Ontario

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Nov 13, 2019	2019_598570_0024	019755-19	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Lakefield
19 Fraser Street LAKEFIELD ON K0L 2H0

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

SAMI JAROUR (570)

Inspection Summary/Résumé de l’inspection

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

This inspection was conducted on the following date(s): October 24, 28 and 29, 2019

Complaint inspection log #0019755-19, related to a fall.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Coordinator, Admission Coordinator, MDS RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

During the course of the inspection, the inspector observed the provision of care and services to residents, staff to resident interactions and resident to resident interactions; reviewed licensee investigations notes and licensee's specific policy related to Falls Prevention and Management.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based

on an assessment of the resident and the needs and preferences of that resident.

A complaint was submitted to the Ministry of Long-Term Care (MLTC), stating resident #001 had fallen on identified date and sustained injuries, transferred to hospital and passed away while in the hospital.

During a telephone interview, the complainant raised concerns regrading resident #001's fall and the injuries sustained. The complainant raised concerns about this home's falls rates being the highest among other homes they looked at.

The home submitted Critical Incident Report (CIR) identifying resident #001 had a fall on an identified date and time, which caused an injury for which the resident was taken to hospital. The CIR indicated resident #001 sustained identified injuries and passed away while in hospital.

A record review of progress notes for resident #001 identified that on an identified date and time, PSW #101 found resident #001 on the floor on an identified position. The resident was assessed by RN #113 and RPN #103 and was transferred to hospital due to identified injuries. The progress note stated that the resident may have tripped on their footwear.

A review of resident #001's falls risk assessment, identified the resident was at an identified risk for falls.

Review of the licensee's Falls Prevention and Management Program (last updated: February 2017), appendix 4 – RC-15-01-01 A4 directs if a resident score < 7 on Scott's Fall Risk Screen, plan in place to watch risk and and follow universal fall prevention plan, including:
-Bed in low position, call bell in place
-Good fitting foot wear
-Incontinence precautions
-Environment uncluttered, good lighting, accessible grab bars, non-slip floors
-Recommend vitamin D supplements
-Apply strategies based on risk items above

A review of resident #001's plan of care under falls focus, directed staff to ensure they complete the 4 P's (pain, prompt toileting, possessions, positioning) prior to leaving the resident alone in room; monitor daily for change in mental status and ability to remember

and follow instructions. The plan of care under dressing revealed that the resident required limited assistance by one staff. The plan of care under falls and dressing did not indicate the use of specified footwear and whether the specified footwear was good fitting as directed in the Scott’s Fall Risk Assessment; the plan of care under dressing did not indicate what kind of footwear the resident was using and whether the resident required assistance with the footwear.

An interview with PSW #101, who worked at an identified shift when resident #001 was found on the floor. PSW indicated the resident was checked at an earlier time and refused to be toileted, the resident was approached two to three times but continued to refuse. PSW #101 indicated when the resident was found on the floor, the mobility aid was pushed away and noted the resident was wearing a specified footwear which was not done up. The PSW indicated that the specified footwear was not the preferred footwear.

An interview with PSW #108 indicated that resident #001 had a specified footwear and that it would not be safe to walk with when the footwear was not on the resident's feet properly.

An interview with RPN #103 who worked at specified shift, indicated that resident #001 was found on the floor in a specified position.The RPN further indicated that they noted the resident’s footwear was not done up properly. The RPN indicated as part of fall prevention, if a resident had a specified footwear, the family should be informed that the footwear was not safe.

An interview with the Director of Care (DOC), they indicated when resident #001 was found on the floor, staff noted that resident’s footwear was a concern as the the footwear was not put on properly. The DOC indicated it would not be safe for the resident to walk with a footwear that was not properly done. The DOC indicated there were no documentation to indicate that the footwear used by resident #001 was assessed to determine if it was considered proper or safe footwear.

An interview with the Administrator, they confirmed upon review of the home’s policy of falls prevention and management program, that good fitting footwear should be considered as part of the plan of care. The Administrator acknowledged that the written plan of care and the progress notes did not indicate that the footwear used by resident #001 was considered a good fitting footwear.

The licensee did not ensure that the care set out in resident's #001's plan of care related to falls prevention was based on the resident's assessed needs of using a good fitting footwear. [s. 6. (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 the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

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. (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:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that when making a report of an incident to the Director the names of any staff members who were present or who discovered the incident were included in that report.

The home submitted Critical Incident Report (CIR) identifying resident #001 had a fall on an identified date and time, which caused an injury for which the resident was taken to hospital. The CIR indicated resident #001 sustained identified injuries and passed away while in hospital..

A review of the CIR did not provide any documentation related to the name of the staff member who found the resident on the floor and reported the incident to RPN #103 and RN #113 on an identified date and time. The CIR did not include the name of the RPN who responded and assessed the resident with RN #113.

An interview with director if care (DOC) indicated the CIR was submitted by the Administrator of the home. The DOC identified the staff who discovered the incident as PSW #101 and the registered practical nurse who responded to the incident as assessed the resident with RN #113 was RPN #103.

An interview with the administrator, they indicated awareness of the reporting requirements and that they did not include the names of staff involved as it was missed. [s. 107. (4) 2.]

Issued on this 25th day of November, 2019

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

Original report signed by the inspector.