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
Mar 31, 2022	2022_595110_0002	005158-21, 008724-21, 012109-21, 012163-21	Critical Incident System

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 Rouge Valley
551 Conlins Road Toronto ON M1B 5S1

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

DIANE BROWN (110), JULIE DUNN (706026)

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): Janaury 20, 21, 24, 25, 28, 2022.

The following intake was completed in this Critical Incident System (CIS) inspection:

Log #005158-21 related to an incident requiring a transfer to hospital.
Log #008724-21 related to Follow-up to CO#001 from inspection #2021_882760_0014 / 005084-21 regarding medication administration.
Log #012109-21 related to resident fall resulting in transfer to hospital.
Log #012163-21 related to resident fall resulting in transfer to hospital.
An Infection Prevention and Control inspection was also completed in the home.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Administrator, Director of Care, Assistant Director of Care, Toronto Public Health, RAI coordinator, Registered nurses, Registered Practical Nurse, housekeeping services, physiotherapist, Personal Support Workers, residents.

During the course of the inspection, the inspector toured the home, observed infection prevention and control practices, meal and nourishment service, medication administration and resident care. A review resident health records, relevant policies, education records and audits were also completed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 131. (2)	CO #001	2021_882760_0014	706026

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. (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).

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 :

1. The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident (CI) was submitted to the Ministry of Long-Term Care reporting resident #001's fall and significant change in status.

The resident had a history of falls prior to admission. At the time of admission the plan of care included a bed safety device as a fall prevention measure then later modified to include a chair device to be applied for safety.

During a night shift, the resident’s assigned PSW, #118, last saw the resident, prior to their fall with injury sitting in a causal chair in their room. An interview with the PSW identified that there was no safety device on the casual chair.

An interview the physiotherapist (PT) confirmed the resident’s mobility aid had the fall prevention safety device, not the casual chair. Personal Support Worker #112 and a Registered Nurse both stated the resident was unsafe sitting in a causal chair, as the resident would try and get up. The staff shared the resident should have been transferred to their mobility aid or assisted back to bed but not left unattended in the casual chair. The RAI coordinator stated the clinical assessments revealed the resident was at high risk for falls and should be in bed or sitting in their mobility aid; both included a safety device.

The licensee failed to ensure the resident’s plan of care was provided, when staff

identified the resident sitting in a casual chair and not assisted back to bed or in the mobility aid equipped with a safety device.

Sources: Record review, room observations, staff interviews PSW, #112, $116, #118, The RAI coordinator #113, RPN #115, RN #114 and PT #117. [s. 6. (7)]

2. Resident #004 had a fall. The resident's assigned PSW, #121, found them lying on their back on the floor around 0730hrs. According to the PSW the resident was provided morning care, dressed and placed in their chair watching TV prior to their fall.

The resident's plan of care identified their risk of falls and required staff to provide a falls prevention intervention when being dressed daily. An interview with PSW #121 revealed 'maybe yes and maybe no' when asked if the resident had been provided the falls safety intervention when dressed the morning prior to their fall. The PSW stated they don't always have the intervention available. The PSW also stated that when this occurs they inform the nurse and document 'not applicable' in the point of care (POC) documentation system when prompted to tick by task for the intervention. Not applicable was documented for intervention on the day and shift of the fall, revealing it was not provided to the resident.

The post fall assessment and post fall huddle failed to identify the lack of intervention in place at the time of the resident's fall.
During the course of the inspection, at 1110hrs resident #004 was observed sitting in the lounge. They were observed and assessed, and it was confirmed by a PSW and RPN that the resident was not provided with the falls prevention intervention as required. The PSW shared they were not available in the resident's room.

The licensee failed to ensure that care, a falls prevention intervention, had been provided to resident #004 as set out in their plan of care.

Sources: Point of Care follow-up look back report, Post Fall assessment, interviews with PSW #121, RPN #119, ADOC #122, plan of care and progress notes. [s. 6. (7)]

3. A Critical Incident (CI) was submitted to the Ministry of Long -Term Care reporting

resident #002's fall, resulting in a significant change in status. The resident reportedly fell while they were getting out of bed.

The resident's plan of care directed staff to keep the resident's bed height in a specific position related to their history of falling; to provide the assistance of one staff for toileting and the application of a falls prevention apparatus.

An interview with PSW #126 who discovered the resident on the floor stated the resident's bed was not at the specific height as directed in their plan of care. The PSW stated the resident always got up to go the washroom on their own and to their knowledge was not assigned to have the falls prevention apparatus as identified in the plan of care. The RPN #127 who responded to assess the fallen resident also confirmed the resident's bed height which was not consistent with their plan of care. The RPN was also unaware if the resident had their falls prevention intervention apparatus applied at the time of the fall.

During the inspection an observation was made with full time PSW #124 and RPN #119 of resident #002, while the resident was in bed. The resident's bed height was not consistent with the resident's plan of care.

A record review of the post fall assessment failed to identify the resident's bed height, application of the fall prevention apparatus or toileting needs as a possible factors related to the fall and injury.

The licensee failed to ensure the care was provided to the resident at set out in the plan of care.

Sources: resident bed observations, staff interviews, plan of care, post fall assessment, progress notes. [s. 6. (7)]

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

A Critical Incident (CI) was submitted to the Ministry of Long-Term Care reporting resident #001's fall resulting in a significant change in status.

The resident had a history of falls prior to admission and responsive behaviors with moderately severe cognitive impairment.

The resident fell on date identified as A. The post fall assessment revealed that the fall could have been prevented it the resident had called for assistance.

The resident later fell on date B, with injury. The post fall assessment documented that the fall could have been prevented if the resident had called for assistance.

The resident fell again on date C. The post fall assessment again included reminding the resident to call for help to prevent further falls.

Staff interviews with a RN, RPN and PSWs revealed the resident did not use the call bell and would cognitive not know how to use it.

The plan of care that included reliance on resident #001's ability to use the call bell for assistance, as a fall prevention measure, was not an effective approach when revising the plan of care after each fall.

Sources: Post Fall Assessments, Progress notes, MDS, staff interviews. [s. 6. (11) (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 the care set out in the plan of care was 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. 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 are documented.

A CI was submitted to the Ministry of Long -Term Care reporting resident #002's fall resulting in a significant change in status. The resident reportedly fell to the floor as they were getting out of bed.

During the resident's admission assessment, the physiotherapist (PT) documented their assessment and an intervention for a 1:1 PT program to improve the resident's strength, balance and gait endurance.

During an interview with the PT, the Inspector requested the resident's attendance record for the 1:1 PT program leading up to the fall. The PT revealed that the resident had refused the 1:1 program and it had not been provided.

A record review failed to identify the resident's response or refusal to this intervention prior to the resident's fall.

Sources: progress notes, PT assessments, written plan of care, Interview with PT. [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 16th day of May, 2022

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

Original report signed by the inspector.