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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 7, 2018	2018_749722_0003	019214-18	Resident Quality Inspection

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

Maplewood
12 Maplewood Avenue Box 249 BRIGHTON ON K0K 1H0

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

COREY GREEN (722), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 8, 9, 10, 13, 14, 15, 16, 17, 20, 21, and 22, 2018.

The following intakes were inspected concurrently during this inspection:

Log #007461-18 - Follow-up for compliance order #001 related to responsive behaviours
Log #020962-18 - Critical incident related to alleged staff-to-resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Coordinator, Office Manager, Nutrition Manager, and Maintenance Coordinator; Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and the Housekeeper; as well as residents and resident family members.

The inspectors conducted a tour of the home, observed medication administration, and provision of staff-to-resident care. Inspectors reviewed clinical health records for identified residents, medication audit report, Resident Council meeting minutes, staffing schedules and relevant policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

9 WN(s)
5 VPC(s)
1 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. 54.	CO #001	2018_643111_0004	722

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 O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 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. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all components of the interdisciplinary falls prevention and management program were implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

During staff interviews conducted by Inspector #623 during Stage 1 of the Resident Quality Inspection (RQI), two residents were identified in the home as having had falls within the past 30 days. Review of the progress notes for resident #015 by Inspector #722 indicated that the resident had sustained a number of falls in a specified period, including a number of falls that resulted in injuries. Resident #019 had sustained a fall on a specified date, without injury. During review of progress notes, care plans, assessments and staff interviews related to these falls, Inspector #722 identified that portions of the falls prevention program were not implemented in the home according to existing written policies as detailed below.

Inspector #722 reviewed the home's falls prevention program manual, the Achieva Health Falls Prevention Program, Policy and Procedure Manual (Policy OTP-OPFP-8.0), with a copyright date of 2017, which indicated the following under the Falls Risk Assessment Action Plan:
- Nursing Falls Prevention Program (for residents identified as being at high, medium, or low risk of falls): Post Fall Problem Solving, Environmental Modification, Referral to Physician, Referral to Pharmacy for Medication Review, and Referral to Dietician for Review of Dietary Needs.

The electronic health record and paper chart were reviewed by Inspector #722 for resident #015 related to a specified number of falls that were identified in the progress notes for a specified period. During this period, there was no documentation available related to resident #015's falls that indicated any post fall problem solving had occurred; no referrals to pharmacy were identified for medication review; and no dietitian referrals were identified related to risk of falls.

Review of the written care plan for resident #015 by Inspector #722 during this inspection indicated that there were no revisions to the care plan related to falls prevention after a specified number of falls that occurred on specified dates. The DOC indicated in an interview with Inspector #722 that when a fall occurs, the registered staff and charge nurse on shift would review the care plan and make updates. During the interview, the DOC confirmed that the care plan had not been updated after the falls as identified above for resident #015, and indicated that they were not sure that those care plan reviews were happening regularly.

DOC #103 confirmed during an interview with Inspector #722 that the home has adopted the ACHIEVA Health Falls Prevention Program (Policy OTP-OPFP-8.0) to reduce the risk of falls for residents in the home. During the interview, the DOC indicated that none of the activities identified above under the Nursing Falls Prevention Program have been consistently implemented, and confirmed that they are required according to the policy. Specifically, the DOC indicated that post fall huddles and discussions about resident's risk for falls are done ad hoc and informally.

The Administrator of the home also confirmed in an interview with Inspector #722, that the home has adopted the ACHIEVA Health Falls Prevention Program (Policy OTP-OPFP-8.0) in the home, and also confirmed that the activities required under the Nursing Falls Prevention Program have not been implemented as per the policy.

Inspector #722 reviewed the home's falls prevention program manual during this inspection, the Achieva Health Falls Prevention Program, Policy and Procedure Manual (Policy OTP-OPFP-8.0), with a copyright date of 2017, which indicated the following related to the Falls Prevention Lead and Falls Prevention Committee in the home:
- The physiotherapist's responsibilities for Falls Prevention include the following: Participate in the Interdisciplinary Falls Prevention Committee Team at the LTC/RH; Communicate with the team to determine who has fallen and to strategize on how to prevent future falls.

- Under Health and Safety Policy: 2. The Falls Prevention Lead should know the Resident's abilities and limitations.

In separate interviews with Inspector #722, PSW #124 and #119, RPN #106 and RN #107 indicated that they were unsure who the Falls Prevention Lead in the home was, that they were not aware of an Interdisciplinary Falls Prevention Committee, and had not participated in any interdisciplinary team meetings related to resident falls and/or falls prevention.

The DOC indicated during an interview with Inspector #722, that they thought they may be the Falls Prevention Lead, but were not sure, and confirmed that according to the home's policy, a Falls Prevention Lead was required. The DOC also confirmed that there was no Interdisciplinary Falls Prevention Committee in the home, and that it was required according to the home's falls prevention program.

The home's Administrator also confirmed during an interview with Inspector #722, that there was no formal Interdisciplinary Falls Prevention Committee Team or Falls Prevention Team Lead identified in the home, and that both were required according to their falls prevention program. The Administrator also indicated that the expectation was that the DOC would function in the role as the Falls Prevention Committee Team Lead, but indicated during the interview that they were aware that the DOC was not performing the functions of that role.

Policy OTP-OPFP-8.0 of the ACHIEVA Health Falls Prevention Program Manual was reviewed by Inspector #722, which indicated the following:
- Policy: 1. Assess and identify residents who have fallen or may be at risk to fall due to biological and environmental factors, and 2. Provide treatment strategies to improve strength, balance, mobility, posture, and seating based on Physiotherapy "best practices".
- Eligibility Criteria: 1. Once a referral is received by the Physiotherapist, a comprehensive Physiotherapy Assessment including a Falls Risk test is completed; and 2. Residents who have sustained a fall will be referred immediately by the Physician/Registered Nurse for Assessment by the Physiotherapist.

The progress notes were reviewed for residents #015 and #019 related to falls for a specified period, and indicated that resident #015 had sustained a specified number of falls, and resident #015 had sustained a specified number of falls. Review of the physiotherapy records by Inspector #722 indicated that neither resident was receiving

physiotherapy services. A physiotherapy referral was submitted by RN #105 on a specified date for resident #015, after a specified number of falls that occurred within a specified period of time. Review of the progress notes for both residents indicated that no physiotherapy assessments were completed, and neither resident was included in the physiotherapy treatment program.

During an interview with Inspector #722, the Physiotherapist (PT) confirmed that resident #015 and #019 were not receiving physiotherapy services, and indicated that no physiotherapy assessments were completed for either resident after any of their falls noted above. The PT confirmed that the policy indicated that since both residents were at a high risk for falls, and since a referral was received from RPN #105 for resident #015, that both residents should have had physiotherapy assessments and were potentially eligible to receive physiotherapy services according to the home's falls prevention program.

Inspector #722 reviewed the home's Therapeutic Hip Protector policy (Policy OTP-OPFP-8.2, Effective Date: May 2017), within the home's Falls Prevention Program, which indicated the following:
- 1. Purpose: To provide and implement a program where all residents at risk for falls are provided therapeutic hip protectors to prevent injury and promote comfort through Far Infra Red technology.
- 2. Policy: The Falls prevention program will ensure that all residents identified to be at risk for falls will be provided therapeutic hip protectors to prevent injury in the event of a fall. It is deemed that the following areas of risk will indicate the need for hip protectors to be worn: A diagnosis of Osteoporosis, Osteoarthritis or Osteopenia; Osteoporosis Screening Tool identified enhanced risk; MORSE Falls Risk Assessment; History of previous hip fracture; Diabetic residents with unstable blood sugars and, or on sliding scale insulin; Residents using Glucocorticoids for more than three months continuous use; Residents with dementia; Residents with unsteady walking and, or gait and independently transfers.

Review of resident #015's electronic health record by Inspector #722 indicated that the resident met several of the criteria identified in the policy for use of hip protectors, including specified diagnoses, high risk for falls, and unsteady gait.

During an interview with Inspector #722, RN #112 confirmed that resident #015 does not use hip protectors, and that they are not part of their plan of care. RN #112 indicated that the resident should probably have hip protectors, but was not able to recall the home's

policy on use of hip protectors. When Inspector #722 reviewed the indicators for hip protector use according to the policy, RN #112 confirmed that resident #015 met a number of the criteria.

The DOC indicated during an interview with Inspector #722, that resident #015 does not have hip protectors as part of the resident's plan of care, has never been provided hip protectors, and that the resident meets criteria for therapeutic hip protectors according to the home's falls prevention program.

Inspector #722 reviewed the home's policy related to the MORSE Falls Risk Assessment and Treatment Plan (Policy OTP-OPFP-8.4, Effective: May 2017), which indicated the following:
- 1 Purpose: To provide and implement a program where all residents are assessed for falls risk and to develop an individualized program to prevent falls with and without injury.
- 3. Procedure: All residents on admission will be assessed for falls risk using the MORSE Falls Risk Assessment tool as well as at significant change of status and post fall.

Inspector #722 reviewed the progress notes for resident #015 for a specified period, and identified a specified number of falls. Review of the assessments for resident #015 indicated that only two MORSE falls assessments had been completed. During separate interviews with Inspector #722, RN #107 and RPN #106 indicated that they were not aware that the MORSE falls risk assessment was supposed to be completed for every fall.

The DOC confirmed in an interview with Inspector #722, that the MORSE falls risk assessment tool should be completed on admission, with any significant change in status, and after every fall as per the falls prevention program, and acknowledged that this was not being done by staff as required after each resident fall. The DOC confirmed that registered staff were not aware that this was a requirement after each resident fall.

The licensee has failed to ensure that all components of the falls prevention program were implemented in the home, with the aim to reduce the incidence of falls and the risk of injury, as indicated by the following findings:
- Failed to have an interdisciplinary falls prevention committee in the home with a falls prevention lead, as indicated in Policy OTP-OPFP-8.0
- Failed to implement the Nursing Falls Prevention Program, as indicated in Policy OTP-OPFP-8.0

- Failed to complete physiotherapy assessments for residents #015 and #019, or assess them for potential inclusion in the physiotherapy falls prevention program, as required under Policy OTP-OPFP-8.0
- Failed to complete MORSE falls risk assessments for each resident fall for resident #015 and #019, as required under Policy OTP-OPFP-8.4
- Failed to provide therapeutic hip protectors to resident #015, as required under Policy OTP-OPFP-8.2 [s. 48. (1) 1.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 has failed to ensure that care set out in the plan of care was provided to resident #015 as specified in the plan.

During Stage 1 of the Resident Quality Inspection, resident #015 was identified as having had a fall within a specified period of time during an interview by Inspector #623 with the Clinical Coordinator (CC).

Inspector #722 reviewed resident #015's current written care plan, which specified a number of physiotherapy treatments, to be provided three times per week and 15-30

minutes per day. Inspector #722 reviewed the progress notes, assessments, and physiotherapy treatment records for resident #015 during a specified period of time, and there was no documentation available indicating that resident #015 had received a physiotherapy assessment after any falls during this period and/or received any physiotherapy treatments.

Inspector #722 reviewed a physiotherapy referral completed by RN #105 on as specified date, following a specified number of falls on specified dates. Review of the progress notes for resident #015 by Inspector #722 indicated that there was no documentation which indicated that the resident had been seen by, assessed, or treated by physiotherapy services in the home. Inspector #722 interviewed the Physiotherapist (PT #123) related to resident #015, who indicated that the resident has not been receiving any physiotherapy services. PT #123 also confirmed that a referral was received on as specified date, after the fall that occurred on a specified date that resulted in an injury, and that the resident was not assessed or added to the physiotherapy treatment services record. PT #123 indicated that they were not aware that the resident's plan of care indicated that resident #015 was supposed to be receiving physiotherapy treatments, and confirmed that resident #015 had not been receiving physiotherapy treatments as per the plan of care.

During an interview with the Director of Care (DOC) by Inspector #722, the DOC indicated that ACHIEVA Health provides physiotherapy services within the home, and that PT #123 is on contract from ACHIEVA Health to provide the services. The DOC confirmed that the resident's plan of care indicated that resident #015 should have been receiving physiotherapy services. The DOC also confirmed that there is no recent documentation indicating that the resident has been assessed by the physiotherapist or received any physiotherapy treatments.

The licensee has failed to ensure that resident #015 received physiotherapy treatments as set out in resident #015's plan of care. [s. 6. (7)]

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

During Stage 1 of the Resident Quality Inspection, resident #015 was identified as having had a fall within a specified period of time during an interview by Inspector #623 with the Clinical Coordinator (CC) #102 . Inspector #722 reviewed the progress notes for resident

#015 and identified that a specified number of falls had occurred over a specified period, and resident #015 sustained an injury after two of the falls. Inspector #722 reviewed two MORSE falls risk assessments that were completed on specified dates that indicated resident #015 was a high risk for falls.

Inspector #722 reviewed the progress notes, assessments and several versions of the written care plans for resident #015 related to the falls that were documented during the specified period. A post falls investigation was done for half of those falls, no MORSE falls assessments were completed immediately after any of the falls, and a physiotherapy referral was submitted after the fall on a specified date, but the resident was not assessed by the Physiotherapist.

Inspector #722 reviewed resident #015's current written care plan, which indicated the following interventions related to falls:
- Physiotherapy (Goal: To prevent falls over the next quarter): specified treatments three times per week for 15-30 minutes per day
- Sleep and Rest: specified interventions at bedtime and overnight, including toileting routines
- Falls: specified interventions related to mobility, foot wear, use of call bed, personal assistive devices, and various alarms

Inspector #722 reviewed an earlier version of resident #015's written care plan effective in late 2017 as the reference care plan, and determined that no new interventions were added/removed from the Falls section of the resident's care plan after three-quarters of the falls that occurred during this period; and new fall-related interventions were only added on three specified dates. During an interview with Inspector #722, the DOC identified one new specified intervention related to falls prevention that was added on a specified date to resident #015's plan of care after one of their falls during the specified period.

Review of the progress notes for resident #015 by Inspector #722, as well as separate interviews with the DOC and RPN #125, indicated that new specified interventions were added to the resident's written care plan on a specified date of the most recent fall, only after the substitute decision maker (SDM) had requested that they be added. The progress notes also indicated that the SDM requested that a sign be placed above resident #015's bed to ensure staff were aware that specified interventions should be in place; however, this intervention was not added to the written care plan and there were no instructions for staff related to the sign identified elsewhere by Inspector #722 in the

resident's plan of care.

Review of resident #015's current written care plan by Inspector #722 indicated that the resident was supposed to be receiving physiotherapy treatments as a falls prevention intervention. In an interview with Inspector #722, PT #123 indicated that the physiotherapy treatments identified in the plan of care were not being provided. PT #123 indicated that they had received a referral on a specified date, after two recent falls that occurred on specified dates, but the resident was not assessed and/or new interventions added to the resident's plan of care by the physiotherapy department. PT #123 also confirmed that resident #015 did not receive any physiotherapy assessments after any of their falls over a specified period.

During separate interviews with Inspector #722, PSW #124, RPN #125, and RN #107, indicated that they had not participated in any interdisciplinary team discussions related to new interventions to address resident #015's risk of falls. Registered staff interviewed confirmed that they were aware that resident #015 was a high risk for falls for a long period of time, and confirmed that new falls prevention interventions were added to the resident's plan of care after the resident sustained a fracture during the most recent fall on a specified date, and indicated that those interventions were requested by the SDM.

In an interview with Inspector #722, the DOC confirmed that resident #015's care plan was not reviewed by the interdisciplinary team for risk of falls every six months and/or as needed for change in condition. The DOC indicated that the resident's plan of care may have been reviewed for risk of falls in nursing huddles, ad hoc discussions with staff, and in Quality Improvement meetings that included the management team, but verified that there was no documentation indicating that falls-related interventions were reviewed and the plan of care revised accordingly. During this interview, the DOC also confirmed that many of the interventions added to resident #015's written care plan over the period when the specified number of falls occurred were not interventions, but were assessment findings and potential causes of falls. The DOC also confirmed that specified falls prevention interventions were only added to resident #015's plan of care after a specified number of falls resulting in various injuries had occurred during the specified period; that these interventions were only added after they were requested by the resident's SDM; and that different interventions related to falls should have been considered sooner.

The licensee failed to ensure that different fall prevention approaches were considered in the revision of the plan of care, when the resident was reassessed and the plan of care was being revised because care set out in the plan has not been effective, when no

revisions were made to the resident's plan of care after nine falls that occurred over a specified period; and the resident was not assessed and/or physiotherapy treatments provided by the physiotherapist after any of their falls during the specified period. [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 by ensuring that residents at risk of falls are assessed and receive physiotherapy services according to the falls prevention program, that physiotherapy services are provided to residents as indicated in the plan of care, and that different approaches for fall prevention are considered when the resident's plan of care is being revised because care set out in the plan has not been effective,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's risk of falls.

During stage 1 of the Resident Quality Inspection (RQI), resident #015 was identified as having had a fall within a specified period of time during an interview by Inspector #623 with the Clinical Coordinator (CC) #102, which triggered for further inspection. Inspector #722 reviewed the progress notes for resident #015 and identified a specified number of documented falls over a specified period. The progress notes indicated that resident #015 sustained an injury after a number of the falls, on specified dates. Inspector #722 reviewed two MORSE falls risk assessments that were completed on specified dates that

indicated resident #015 was a high risk for falls.

Inspector #722 reviewed the progress notes and assessments for resident #015, which indicated that all falls risk assessments for resident #015 had been completed by registered nurses (RNs) in the home for the specified number of falls over a specified period. During this period, a focused assessment was conducted by an RN for each fall that included vital signs, injuries sustained, and range of motion; a formal post falls assessment was done for a specified number of those falls by RNs in the home; the quarterly MORSE falls risk assessments were completed by an RN on specified dates; and the RAI-MDS assessment was completed by an RN on a specified date. Two assessments were completed by MD #126 on specified dates, and documented in the progress notes for resident #015, that identified the injuries sustained during the falls on specified dates; the MD assessments did not include falls risk and there were no interventions and/or instructions provided related to falls prevention. A physiotherapy referral was submitted by an RN after the fall on a specified date; however, the resident was not assessed by the Physiotherapist, which was confirmed by PT #123 when interviewed by Inspector #722. Inspector #722 did not identify any further assessments and/or interventions related to falls prevention in the resident's electronic health record.

In separate interviews with Inspector #722, PSW #124, RPN #125, and RPN #106 indicated that when a resident falls, it is the responsibility of the registered nurse (RN) on duty to assess the resident; and they did not recall being involved in any meetings with any other disciplines in the home (e.g., physiotherapy, dietary, etc.) related to falls prevention or any resident's risk of falls where assessments and new interventions were discussed.

RN #107 was interviewed by Inspector #722, and indicated that when a resident falls, the RN is called to do a brief assessment to determine the resident's status (e.g., including injuries, vital signs, and range of motion) and course of action. RN #107 also indicated that the RN on duty is responsible for completing the formal post fall assessment in the electronic health record within 24 hours after a resident fall. RN #107 indicated during the interview that they have never been involved in any meetings and/or discussions with other staff in the home (e.g., physiotherapy, dietary, medical) related to falls risk assessments and/or interventions for resident #015. RN #107 confirmed during the interview that there is no interdisciplinary falls prevention committee in the home and/or falls prevention lead that they were aware of.

During an interview with Inspector #722, the DOC indicated that the expectation when a

resident falls is that registered staff and the charge nurse on shift would review the care plan and make updates; the DOC indicated that they were not sure that those reviews were happening. The DOC also indicated that care plans in general are reviewed by the Clinical Coordinator (CC) during staff huddles to discuss different approaches to care for residents, including risks of falls, but indicated that those huddles only include the PSWs and nursing staff, there is no documentation, and it is not clear if the written care plans were updated after the huddles with new interventions. During the interview with Inspector #722, the DOC also indicated that when the physiotherapist received the referral from the registered staff on a specified date, after the falls that occurred on specified dates, that a physiotherapy assessment was not done and that it should have been done. The DOC also confirmed that they were aware the interdisciplinary assessments are required and that there was no indication in resident #015's plan of care indicating that interdisciplinary assessments had been done. The DOC confirmed that the home does not have a formal falls prevention committee where the interdisciplinary team can meet to discuss residents at risk for falls.

The licensee failed to ensure that resident #015's plan of care was based on an interdisciplinary assessment with respect to the resident's risk of falls. [s. 26. (3) 10.]

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 plan of care for each resident in the home is based on, at a minimum, an interdisciplinary assessment of the resident's health conditions, including risk of falls,, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written staffing plan for the nursing and personal support services programs.

This inspection was initiated when Inspector #722, during a staff interview with RPN #118, discovered that there were two RPN's on duty in the home on a specified date during a specified shift, and no RN.

During an interview with Inspector #722, the DOC indicated there is no written staffing plan for nursing and personal support services. The DOC indicated that this is a process that staff know and it is verbally communicated, but it is not written.

During an interview with Inspector #623, the Office Manager indicated that there is no written staffing plan for nursing and personal support services. Registered staff are aware of the expectation for the allocation of nursing staff in the event that a shift cannot be covered, but this is not a formal written plan.

During an interview with Inspector #623, the Administrator indicated that there is no written staffing plan for the nursing and personal support services programs.

The licensee failed to ensure that there is a written staffing plan for the nursing and personal support services programs. [s. 31. (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 by ensuring that there is a written staffing plan for the nursing and personal support services programs,, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident of a long-term care home has their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and in the case of new items, of acquiring.

Inspector #722 completed the initial home tour on a specified date. The spa room was observed at 1115 hours and the following was noted: On one of the lower shelves of the white shelving unit, a bin was observed with multiple personal care items that were not labelled. During an interview with Inspector #722, PSW #101 indicated that the unlabelled items were "communal" items, and were used for all residents. PSW #101 indicated that the items probably should not be shared.

During Stage 1 of the RQI, the following was observed by Inspected #722:
- Bathroom shared by two residents in specified room: empty urinal hanging from the safety rail, a bedpan on the floor, and an unlabelled empty specimen container on the floor; and unlabelled personal care items were found on the bathroom counter (Resident #001 indicated that all items that are in the bathroom belong to their roommate.)
- Bathroom shared by two residents, in another specified room: unlabelled urine collection basin and unlabelled bedpan in racks on wall
- Bathroom shared by four residents, in another specified room: unlabelled urinal and wash basin hanging from racks on wall, bedpan labelled with name of a resident who does not reside in that room, unlabelled specimen collection container on back of toilet
- Bathroom shared by two residents, in another specified room: one unlabelled bed pan in rack on wall
- Bathroom shared by four residents, in another specified room: one wash basin unlabelled in rack, one unlabelled specimen container (empty) on back of toilet, and reading glasses unlabelled on the bathroom counter

During Stage 1 of the RQI, Inspector #623 observed the following:
- Bathroom shared by four residents, in another specified room: three basins, one bedpan and a urinal in three holders on the wall of the bathroom, and no labels on any of the items
- Bathroom shared with four residents, in another specified room: two soiled urine hats unlabelled in bathroom, one beside toilet, one in wire holder on wall; a used bed pan unlabelled in a wire holder on wall

During an interview with Inspector #623, Environmental Services Manager (ESM) #110 indicated that the residents' personal items such as bedpan, basin and urinals are dedicated to one specific resident and should be labeled as such. The ESM indicated that nursing is responsible to ensure that these items are labelled and they are also responsible for the cleaning of these items once weekly and as needed.

During an interview with Inspector #623, PSW #121 indicated that all residents' personal care item are required to be labelled. PSW indicated that they were unsure as to why the residents in one of the rooms specified above did not have labels on the basins, bed pan or urinal that were in the wire racks in the bathroom. PSW #121 indicated that when providing morning care for the residents in that room, they would pick any basin to use, and then have it cleaned using a Virox wipe following use. PSW #121 indicated that when a resident is admitted, their personal items are to be labelled by the PSW assigned to them. PSW #121 was uncertain who was responsible for labeling personal items when a resident has been in the home for a long time. PSW #121 was unable to identify which items belonged to which resident in one of the bathrooms specified above, that was shared by four residents and where the unlabelled basins (3), urinal and bedpan were observed.

During an interview with Inspector #623, RPN #106 indicated that the PSWs are responsible for ensuring that all residents' personal care items are labelled. RPN #106 indicated that all basins, bedpans, and urinals need to be labelled for the specific resident that they are assigned to, and that these are not shared items. RPN #106 was unable to identify which items belonged to which resident in one of the bathrooms specified above, that was shared by four residents and where the unlabelled basins (3), urinal and bedpan were observed..

During an interview with Inspector #623, the Director of Care (DOC) indicated that when a resident is admitted to the home a PSW is assigned to label all personal items. The DOC indicated that the PSWs are responsible to ensure that all resident care items are

labelled on an ongoing basis, including bedpans, urinals and basins. The DOC indicated that it is the expectation of the licensee, that all resident personal care items are labelled and in the correct residents' room.

The licensee failed to ensure that residents' personal items are labelled within 48 hours of admission and, in the case of new items, of acquiring. [s. 37. (1) (a)]

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 by ensuring that every resident of the long-term care home has their personal items labelled within 48 hours of admission, or within 48 hours of acquiring new items,, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

During stage 1 of the Resident Quality Inspection, resident #015 was identified as having a fall within the past 30 days in a staff interview conducted by inspector #623 with the home's Clinical Coordinator (CC) #102, as well as in the most recent RAI-MDS Assessment. Review of the progress notes and critical incident reports indicated that resident #015 had sustained a specified number of falls over a specified period in 2018,

two of which resulted in injury.

Inspector #722 reviewed the home's fall prevention policy (OTP-OPFP-8.6), which indicated that the post fall assessment shall be initiated as soon as possible after the resident has been assessed and is safe and comfortable. The policy also indicated that the post fall assessment shall be completed within twenty-four hours of the fall and provided to the Director of Care for review on the electronic record, and that the completed post fall assessment shall be filed in the resident's electronic clinical record. The Post Fall Investigation Assessment form (OTP-OPFP-8.7) identified all information required for the post fall assessment, which is to be captured using the electronic tool in the resident's electronic medical record.

Inspector #722 reviewed the post fall assessments for resident #015 related to the specified number of falls during the specified period, and identified post falls assessments completed by registered nursing staff in the electronic medical record for only half of the falls; no post fall assessments were documented in the electronic medical record for the other falls.

During an interview with Inspector #722, RN #112 indicated that the expectation is that a post fall assessment should be done after any resident fall, and that the assessment is completed in the electronic health record using the post fall assessment tool. RN #112 confirmed that post fall assessments using the appropriate tool were not completed on the dates indicated above, and confirmed that these assessments should have been completed as per the home's falls prevention policies.

Inspector #722 interviewed the DOC related to falls involving resident #015. The DOC indicated that a post-fall assessment should be completed for every resident fall using the tool in the electronic health record. The DOC indicated that the expectation is that the tool is completed without exception and that the assessment in the progress notes is not adequate after a resident fall. The DOC confirmed that the appropriate post fall assessments were not completed for resident #015 for a specified number of falls on specified dates.

The licensee failed to ensure that when resident #015 sustained a specified number of falls on specified dates, that a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (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 by ensuring that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls,, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45.(1) and 45.1 of the regulation).

Under O.Reg 79/10, section 45. (1) 1. For homes with a licensed bed capacity of 64 beds of fewer,
i. a registered nurse who works at the home pursuant to a contract or agreement between the nurse and the licensee and who is a member if the regular nursing staff may be used,
ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met,
A. a registered nurse who works at the home pursuant to a contract or agreement between the licensee and as employment agency or other third party may be used if the

Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone., or
B. a registered practical nurse who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone.

On a specified date, it was discovered by Inspector #722 during a staff interview with RPN #118, that there was no RN on duty in the home on that date during a specified shift; and that there were two RPN's on duty in the home at that time.

During an interview with Inspector #722, the DOC confirmed that there was no RN in the building for the specified shift on the specified date. The DOC indicated that the schedule provided to the inspector at the beginning of the inspection identified that there was no RN scheduled for a particular shift on a specified date, and that the RN who was scheduled was unable to work the shift due to an appointment. The DOC indicated that all efforts were exhausted to cover the shift including contacting the agency, but there was no one available. The DOC indicated that they were unaware that they were on-call that evening, and were unsure if the staff were informed that the DOC was on-call. The DOC indicated that Office Manager #122 does the scheduling and is supposed to notify the DOC when a shift cannot be covered, so that they are aware that they are on call.

During an interview with Inspector #623, Office Manager #122 indicated that when they are short an RN, it is understood that the DOC is either available in the building, or on-call, available by phone. The Office Manager indicated that staffing concerns are discussed at the manager morning meeting, the DOC is notified verbally if there are any gaps in RN coverage. It is understood that if the shift cannot be covered by an RN, that the DOC will be available. There is no written record or notification that is provided to the DOC, the communication is verbal. The Office Manager indicated that the RN's in the home have never been asked to be on call, it has always been the responsibility of the DOC.

During an interview with Inspector #623, the Administrator indicated that the expectation is that the Director of Care (DOC) is available by phone when an RN that is a member of the regular nursing staff, is not present in the home. The Administrator indicated that the DOC is informed verbally of all nursing staffing concerns, by the Office Manager during business hours, or by the RN Charge Nurse.

The licensee failed to ensure that there was at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement. The allowable exception for a home with 64 beds of fewer, was not followed, when the DOC was unaware that they were on call and there was no RN who is a regular employee of the home, designated to be available by phone when two RPN's were scheduled to work a specified shift on a specified date, with no RN in the building. [s. 8. (3)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that when there is no Family Council, that they convene semi-annual meetings to advise residents' families and persons of importance to residents of the right to establish a Family Council.

The Administrator was interviewed by Inspector #722 related to the Family Council. The Administrator confirmed that there is currently no functioning Family Council in the home. When asked if the licensee convenes semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council, the Administrator indicated that there have been three Family Information Nights scheduled in the past year: one to discuss the Resident Quality Inspection (RQI) report, one to discuss the upcoming accreditation, and another to discuss a critical incident (CI) inspection report.

The Administrator indicated that at each of these meetings, they would have discussed their right to establish a Family Council. The Administrator was unable to locate and/or provide an agenda for any of these meetings indicating the purpose of the meeting, and indicated that there are no meeting minutes available for any of these meetings. The Administrator indicated that an invite was mailed out to resident family members prior to the meetings, but was unable to show any evidence of an invite (via mail or email) to resident family members over a specified period. The Administrator indicated that posters have been posted in the home to announce the Family Information Nights, but was unable to produce any of the materials and confirmed that there is no Family Council bulletin board at present in the home.

Inspector #722 observed the information bulletin boards in the front lobby of the home during the initial home tour on a specified date, and again on another specified date, related to Family Council, and there were no notices present indicating that a meeting was being convened involving resident family members or persons of importance to residents.

The licensee has failed to convene any meetings specifically to advise residents' families and persons of importance to residents of the right to establish a Family Council. [s. 59. (7) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

During the Resident Quality Inspection (RQI), Inspector #623 reviewed the medication incident reports that were discussed at the most recent quarterly PAC meeting held on July 26, 2018. The last medication incident was selected for further review as required according to the medication inspection protocol.

The medication incident report indicated the following:

On a specified date, it was discovered that resident #017 had been receiving a treatment cream to a specified area twice daily. A physicians order was received on a specified date indicating that the treatment cream was to be discontinued as the affected area was now healed. This order was first checked by RN #117 and second checked by RN #112. The order was not removed from the PSW's treatment records and the treatment cream was not placed in the location for destruction, and remained available to the PSW staff. On June 8, 2018, it was discovered that the treatment cream had been applied twice daily by the PSW for seven days, without an order.

During an interview with Inspector #623, RN #112 indicated that when an order is received, the nurse that completes the second check is ensuring that the order has been processed by the nurse that signed for the first check. The RN indicated that the second check verification is completed by ensuring that orders are entered or removed from the electronic records, the appropriate requisition is completed if required, ensuring the pharmacy is made aware of the changes. If a medication is discontinued, this would also include ensuring that the medication has been removed from the cart and placed into the bin for destruction. If it was a treatment cream, it would be removed to ensure that it is no longer available for use and the treatment would be removed from the paper treatment administration record (TAR) that the PSWs sign on. RN #112 indicated that they did complete the second check of the physician order for resident #017, to discontinue the

treatment cream. The RN indicated that they were uncertain of why the treatment cream was not removed from the paper TAR or why the treatment cream was not placed into the bin for destruction, once the treatment was discontinued.

RN #117 was not available for an interview during this inspection.

During an interview with Inspector #623, the DOC indicated that the expectation of the licensee is that when a physician order is received, the RN or RPN will complete a first and second check during the processing of the orders, to ensure that appropriate action is taken to implement the orders. The expectation is that the nurse who completes the second check, is verifying that the order was processed correctly. The DOC indicated that during a specified period, resident #017 received a treatment cream for a specified number of days without an order.

The licensee failed to ensure that no drug was used by or administered to resident #017 unless the drug has been prescribed for the resident. [s. 131. (1)]

Issued on this 18th day of January, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	COREY GREEN (722), SARAH GILLIS (623)
Inspection No. / No de l'inspection :	2018_749722_0003
Log No. / No de registre :	019214-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 7, 2018
Licensee / Titulaire de permis :	0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	Maplewood 12 Maplewood Avenue, Box 249, BRIGHTON, ON, K0K-1H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rachel Corkery

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership, you are hereby required to comply with the following order(s) by the date (s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee must be compliant with s. 48. (1) 1. of O.Reg 79/10 of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must:

1. Implement the Nursing Falls Prevention Program, as per Policy OTP-OPFP-8.0;
2. Designate a falls prevention lead and establish an interdisciplinary falls prevention committee, with supporting documentation (e.g., meeting agenda, minutes, participants, etc.), as per Policy OTP-OPFP-8.0;
3. Ensure all residents who sustain a fall receive a post fall assessment, and any other assessments as required, under the licensee's falls prevention program;
4. Ensure residents who sustain a fall and/or are identified at risk for falls, including resident #015, receive a physiotherapy assessment and are included in the physiotherapy program, as per the falls prevention program;
5. Provide therapeutic hip protectors to any eligible resident, specifically resident #015, as per the home's policy, and clearly document any refusals to use the hip protectors by the resident and/or their substitute decision maker in the resident's electronic health record.

The licensee shall prepare, submit, and implement a plan of correction to ensure that the home is compliant with s. 48. (1) 1. of O.Reg 79/10 of the Long-Term Care Homes Act, 2007, as specified above.

The plan is to be submitted by e-mail to CentralEastSAO.MOH@ontario.ca referencing report #2018_749722_0003 to the attention of Corey Green, LTC Homes Inspector, MOHLTC, by January 11, 2019, and implemented by March 1, 2019. Please ensure that the submitted written plan does not contain any personal information and/or personal health information.

Grounds / Motifs :

1. The licensee has failed to ensure that all components of the interdisciplinary falls prevention and management program were implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

During staff interviews conducted by Inspector #623 during Stage 1 of the Resident Quality Inspection (RQI), two residents were identified in the home as

having had falls within the past 30 days. Review of the progress notes for resident #015 by Inspector #722 indicated that the resident had sustained a number of falls in a specified period, including a number of falls that resulted in injuries. Resident #019 had sustained a fall on a specified date, without injury. During review of progress notes, care plans, assessments and staff interviews related to these falls, Inspector #722 identified that portions of the falls prevention program were not implemented in the home according to existing written policies as detailed below.

Inspector #722 reviewed the home's falls prevention program manual, the Achieva Health Falls Prevention Program, Policy and Procedure Manual (Policy OTP-OPFP-8.0), with a copyright date of 2017, which indicated the following under the Falls Risk Assessment Action Plan:
- Nursing Falls Prevention Program (for residents identified as being at high, medium, or low risk of falls): Post Fall Problem Solving, Environmental Modification, Referral to Physician, Referral to Pharmacy for Medication Review, and Referral to Dietician for Review of Dietary Needs.

The electronic health record and paper chart were reviewed by Inspector #722 for resident #015 related to a specified number of falls that were identified in the progress notes for a specified period. During this period, there was no documentation available related to resident #015's falls that indicated any post fall problem solving had occurred; no referrals to pharmacy were identified for medication review; and no dietitian referrals were identified related to risk of falls.

Review of the written care plan for resident #015 by Inspector #722 during this inspection indicated that there were no revisions to the care plan related to falls prevention after a specified number of falls that occurred on specified dates. The DOC indicated in an interview with Inspector #722 that when a fall occurs, the registered staff and charge nurse on shift would review the care plan and make updates. During the interview, the DOC confirmed that the care plan had not been updated after the falls as identified above for resident #015, and indicated that they were not sure that those care plan reviews were happening regularly.

DOC #103 confirmed during an interview with Inspector #722 that the home has adopted the ACHIEVA Health Falls Prevention Program (Policy OTP-OPFP-8.0)

to reduce the risk of falls for residents in the home. During the interview, the DOC indicated that none of the activities identified above under the Nursing Falls Prevention Program have been consistently implemented, and confirmed that they are required according to the policy. Specifically, the DOC indicated that post fall huddles and discussions about resident's risk for falls are done ad hoc and informally.

The Administrator of the home also confirmed in an interview with Inspector #722, that the home has adopted the ACHIEVA Health Falls Prevention Program (Policy OTP-OPFP-8.0) in the home, and also confirmed that the activities required under the Nursing Falls Prevention Program have not been implemented as per the policy.

Inspector #722 reviewed the home's falls prevention program manual during this inspection, the Achieva Health Falls Prevention Program, Policy and Procedure Manual (Policy OTP-OPFP-8.0), with a copyright date of 2017, which indicated the following related to the Falls Prevention Lead and Falls Prevention Committee in the home:
- The physiotherapist's responsibilities for Falls Prevention include the following: Participate in the Interdisciplinary Falls Prevention Committee Team at the LTC/RH; Communicate with the team to determine who has fallen and to strategize on how to prevent future falls.
- Under Health and Safety Policy: 2. The Falls Prevention Lead should know the Resident's abilities and limitations.

In separate interviews with Inspector #722, PSW #124 and #119, RPN #106 and RN #107 indicated that they were unsure who the Falls Prevention Lead in the home was, that they were not aware of an Interdisciplinary Falls Prevention Committee, and had not participated in any interdisciplinary team meetings related to resident falls and/or falls prevention.

The DOC indicated during an interview with Inspector #722, that they thought they may be the Falls Prevention Lead, but were not sure, and confirmed that according to the home's policy, a Falls Prevention Lead was required. The DOC also confirmed that there was no Interdisciplinary Falls Prevention Committee in the home, and that it was required according to the home's falls prevention program.

The home's Administrator also confirmed during an interview with Inspector #722, that there was no formal Interdisciplinary Falls Prevention Committee Team or Falls Prevention Team Lead identified in the home, and that both were required according to their falls prevention program. The Administrator also indicated that the expectation was that the DOC would function in the role as the Falls Prevention Committee Team Lead, but indicated during the interview that they were aware that the DOC was not performing the functions of that role.

Policy OTP-OPFP-8.0 of the ACHIEVA Health Falls Prevention Program Manual was reviewed by Inspector #722, which indicated the following:
- Policy: 1. Assess and identify residents who have fallen or may be at risk to fall due to biological and environmental factors, and 2. Provide treatment strategies to improve strength, balance, mobility, posture, and seating based on Physiotherapy "best practices".
- Eligibility Criteria: 1. Once a referral is received by the Physiotherapist, a comprehensive Physiotherapy Assessment including a Falls Risk test is completed; and 2. Residents who have sustained a fall will be referred immediately by the Physician/Registered Nurse for Assessment by the Physiotherapist.

The progress notes were reviewed for residents #015 and #019 related to falls for a specified period, and indicated that resident #015 had sustained a specified number of falls, and resident #015 had sustained a specified number of falls. Review of the physiotherapy records by Inspector #722 indicated that neither resident was receiving physiotherapy services. A physiotherapy referral was submitted by RN #105 on a specified date for resident #015, after a specified number of falls that occurred within a specified period of time. Review of the progress notes for both residents indicated that no physiotherapy assessments were completed, and neither resident was included in the physiotherapy treatment program.

During an interview with Inspector #722, the Physiotherapist (PT) confirmed that resident #015 and #019 were not receiving physiotherapy services, and indicated that no physiotherapy assessments were completed for either resident after any of their falls noted above. The PT confirmed that the policy indicated that since both residents were at a high risk for falls, and since a referral was

received from RPN #105 for resident #015, that both residents should have had physiotherapy assessments and were potentially eligible to receive physiotherapy services according to the home's falls prevention program.

Inspector #722 reviewed the home's Therapeutic Hip Protector policy (Policy OTP-OPFP-8.2, Effective Date: May 2017), within the home's Falls Prevention Program, which indicated the following:
- 1. Purpose: To provide and implement a program where all residents at risk for falls are provided therapeutic hip protectors to prevent injury and promote comfort through Far Infra Red technology.
- 2. Policy: The Falls prevention program will ensure that all residents identified to be at risk for falls will be provided therapeutic hip protectors to prevent injury in the event of a fall. It is deemed that the following areas of risk will indicate the need for hip protectors to be worn: A diagnosis of Osteoporosis, Osteoarthritis or Osteopenia; Osteoporosis Screening Tool identified enhanced risk; MORSE Falls Risk Assessment; History of previous hip fracture; Diabetic residents with unstable blood sugars and, or on sliding scale insulin; Residents using Glucocorticoids for more than three months continuous use; Residents with dementia; Residents with unsteady walking and, or gait and independently transfers.

Review of resident #015's electronic health record by Inspector #722 indicated that the resident met several of the criteria identified in the policy for use of hip protectors, including specified diagnoses, high risk for falls, and unsteady gait.

During an interview with Inspector #722, RN #112 confirmed that resident #015 does not use hip protectors, and that they are not part of their plan of care. RN #112 indicated that the resident should probably have hip protectors, but was not able to recall the home's policy on use of hip protectors. When Inspector #722 reviewed the indicators for hip protector use according to the policy, RN #112 confirmed that resident #015 met a number of the criteria.

The DOC indicated during an interview with Inspector #722, that resident #015 does not have hip protectors as part of the resident's plan of care, has never been provided hip protectors, and that the resident meets criteria for therapeutic hip protectors according to the home's falls prevention program.

Inspector #722 reviewed the home's policy related to the MORSE Falls Risk Assessment and Treatment Plan (Policy OTP-OPFP-8.4, Effective: May 2017), which indicated the following:
- 1 Purpose: To provide and implement a program where all residents are assessed for falls risk and to develop an individualized program to prevent falls with and without injury.
- 3. Procedure: All residents on admission will be assessed for falls risk using the MORSE Falls Risk Assessment tool as well as at significant change of status and post fall.

Inspector #722 reviewed the progress notes for resident #015 for a specified period, and identified a specified number of falls. Review of the assessments for resident #015 indicated that only two MORSE falls assessments had been completed. During separate interviews with Inspector #722, RN #107 and RPN #106 indicated that they were not aware that the MORSE falls risk assessment was supposed to be completed for every fall.

The DOC confirmed in an interview with Inspector #722, that the MORSE falls risk assessment tool should be completed on admission, with any significant change in status, and after every fall as per the falls prevention program, and acknowledged that this was not being done by staff as required after each resident fall. The DOC confirmed that registered staff were not aware that this was a requirement after each resident fall.

The licensee has failed to ensure that all components of the falls prevention program were implemented in the home, with the aim to reduce the incidence of falls and the risk of injury, as indicated by the following findings:
- Failed to have an interdisciplinary falls prevention committee in the home with a falls prevention lead, as indicated in Policy OTP-OPFP-8.0
- Failed to implement the Nursing Falls Prevention Program, as indicated in Policy OTP-OPFP-8.0
- Failed to complete physiotherapy assessments for residents #015 and #019, or assess them for potential inclusion in the physiotherapy falls prevention program, as required under Policy OTP-OPFP-8.0
- Failed to complete MORSE falls risk assessments for each resident fall for resident #015 and #019, as required under Policy OTP-OPFP-8.4
- Failed to provide therapeutic hip protectors to resident #015, as required under

Policy OTP-OPFP-8.2

The severity of this issue was determined to be a level 3 as there was actual harm to a resident. The scope of the issue was a level 3 (widespread), as the lack of a falls prevention program impacts every resident in the home. The home had a level 2 compliance history as they had previous unrelated noncompliance. (722) (722)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 7th day of December, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Corey Green

Service Area Office /
Bureau régional de services : Central East Service Area Office