Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
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Original Public Report

Report Issue Date: December 13, 2022	
Inspection Number: 2022-1321-0002	
Inspection Type: Follow up Critical Incident System	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Fountain View Care Community, Toronto	
Lead Inspector Fiona Wong (740849)	**Inspector Digital Signature** Fiona Hoi Kwan Wong-Dip Digitally signed by Fiona Hoi Kwan Wong-Dip Date: 2022.12.29 08:58:02 -05'00'
Additional Inspector(s) Christine Francis (740880) Ivy Lam (646) April Chan (704759)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 21-25, 28, 2022

The following intake(s) were inspected:

- Intake: #00001135 – Critical Incident System (CIS): 2836-000012-22 – related to resident to resident abuse
- Intake: #00002205 – CIS: 2836-000011-22 – related to resident to resident abuse
- Intake: #00004173 – CIS: 2836-000027-21 – related to falls prevention and management
- Intake: #00006928 – CIS: 2836-000005-22 – related to injury of unknown cause
- Intake: #00007100 – CIS: 2836-000006-22 – related to potential staff to resident abuse
- Intake: #00007064 – Compliance Order (CO) #001 related to Infection Prevention and Control (IPAC) from inspection #2022_1321_0001

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The following intakes were completed in the CIS Inspection: Intake #00001752 (CIS: 2836-000031-21), Intake #00002995 (CIS: 2836-000012-21), Intake #00003063 (CIS: 2836-000001-21), Intake #00003529 (CIS: 2836-000015-21), Intake #00003940 – (CIS: 2836-000014-21), Intake #00004426 – CIS: 2836-000032-21, Intake #00004427 – CIS: 2836-000006-21, Intake #00004492 – CIS: 2836-000019-21 were related to falls prevention and management

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be **COMPLIED**.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg. 246/22	s. 102 (7) (11)	2022_1321_0001	001	740849

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management
Responsive Behaviours
Prevention of Abuse and Neglect
Resident Care and Support Services
Skin and Wound Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that there was in place a hand hygiene program in accordance with the "IPAC Standard for Long Term Care Homes April 2022" (IPAC Standard).

Specifically, the IPAC Lead failed to ensure that the hand hygiene program included access to 70-90% Alcohol-Based Hand Rub (ABHR) as was required by Additional Requirement 10.1 under the IPAC Standard. The IPAC lead failed to remove expired ABHR that was in use in the home.

Rationale and Summary
On November 21, 2022, expired hand sanitizing wipes and ABHR were located at the entrance of a dining room. They were observed to be used by multiple staff and residents. They were immediately removed after the Assistant Director of Care (ADOC) was notified.

On November 22, 2022, the IPAC Lead stated once the home was notified of the expired products, they were removed from being in use. The IPAC Lead indicated that when the hand sanitizing products were expired, they would not be as effective to kill viruses.

There was low risk to residents when expired hand sanitizing products were in use because they were recently expired.

Sources: Inspectors #740849 and #704759's observations, Interview with IPAC Lead.

[740849]

Date Remedy Implemented: November 22, 2022

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care was revised when the resident's care needs changed.

Rationale and Summary

On a specified date, a resident was observed being transferred with the assistance of one staff member.

The resident's written care plan indicated that they required assistance by two team members for transfers.

Two Personal Support Workers (PSW) and the Physiotherapist (PT) confirmed that the resident's current transfer status was one person assist, and that the written care plan was not revised when the resident's care needs changed. The written care plan was updated during inspection to reflect one team member for transfers.

There was low risk to the resident when their written care plan was not revised to reflect their assessed transfer status.

Sources: Observation on a specified date, interviews with 2 PSWs, PT and the resident's plan of care.

[740880]

Date Remedy Implemented: November 24, 2022

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (2)

The licensee has failed to ensure the care set out in the plan of care was based on an assessment of a resident.

Rationale and Summary
A resident was assessed by the home's PT and offered a mobility device for locomotion and transfers. The PT and a Registered Practical Nurse (RPN) both indicated that staff provided verbal and physical cuing to the resident to use the recommended mobility device.

The resident's plan of care for locomotion indicated they were independent with ambulation until 10 months later, when it was revised to reflect that they required use of another mobility device. The registered staff of the home area was responsible to update the resident's plan of care including locomotion, based on an assessment of the resident, but it was not done.

There was risk identified when care set out in plan of care was not based on the initial physiotherapy assessment of the resident.

Sources: the resident's assessments, clinical records, written care plan, interview with a PT, RPN and DOC.

[704759]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (1) 3.

The licensee has failed to ensure staff complied with the home's responsive behaviour policy to complete an observation tool for a resident.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that there are resident monitoring and internal reporting protocols to meet the needs of residents with responsive behaviours and are complied with.

Specifically, staff did not complete the observation tool, Behavioural Supports Ontario – Dementia Observation System (BSO-DOS), which was included in the licensee's Responsive Behaviours Management policy.

Rationale and Summary
The home's policy on Responsive Behaviours Management indicated that the nurse is responsible for initiating observation tools such as the BSO-DOS and the PSW will recognize, verbally report, and document changes in resident behaviour.

A resident had a 10-day BSO-DOS initiated after exhibiting responsive behaviours.

Review of the DOS data collection sheet showed missing information on multiple dates and times. A PSW, BSO Lead, and Director of Care (DOC) indicated that the data collection sheet was blank because DOS was not done.

There was minimal risk identified when the home's observation tool was not done for the resident per the home's policy.

Sources: CIS #2836-000012-22, the home's Responsive Behaviours Management policy (statID #11667509, revised November 2020), the resident's clinical records, interviews with a PSW, BSO Lead and DOC.

[704759]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure the additional requirements under the "IPAC Standard for Long-Term Care Homes April 2022" (IPAC Standard) were followed.

Specifically, Additional Requirement 6.1 under the IPAC Standard states that the licensee shall ensure that the Personal Protective Equipment (PPE) supply and stewardship plan is consistent with any relevant Directives and/or Guidance, regarding appropriate PPE use.

Rationale and Summary
A PSW doffed PPE outside of a resident's room that required droplet and contact precautions, but the face shield was not disinfected. The PSW walked across the hallway and into the dining room while continuing to wear the same face shield that was not disinfected.

The PSW stated that the face shield was not disinfected nor discarded because direct resident

care was not provided. The IPAC Lead clarified that the face shield should have been disinfected during the doffing process whether resident care was provided or not.

There was low risk to residents as the PSW did not provide direct resident care to the resident who required droplet and contact precautions.

Sources: Inspector #740849's observations, Interview with a PSW and IPAC Lead.

[740849]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (1) 2.

Non-compliance was identified with s. 53 (1) 2 of O. Reg 79/10 under the Long-Term Care Homes Act, 2007 and s. 58 (1) 2 of O. Reg. 246/22 under the Fixing Long-Term Care Act, 2021.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 53 (1) 2. of O. Reg 79/10 of the LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 58 (1) 2. of O. Reg. 246/22 under the FLTCA.

The licensee has failed to ensure that written strategies to prevent, minimize, or respond to a resident's reoccurring responsive behaviours were developed and revised when not effective.

Rationale and Summary
A resident had a history of responsive behaviours relating to their diagnoses.

Within seven months, the resident had seven incidences of specified responsive behaviours. The resident's written care plan was not revised to address the specified responsive behaviours. A PSW stated they were unaware of any specific interventions to manage the resident's specified responsive behaviours.

The home's Responsive Behaviours Management policy (VII-F-10.10, policystat ID 11667509, last revised November 2020) stated that the nurse will strategize with frontline team members on additional interventions required or on the effectiveness of interventions. It also indicated that the interprofessional care team will evaluate the effectiveness of the plan and revise as needed.

The DOC acknowledged that the resident's responsive behaviour care plan was not effective and should have been updated with new or revised strategies to prevent or minimize reoccurrences of the specified responsive behaviours.

There was moderate risk as the resident's specified responsive behaviours could make co-residents uncomfortable and potentially fearful when there were ineffective written strategies to prevent or minimize reoccurrences.

Sources: the resident's written care plan and progress notes, interview with DOC, the home's responsive behaviour management policy (VII-F-10.10, policystat ID 11667509, revised November 2020).

[740849]

WRITTEN NOTIFICATION: Duty to Protect

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect a resident from abuse by another resident who had a history of responsive behaviours.

Section 2 (1) (c) of the Ontario Regulation 246/22 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary
A resident had a history of responsive behaviours related to their diagnoses.

The home's camera footage captured the resident physically injuring another resident.

The DOC and an RPN confirmed that physical abuse was substantiated.

There was minimal physical harm to the other resident however there was moderate risk given the resident's history of responsive behaviours.

Sources: The resident's progress notes and written care plan, the other resident's progress notes, the home's investigation documents, interview with DOC.

[740849]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (1) 1.

Non-compliance was identified with s. 53 (1) 1 of O. Reg 79/10 under the Long-Term Care Homes Act, 2007 and s. 58 (1) 1 of O. Reg. 246/22 under the Fixing Long-Term Care Act, 2021.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 53 (1) 1. of O. Reg 79/10 of the LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 58 (1) 1. of O. Reg. 246/22 under the FLTCA.

(i) The licensee has failed to ensure that there were written identification of behavioural triggers that may have resulted in resident's responsive behaviours.

Rationale and Summary
On two specified dates, a resident exhibited responsive behaviours. The DOC identified the responsive behavioural trigger for the resident on the two specified dates.

The resident's written care plan did not indicate the specified responsive behavioural trigger.

The home's responsive behaviour management policy (VII-F-10.10, policystat ID 11667509, revised November 2020) stated that the interdisciplinary care team will identify possible triggers for responsive behaviours. The DOC acknowledged that this responsive behaviour trigger should have been written in the resident's plan of care.

There was moderate risk when the resident's behavioural triggers were not identified as the resident's responsive behaviours could make co-residents uncomfortable and potentially fearful.

Sources: the resident's written care plan and progress notes, interview with DOC, the home's responsive behaviour management policy (VII-F-10.10, policystat ID 11667509, revised November 2020).

[740849]

(ii) The licensee has failed to ensure that a resident's written approaches were developed to include identified triggers to responsive behaviours.

Rationale and Summary
A resident had cognitive impairment and responsive behaviours that required strategies to manage.

The resident had a history of responsive behaviours prior to admission to the home. The resident exhibited responsive behaviours on two specified dates. At the time of those incidents, behavioural triggers were identified for the resident.

On another specified date, the resident was involved in an alleged abuse incident.

Six days prior to this incident, the resident was experiencing the same behavioural triggers. On the same day the resident displayed responsive behaviours.

The home's policy on Responsive Behaviours Management stated that the nurse will screen and assist in developing the plan of care to minimize risks to self and others. At the time of incident,

the resident's responsive behaviours plan of care did not identify the specified triggers. A RPN indicated that when the specified behavioural trigger occurred the resident was more resistive to receiving treatment. The BSO lead acknowledged that the specified behavioural trigger should also be identified in the resident's responsive behavioural plan of care.

A RPN identified that the resident displayed responsive behaviours at certain times of the day. A PSW indicated the resident was more resistive to care during certain times of the day.

An external behavioural outreach assessment suggested that the resident exhibited responsive behaviours during certain times of the day. Both the RPN and BSO Lead agreed that it should be identified as a responsive behavioural trigger in the resident's plan of care.

The plan of care was eventually revised to include the responsive behaviour triggers. There was risk to residents' safety when the resident's responsive behaviour plan of care did not identify specific triggers.

Sources: CIS #2836-000012-22, the home's Responsive Behaviours Management policy (statID #11667509, revised November 2020), the resident's written care plan, clinical records and assessments, interviews with a PSW, RPN, and BSO Lead.

[704759]

WRITTEN NOTIFICATION: Plan of Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (4) (b)

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident 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.

Rationale and Summary
The home's Skin & Wound Care Management protocol indicated that the registered staff were to collaborate with the interprofessional team on development of the care plan, and were to

update the care plan. The PT was to assess the resident, advise the team on transferring techniques, develop a treatment plan and communicate the plan to the interprofessional team.

When a resident returned to the home with a new injury, the PT assessed the resident and recommended interventions to minimize risk of further skin alterations. They documented they had relayed the suggested interventions to a RN.

The resident's written care plan with history did not indicate the above interventions were included in the written care plan. Observations of the resident's room did not show either of the interventions. Interviews with a PSW and a RN indicated they did not recall if the resident had either of those interventions.

The PT indicated that they had suggested interventions for the resident to prevent future injury. Another intervention was to minimize risk of further skin alterations.

The RN indicated that they were busy at the time and they might have missed entering the intervention for the resident. They also thought the intervention might not be needed. The RN indicated they preferred to update the written care plan after they had all the interventions in place, and if they could not locate the equipment that day for the resident, they might not have updated the written care plan for the resident.

The DOC indicated that the team should have collaborated regarding the use of the recommended interventions, and documented whether or not the interventions would be implemented.

There was a risk that appropriate interventions would not be provided for the resident when the interprofessional team did not collaborate in developing and implementing a plan for the resident.

Sources: the resident's assessment records, progress notes, written care plan, Physician's assessment, Physiotherapist's assessments, Skin & Wound Care Management Protocol VII-G-10.92 policy; Observations of resident, resident and staff interactions and resident room environment; Interviews with a PSW, RN, PT, DOC/previous falls lead, and other staff.

[646]

WRITTEN NOTIFICATION: General Requirements

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 30 (2)

The licensee has failed to ensure that any actions taken with respect to the resident under the skin and wound program, including assessments, reassessments, and a resident's responses to interventions were documented.

Rationale and Summary
The home's Skin & Wound Care Management program indicated that PSWs were to document electronically using Point of Care (POC) any abnormal or unusual skin conditions.

On a specified date, skin and wound assessments for a resident showed the abnormal skin condition resolved. PSWs' documentation showed that prior to the skin condition resolving, the PSWs had documented no skin alterations were observed.

A PSW indicated that they recalled the resident's abnormal skin condition, and the PSWs should have continued to document abnormality on POC until the resident's skin condition was resolved. The skin and wound lead and DOC indicated that the PSWs should have followed their training and the home's process to document any skin issues noted during care.

There was a risk that changes to the resident's abnormal skin condition would not be captured timely, and appropriate actions would not be taken when the PSWs on all shifts did not document the presence or progression of their injury for multiple days.

Sources: the resident's clinical records, progress notes, written care plan, Physician's assessment, Physiotherapist's assessments, Skin & Wound Care Management Protocol VII-G-10.92 policy; Observations of resident, resident and staff interactions and resident room environment; Interviews with a PSW, Skin and Wound lead, DOC, and other staff.

[646]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 50 (2) (b) (iv)

The licensee has failed to ensure that a resident who exhibited altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
On a specified date, an initial skin and wound assessment was completed for a resident.

The first weekly assessment was completed one day late. Then next assessment was completed one day late from the previous assessment. The next one completed one day late from the previous assessment.

There was no assessment for the following week. A final assessment was completed the following week, to indicate the abnormal skin condition had been resolved.

The Skin and Wound lead and the DOC indicated the weekly skin assessments should have been completed weekly, and should not have been late or missed.

There was a risk that changes to the resident's abnormal skin condition would not be captured timely, and appropriate actions would not be taken when weekly assessments were not completed as required.

Sources: the resident's clinical records, progress notes, written care plan, Physician's assessment, Physiotherapist's assessments, Skin & Wound Care Management Protocol VII-G-10.92 policy; Observations of resident and resident and staff interactions; Interviews with a RN, Skin and Wound lead, DOC, and other staff.

[646]

WRITTEN NOTIFICATION: Falls prevention and management

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 49 (1)

The licensee has failed to comply with the strategy to monitor a resident after their fall.

In accordance with O. Reg. 79/10 s. 8 (1) (b), the licensee is required to ensure the falls prevention and management program, at a minimum, provides for strategies to monitor residents, and must be complied with.

Rationale and Summary
Specifically, staff did not comply with the home's specified assessment, which was captured in the licensee's policy "Falls Prevention & Management, VII-G-30.10" dated December 2021.

On a specified date, the resident had an unwitnessed fall. In an interview with an ADOC, it was acknowledged that the specified assessment should have been completed following the resident's fall, however it was not completed.

As a result, there was a risk that if the resident had sustained an injury, it would not have been immediately identified and treated.

Sources: the resident's progress notes and assessments, interview with a ADOC, and licensee's policy titled "Falls Prevention & Management, VII-G-30.10" last revised December 2021.

[740880]

WRITTEN NOTIFICATION: Plan of Care

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of a resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary
i) A resident was assessed upon admission to require one-person assistance for transfers. The

RAI-MDS Coordinator indicated the resident required two-person assistance for transfers. After the resident had a fall, the PT indicated that the resident was to continue with one-person assistance for transfers.

The PSW's documentation indicated that staff continued to provide one-person assistance for transferring the resident.

The RAI-MDS Coordinator indicated that because the resident was transferred once with two-persons during the MDS 7-day observation period, the algorithm would deem the resident as requiring two-person assistance. The RAI-MDS Coordinator indicated that they had updated the written care plan but did not notify the registered staff or PSW on the home area of the change in the written care plan.

The PT indicated the fall did not have any impact on their transfer ability, and kept the resident at the same level. They were not aware that the RAI-MDS Coordinator had updated the written care plan. They notified the registered staff of the change.

A RPN indicated that the PT usually provided the registered staff an update after their assessment of residents, and the registered staff was responsible for updating the written care plan. The RPN could not recall if they had received the communication from the PT and indicated that they had not updated the resident's transfer status at that time.

The DOC indicated that the RAI-MDS Coordinator should have discussed with the team prior to updating the resident's transfer status, and staff should have collaborated to ensure the resident had a consistent assessment for their transfer status.

There was a risk that the resident would not receive appropriate assistance with transferring when the interdisciplinary team did not collaborate in their assessment.

Sources: Review of the resident's written care plan with history, progress notes, physiotherapist assessments; Observations of resident, resident and staff interactions, and resident's room environment; and interviews with the resident, resident's private caregiver, an RPN, PT, DOC, and other staff.

ii) A resident's written care plan indicated that the resident required assistance by two team members for transfers.

On a specified date, the resident was transferred by a non-staff member and a PSW.

The non-staff member indicated that they regularly transferred the resident with another PSW. They were instructed by PSWs and registered staff on how to assist to transfer the resident.

The falls lead and DOC indicated that the non-staff member was not a staff member of the home and should not be considered the second team member for transfer assistance. They were not aware that the resident was being transferred by the non-staff member.

The DOC further indicated that it was possible for this non-staff member to provide transfer assistance for manual transfers if it was the resident's preference, and the Substitute Decision Maker (SDM) agreed. The team would have to collaborate on a further assessment of the resident's transfer status, and proper training would need to be provided for the non-staff member.

There was a risk that the resident would not receive proper transfer assistance when the team did not collaborate to assess and determine who was able to provide transfer assistance for the resident.

Sources: Review of the resident's written care plan with history, progress notes, PT assessments; Observations of resident, resident and staff interactions, and resident's room environment; and Interviews with the resident, the non-staff member, PSW, RPN, PT, DOC, and other staff.

[646]

WRITTEN NOTIFICATION: Plan of care

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

Non-compliance with: FLTCA, 2021 s. 6 (7)

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

Rationale and Summary
The resident's plan of care indicated that they required a falls prevention device when they were in their mobility device.

On a specified date, the resident was observed in their mobility device, however no falls prevention device was observed.

A PSW acknowledged that the resident did not have a falls prevention device attached to their mobility device, and it had been broken over the past month. The PT acknowledged that the resident was at risk of fall, and the ADOC acknowledged that the resident could potentially fall and sustained an injury in which the staff would not be alerted to.

Due to the licensee failing to ensure that a falls prevention device was in place, there was a potential risk of the resident experiencing another fall with injury.

Sources: Observation on a specified date, interviews with a PSW, PT, ADOC, and the resident's plan of care.

[740880]