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
Nov 12, 2020	2020_792659_0025	019574-20	Critical Incident System

Licensee/Titulaire de permis

Fairview Mennonite Homes
515 Langs Drive CAMBRIDGE ON N3H 5E4

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

Fairview Mennonite Home
515 Langs Drive CAMBRIDGE ON N3H 5E4

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

JANETM EVANS (659)

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): November 3, 4, 5 and 6, 2020.

The following intake was included in this inspection: Log #019574-20\Critical Incident (CI) #2992-000005-20 related to a resident fall with injury.

During the course of the inspection, the inspector(s) spoke with the Executive Director, co-Directors of Care (co-DOC), Assistant Directors of Care (ADOC), Registered nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers and residents.

Observations were made of general care and cleanliness, staff to resident interactions, and fall intervention equipment and devices. A review of relevant policies and procedures as well as resident clinical documentation was completed.

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

During the course of this inspection, Non-Compliances were issued.
- **1 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. (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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for a resident related to pain management was provided as specified in the plan.

A resident complained of discomfort post fall and were unable to walk. The resident was given pain medication and assisted to bed. A PAINAD completed that same day post fall, documented a score of two.

The resident's plan of care documented staff were to administer pain medication as needed and assess the effectiveness.

The following day, a numerical pain score of seven on a scale of ten was documented for the resident. The resident complained of pain with repositioning but was not able to identify a specific site for the pain. There was no documented pharmacologic or non pharmacologic treatment provided for pain management at that time. A Medical Directive was available to be administered for pain as needed but was not used.

Oncoming staff assessed the resident to have increased pain. The resident was reluctant to move and exhibited facial grimacing when doing this.

Sources: Progress notes and plan of care, September eMAR and Medical Directives, September 2020 pain vitals, interviews. [s. 6. (7)]

2. The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed and revised when care set out in the plan related to falls prevention had

not been effective.

A resident was identified as at risk for falls. They had four falls in a two month period and sustained injuries with three of the four falls. With their last fall in September 2020, the resident was unable to ambulate post fall. They were transferred to hospital after an xray confirmed they had sustained an injury.

The resident's plan of care related to falls interventions was last updated August 2020, to include, remind resident to call for help. This intervention had already been included in the resident’s plan of care in 2019.

Staff reported that due to the resident’s short term memory impairment, they would not recall the instructions to call for help or use their mobility aid, despite being cued for this multiple times a day.

Failure to reassess the resident and revise the resident’s plan of care related to fall prevention interventions, when the current interventions were not effective, and failure to address the resident's pain, may have contributed to the harm sustained by the resident from their last fall September 2020.

Sources: Fall Risk assessment, Post fall huddles, Plan of care, StL Diagnostic Imaging report, staff interviews [s. 6. (10) (c)]

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 residents' plan of care are reviewed and revised when care set out in the plan related to falls prevention have not been effective and that staff follow the plan for pain management as documented to residents' plan of care, to be implemented voluntarily.

Issued on this 13th day of November, 2020

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

Original report signed by the inspector.