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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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
Dec 17, 2018; Jan 21, 23, 2019	2018_749722_0006	005219-18, 008480-18, 019169-18, 023424-18, 025343-18	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the City of Peterborough and The Corporation of the County of Peterborough
c/o Fairhaven 881 Dutton Road PETERBOROUGH ON K9H 7S4

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

Fairhaven
881 Dutton Road PETERBOROUGH ON K9H 7S4

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): September 12, 13, 14, 17, 19, 20, 21, and 24, 2018

The following critical incident intakes were inspected concurrently during this inspection:

Log #005219-18 - acute respiratory illness outbreak
Log #008480-18 - acute respiratory illness outbreak
Log #023424-18 - acute respiratory illness outbreak
Log #019169-18 - fall resulting in injury
Log #025343-18 - fall resulting in change in condition

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Resident Care Supervisors, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

During the course of the inspection, the inspector reviewed incident reports, resident clinical health records (electronic and hard copy), administrative records, and relevant home policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. (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 has failed to ensure that when resident #007 was reassessed and the plan of care reviewed and revised related to fall prevention, and the plan of care was being revised because care set out in the plan was not effective, that different approaches related to fall prevention were considered in the revision of the plan of care.

Related to log #019169-18

On a specified date, a critical incident report was submitted to the Director detailing a fall that occurred on a specified date, involving resident #007 that resulted in an injury. The resident was transferred to hospital and diagnosed with an injury. Review of the resident's electronic health record and plan of care indicated that the resident had a history of falls, with a specified number of falls resulting in injuries during a specified period of time, and no new interventions related to falls prevention indicated in the plan of care.

Inspector #722 reviewed the progress notes for resident #007 related to falls during a specified period. The progress notes indicated that resident #007 sustained a specified number of falls, at specified times, and sustained injuries after each fall as described in the progress notes. .

Inspector #722 reviewed the assessments for resident #007 for each of the falls noted above, which indicated that the resident was briefly assessed by registered staff on duty when each fall identified above occurred; and post falls assessments were also completed by registered staff after each fall, all of which indicated that resident #007 was at a high risk for falls.

Inspector #722 reviewed resident #007's written plan of care, including the history of revisions, to identify falls prevention interventions from admission on a specified date, to another specified date, which indicated the following:
- Reinforcing need for resident to call for assistance and sign posted in resident's room as reminder
- Avoid turning sharply when ambulating with resident
- Resident to wear proper and non-slip footwear
- Reminders for resident to call staff for all transfers and to avoid standing up without assistance
- Independent mobility with specified mobility device, a different specified mobilty device

for long distances
- Call bell within reach when in bed and easy chair
- Check every hour to ensure safety
- Encourage resident to use handrails or assistive devices properly
- Ensure environment is free of clutter, and to have commonly used items within easy reach.

Inspector #722 reviewed the written care plan for resident #007, including the history of revisions to interventions, for a specified period after the interventions listed above, and found that no new interventions were added by registered staff to reduce the resident's risk for falls after a specified number of falls. The resident was assessed after each of these falls; however, no new interventions were added to the resident's plan of care until after the latest fall on a specified date, and sustained an injury. The following falls prevention interventions were added after the latest fall among those reviewed above: Apply bed alarm to resident when in bed and chair, and two-person assist for transferring and toileting.

Inspector #722 reviewed the physiotherapy (PT) assessments that were completed for resident #007 after the falls that occurred on specified dates. The PT assessment on one of those dates indicated that the resident required assistance for transfer, and was reminded to use the nurse call bell for assistance; PT #157 recommended that the call bell be placed within reach of the resident (see below). Both of these interventions were part of resident #007's written care plan prior to a specified date, and no new interventions were recommended by the physiotherapist. The PT assessment on another specified date, indicated that the resident had sustained an injury from a fall, declined an assessment, and refused exercise at the time of the assessment; PT #157 did not make any further recommendations for falls prevention in the assessment.

Review of progress notes for resident #007 by Inspector #722 indicated that resident #007 had previously been discharged from PT services on a specified date, as requested by the physician. Review of the current written care plan by Inspector #722, including the history of revisions, indicated that no new PT interventions to reduce risk for falls were considered or added to resident #007's plan of care after either of the PT assessments.

RN #128, the Resident Care Manager, was interviewed by Inspector #722 on a specified date. During the interview, RN #128 reviewed the current written care plan for resident #007, including the revision history for interventions, and indicated that no new interventions to reduce the risk for falls had been added to the resident's written care

plan after the falls that occurred on specified dates. RN #128 was unable to identify new approaches to falls prevention, but indicated that the bed alarm was added to the resident's plan of care after the latest fall reviewed during the specified period, when the resident returned from the hospital.

Inspector #722 interviewed RPN #140 on a specified date, the falls prevention lead in the home, who indicated that the falls prevention team does not follow all residents identified as high risk for falls, only those who have more than one fall in a month. RPN #140 indicated that the fall prevention team was not closely following resident #007 and that, according to the care plan, there were no new interventions for reducing the risk for falls implemented after resident #007's falls that occurred specified dates; and that until the latest fall during the specified period reviewed, that resulted in an injury, all the previous interventions related to falls prevention had stayed the same.

The licensee failed to ensure that when resident #007 was reassessed and the plan of care reviewed after the falls that occurred on specified dates, when the plan of care was being revised because care set out in the plan had not been effective, that different approaches related to falls prevention were considered in the revision of the plan of care. [s. 6. (11) (b)]

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 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.

Under O. Reg. 79/10, section 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Under O. Reg. 79/10, section 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The licensee's falls prevention policy (Policy #: RPM-N-410), which was reviewed by Inspector #722 on a specified date, was initially approved on a specified date, and reviewed on a specified date. The policy directed that the registered nurse (RN) was responsible for completing a resident physical assessment when a fall occurred with injury and document findings in risk management.

Related to log #025343-18

A Critical Incident Report (CIR) was received by the Director on a specified date, which indicated that resident #028 had sustained a fall at a specified date and time, where the resident initially sustained a minor injury. Review of the CIR also indicated that the resident was assessed by RPN #156 immediately after the fall, where an injury occurred, but there was no indication that the resident had been assessed by an RN.

Inspector #722 reviewed the progress notes for resident #028 for the fall that occurred on a specified date, which indicated the following:
- Resident #028 fell in a specified location in the home at a specified time, and details of the fall were specified
- PSW #159 was near the resident and witnessed the fall, and indicated that the resident did not hit their head
- RPN #156 was notified, assessed resident #028's range of motion, vital signs, and for injuries

- RPN #156 noted that resident #028 had sustained minor injuries as specified in the progress notes
- Inspector #722 was not able to identify a note that indicated the resident had been assessed by the RN on duty

On a specified date and time, Inspector #722 interviewed PSW #159 related to resident #028's fall on a specified date, who indicated that they were in a specified location with the resident at the time of the fall, observed the resident fall, and were present when RPN #156 heard the resident fall attended to the resident. PSW #159 assisted RPN #156 with the resident after the fall, and observed RPN #156 assess the resident after the fall.

Inspector #722 interviewed RPN #156 on a specified date and time, who indicated that they were in a specified location and heard resident #028 fall at a specified time on a specified date. RPN #156 indicated that they were on the phone with RN #148 at the time of the fall. RPN #156 indicated that they assessed resident #028, including range of motion, vital signs, pain assessment and neurological assessment. RPN #156 indicated that they assisted the resident, and went to contact RN #148 to see if they could provide resident #028 with specified medication to treat the resident's pain in a specified location. RPN #156 indicated that RN #148 gave approval to give the specified medication at a specified time. RPN #156 indicated that RN #148 did not attend the fall or complete an assessment of resident #028 during the shift, and indicated that they would usually ask the RN on duty to assess the resident for significant injuries or if they felt they wanted the RN to assess the resident.

On a specified date and time, Inspector #722 interviewed RN #148, who confirmed that they were on duty in the home the night resident #028 fell on the specified date. RN #148 indicated that they were in their office when they received the phone call from RPN #156 regarding resident #028's fall. RN #148 indicated that after discussing the fall with RPN #156, they indicated that they did not need to go down to assess resident #028, because the RPN had done all the assessments that the RN would have done, and the RPN indicated that they felt good and that everything was normal for the resident. RN #148 indicated that they stayed in the office and did not go down to assess the resident.

RN #148 also indicated that at a specified time, the RPN notified them of an injury hat resident #028 had sustained as a result of the fall, RN #148 advised the RPN how to treat the injury, stayed on the phone with the RPN while they completed a specified assessment when the resident made a specified complaint, and approved the RPN to

give a specified medication to address the resident's complaint. RN #148 confirmed during the interview with Inspector #722 that they did not see resident #028 before the end of their shift on the date the fall occurred with injury. RN #148 also indicated that the expectation is that the RN will usually go down and assess the resident after a fall if they are able to get there, and that they are expected to assess the resident when there has been an injury.

Inspector #722 interviewed the Director of Care (DOC) on a specified date and time related to the home's falls prevention policy, specifically related to RN responsibilities for completing a physical assessment when a fall with injury occurs. The DOC indicated that if there is a serious injury, the RN is called down right away, and that the severity of the injury dictates if the RN goes right down to see the resident. The DOC indicated that the current policy needs to be revised, and acknowledged that the policy does not currently indicate that the RN only needs to assess the resident after a fall when a serious injury occurs.

The licensee failed to ensure that the home's falls prevention policy (Policy Number: RCM-N-410) was complied with when resident #028 was not assessed by a Registered Nurse (RN) after sustaining a fall with injury. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 30th day of January, 2019

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

Original report signed by the inspector.