plan in the electronic health record was to be used to document all interventions required in the 24-hour care plan for residents admitted to the home, based on information from various sources, including the Local Health Integration Network (LHIN) admission documents, Resident Assessment Instrument - Minimum Data Set (RAI-MDS) findings, and initial meeting with the resident and family. They stated that initial interventions on admission may also be found in the New Admission Profile and/or the Admission Care Plan in the resident’s paper chart.

The ADOC acknowledged that there were no interventions related to mobility, transfer status, or transfer assistance for toileting specified in resident #001’s 24-hour care plan, when they were initially admitted to the home. They also confirmed that several ADLs were not specified, including mobility and transfer status, in the 24-hour care plan for residents #004 and #005. [s. 24. (2) 3.]

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 the 24-hour admission care plan includes the type and level of assistance required relating to activities of daily living, to be implemented voluntarily.

WN #4: 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 has 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.

A CIS report was received by the MLTC for resident #001, who sustained an injury that resulted in hospitalization. The resident sustained two separate falls on two specified dates within 48 hours and the specified injury was identified a period of time after the falls.

Under O. Reg. 79/10, s. 48. (1), every licensee of a long-term care home shall ensure that a falls prevention and management program is developed and implemented in the home to reduce the incidence of falls and the risk of injury .

The home's Falls Management and Prevention Program policy, revised July 2019, was reviewed and defined an unwitnessed fall as follows: when a resident is found on the floor and neither the resident nor anyone else knows how he or she got there. According to the policy, registered nursing staff were required to initiate the Head Injury Routine (HIR) for all unwitnessed falls, and it should be done every half hour for two hours, every one hour for six hours, every four hours for eight hours, and every eight hours for 56 hours, for a total of 72 hours of monitoring.

The progress notes and risk management incident reports for falls were reviewed for resident #001 in the electronic health record, which confirmed that the resident sustained six unwitnessed falls on six specified dates. Progress notes indicated that the HIR had been initiated for five of the six falls.

Inspector #722 reviewed the HIR record for each of the falls for resident #001:
- First fall: missing 7/20 entries due to resident being at meals (3) or sleeping (4).
- Second fall: no HIR record could be identified for this fall.

- Third fall: missing 6/20 entries due to resident sleeping (3) or left blank (3).
- Fourth fall: missing 8/20 entries due to refused (3), sleeping (2), or left blank (3).
- Fifth fall: missing 16/20 entries due to refused (10), sleeping (3), or left blank (3).
- Sixth fall: missing 18/20 entries due to refused (1), sleeping (6), or left blank (11).

The resident sample was expanded to determine the scope of this area of non-compliance related to completion of the HIR records for unwitnessed falls. The progress notes and risk management incident report were reviewed for resident #003 related to falls. Resident #003 sustained an unwitnessed fall without injury on a specified date. The progress notes indicated that the HIR was initiated, but Inspector #722 was unable to locate the HIR record in the resident's health chart, or at the nursing station. ADOC #110 also searched for the HIR record for resident #003's fall and was unable to locate it.

RPN #103, the Falls Prevention Lead, and ADOC #110, both indicated in separate interviews that the HIR should be initiated for all unwitnessed falls, and a copy should either be kept on a clipboard in the nursing station, or in the resident's paper health chart on the unit.

ADOC #110 confirmed that the HIR records that were identified for resident #001 were incomplete, and that although the resident may refuse vital signs, portions of the assessment may be completed by registered staff even when the resident refuses (e.g., level of alertness, verbal response, etc.). They also stated that the HIR assessment should be completed when the resident was sleeping after sustaining an unwitnessed fall.

The ADOC acknowledged that the home's Falls Management and Prevention Program policy was not followed by registered staff when documentation in the HIR records were not initiated and/or completed as per the policy for residents #001 and #003. [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.

Issued on this 13th day of February, 2020

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

Original report signed by the inspector.