Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

# Inspection Report under the Long-Term Care Homes Act, 2007

# 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**
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## 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 4, 2019 | 2019_716554_0005 | 010851-19, 017676-19, 018458-19, 018831-19 | Critical Incident System |

**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**

KELLY BURNS (554)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): September 25-27, September 30, and October 01-04, 2019.**

**The following intakes were inspected, #017676-19, #018458-19, #018471-19 and #018831-19.**
**All intakes inspected related to falls that caused an injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health condition.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Clinical Coordinator (CC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Housekeeper (HSK), the Physiotherapist (PT) and residents.**

**The following Inspection Protocols were used during this inspection:**
**Critical Incident Response**
**Falls Prevention**
**Safe and Secure Home**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **4 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**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).**

**Findings/Faits saillants :**

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Related to Log #017676-19:

A CIR was submitted to the Director on an identified date regarding a fall that caused an injury to resident #002 for which the resident was taken to hospital and resulted in a significant change in the resident's health condition.

During interviews PSW #102, PSW #111, RPN #101 and RN #100 indicated to Inspector #554 that resident #002 was identified as being at risk for falls.

Resident #002 was observed by Inspector #554 in a mobility aid. The resident's mobility aid was equipped with a safety device. The safety device was not attached to resident #002 during this observation. Inspector #554 attended resident's room, the transfer logo on the head board of the resident's bed indicated the resident was assessed to be a specific transfer.

The plan of care was reviewed by Inspector #554 for identified dates. The written care plan which is part of the plan of care and directed the following:

- Transfers: Interventions include, transfer logo on head of bed; position mobility aid by bed prior to transfers and cue resident to use the mobility aid for balance; limited assistance; received physical help in non-weight bearing assistance; one-person physical

assist.
- Toileting: Interventions include, extensive assistance; received physical help in weight bearing assistance, one-person physical assist.
- Walk in room and corridor: Interventions include, stand resident up slowly and wait until resident is stable while standing before attempting to ambulate; supervision, oversight, encouragement or cueing provided.
- Aids to Daily Living: Interventions include, ensure resident is using a mobility aid as required.
- Falls and Balance: Interventions include, safety device while in bed at bedtime (HS).

The progress notes were reviewed by Inspector #554 for identified dates. The progress notes indicated the following:

On an identified date, the Physiotherapist (PT) documented in a progress note, that resident #002 is not able to use an identified mobility aid properly due to discomfort. The PT indicated in the progress note that resident #002 was unsafe to use the identified mobility aid and was to use an alternative mobility aid.

On an identified date, RN #116 documented in a progress note, that resident was at risk for falls and had a recent fall that resulted in injury. RN #116 indicated that resident uses a mobility aid but requires the mobility aid at times when unsteady. RN #116 indicated care plan was reviewed and remains up to date.

During an interview PSWs #102 and #103 indicated to Inspector #554 that the transfer logo on resident's bed was incorrect, indicating that resident #002 requires two staff for all transfers and for toileting. PSW #102 and PSW #103 indicated that resident uses a mobility aid for mobility. PSW #102 indicated that a safety device is utilized for resident #002, while in the mobility aid and while in bed as a fall prevention intervention.

During an interview PSW #102 reviewed an identified written care plan, with Inspector #554 and indicated that the written care plan was confusing and would be unclear to staff not familiar with resident #002.

During an interview RPN #101, the Clinical Coordinator (CC) and the Director of Care (DOC) indicated to Inspector #554 that the transfer status for each resident is identified in the resident's written care plan and on a logo, which is located on the headboard of the resident's bed. RPN #101, the CC and the DOC indicated that both the written care plan and the logo should be the same.

RPN #101, RN #100, the CC and the DOC reviewed the identified written care plan and two identified progress notes with Inspector #554 and indicated that the plan of care was not consistent, specifically related to transfers, toileting, mobility, aids for daily living (mobility aids used by the resident) and falls and balance. RPN #101, RN #100, the CC and the DOC indicated that the plan of care for resident #002 did not provide clear direction to PSWs and others caring for the resident.

The licensee had failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident #002 related to transfers, toileting, mobility, aids used for daily living and falls and balance.

Related to Resident #004:

During the inspection of Log #017676-19 non-compliance was identified pursuant to LTCHA, s. 6 (1) (c). Inspector #554 expanded the scope to include resident #004 who was at risk for falls.

Resident #004 was observed by Inspector #554 on an identified date seated in a mobility aid in the hallway, a safety device was attached to the resident's mobility aid, but the cord clip of the safety device was not attached to the resident.

The identified written care plan was reviewed by Inspector #554 and identified that resident #004 was at high risk for falls. The written care plan indicated that the resident used a safety device when unwell.

Inspector #554 reviewed the plan of care with PSW #102 and RN #100. During an interview Inspector #554 asked PSW #102 and RN #100 to explain what is meant by safety device when unwell, both PSW #102 and the RN indicated being unsure what the intervention meant. PSW #102 indicated that resident #004 was always to have a safety device in place. PSW #102 and RN #100 indicated that the intervention indicating safety device when unwell was unclear.

The CC indicated to Inspector #554 during an interview that the intervention, safety device when unwell, indicated in resident #004's plan of care was unclear and could be confusing to staff providing care.

The licensee failed to ensure that the plan of care set out clear directions for staff and

others who provide care to resident #004, specifically the use of a safety device as part of the Falls Prevention and Management for resident #004.

Related to Log #018458-19:

A CIR was submitted to the Director on an identified date regarding a fall that caused an injury to resident #003 for which the resident was taken to hospital and resulted in a significant change in the resident's health condition.

The plan of care for resident #003, including the written care plan, progress notes and physiotherapy assessments, was reviewed by Inspector #554 for identified dates.

Resident #003 had an unwitnessed fall on an identified date, sustained injury and was transferred to the hospital and diagnosed to have injury. The resident received treatment was discharged from the hospital on an identified date and readmitted to the long-term care home.

On an identified date, resident #003 was assessed by registered nursing staff to be at risk for falls, was using a mobility aid and that a safety device was being utilized due to falls risk. RN #100 indicated in a progress note that resident was weight bearing as tolerated.

A number of days later, a progress note written by RN #100 indicated that resident was a two-person transfer.

The written care plan for an identified date indicated the following:

- Transferring – Interventions included, one-person transfer.
- Toileting – Interventions included, one-person extensive assistance, physical help in weight bearing.
- Walk in room and in corridor – Interventions included, one-person limited assistance, physical help in weight bearing.
- Aids to Daily Living – Interventions included, fully independent without devices.
- Falls and Balance – Interventions included, monitor gait throughout the day, if resident becomes unsteady have resident sit and rest where resident can be monitored.

The Physiotherapist documented that resident #003 required two-staff to assist with all transfers using an identified mobility aid, PT indicated resident #003 was not to pivot on a

specific side. The PT indicated resident was not able to ambulate at this time and was using an identified mobility aid for locomotion.

During an interview PSW #102 and RN #100 indicated to Inspector #554 that resident #003 was currently a two-person assist for toileting and transferring, used a mobility aid and was currently not ambulating.

The plan of care, including the written care plan and progress notes, for resident #003 was reviewed with PSW #102, RN #100, the CC and Inspector #554. During an interview PSW #102, RN #100, and the CC indicated that the written care plan for resident #003 was unclear and inconsistent as to the assistance required by staff and how resident was to be transferred, specifically indicating that resident #003 was a two-person transfer and not a one-person transfer. PSW #102 and RN #100 further indicated that plan of care did not provide clear direction as the written care plan indicated that resident #003 was ambulatory and did not require use of a mobility aid, which PSW indicated is not the case.

The licensee failed to ensure that the plan of care for resident #003 set out clear directions to staff and others who provide direct care to the resident related to resident #003's needs and assistance required specifically related to transferring, toileting and aids to daily living following an identified fall and subsequent injury and readmission to the long-term care home.

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

Related to Log #017676-19:

A CIR was submitted to the Director on identified date, regarding a fall that caused an injury to resident #002 for which the resident was taken to the hospital and resulted in a significant change in the resident's health condition.

The plan of care, which included progress notes and care plans, for resident #002 was reviewed for the identified dates.

On an identified date, registered nursing staff documented in a progress note that, resident #002 had an unwitnessed fall, resident sustained injuries. Documentation indicated that resident #002 was wearing slippery socks at the time of the fall.

Documentation does not mention if a safety device was in use or if the resident was using a mobility aid at the time of the incident.

The written care plan, for an identified date, indicated resident #002 was identified as being at a risk for falls. Interventions included in the care plan indicated:

- resident is to wear grip socks at bedtime (HS)
- safety device while in bed at HS
- ensure resident is using a mobility aid
- position mobility aid by the bed to cue resident to use it
- ensure resident is toileted during last rounds HS

PSW #118 and RN #117 were not available to be interviewed during this inspection.

During an interview PSW #102, RPN #101 and RN #100 indicated to Inspector #554 that resident #002 was at risk for falls. PSW #102 and the registered nursing staff indicated that resident #002 was to wear non-slip socks while in bed as the resident was known to get out of bed unassisted, remove safety device and self-transfer which was a contributing factor in residents falls. RPN #101 and RN #100 indicated that resident #002 was to have had a safety device on the bed at all times and should have had a mobility aid at the bedside, both registered nursing staff indicated that the progress note pertaining to resident #002's fall on an identified date does not mention a safety device sounding or does it mention if a mobility aid was within the resident's reach.

The DOC indicated to Inspector #554 in an interview that staff are to follow the individual plan of care for each resident. The DOC indicated that contributing factors in resident #002 falling was that resident was not wearing non-grip socks and the safety device had not alarmed at the time of the fall.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident #002 as specified in the plan, specifically related to an identified fall incident where documentation does not indicate that non-slip socks and a safety device were in use at the time of the fall.

Related to Log # 017676-19:

A CIR submitted to the Director on an identified date, regarding a fall that caused an injury to resident #002 for which the resident was taken to the hospital and resulted in a

significant change in the resident's health condition.

The following observation was made by Inspector #554 while inspecting the CIR. Resident #002 was observed by Inspector #554 on an identified date and hour, resident was seated in a mobility aid with a safety device attached to the back of the mobility aid, the clip portion of the safety device was not attached to the resident. Later that same day, resident #002 was observed during three separate times without the safety device clipped to the resident.

The plan of care, specifically the progress notes, for resident #002 were reviewed for identified dates. A progress note written by RPN #101 on an identified date indicated that resident #002 was using a mobility aid for mobility and indicated that a safety device was to be used while resident was in the mobility aid.

During an interview PSW #102, RPN #101 and RN #100 indicated to Inspector #554 that resident #002 was at high risk for falls. PSW #102 and the registered nursing staff indicated that resident was always to have a safety device on while in the mobility aid and in bed due to falls risk. PSW #102 and the registered staff indicated that all staff are to ensure that the safety device is attached to the resident at all times.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident #002 as specified in the plan, specifically related to use of a safety device as a fall prevention and management intervention.

Related to resident #004:

During the inspection of Log #017676-19 non-compliance was identified pursuant to LTCHA, s. 6 (7). Inspector #554 expanded the scope to include resident #004 who is at risk for falls.

Resident #004 was observed by Inspector #554 on an identified date using a mobility aid, a safety device was attached to the resident's mobility aid, but the cord clip of the safety device was not attached to the resident.

During further observations on an identified date, resident #004 was observed seated in a mobility aid and foot propelling down the hallway at an identified hour, resident was observed passing RN #100. Resident #002 was observed not identified personal aids and the cord clip of the safety device was not clipped to the resident. At an identified hour

the same day, resident #004 was seated in a mobility aid at the nursing desk, the safety device cord clip was not attached to the resident, RPN #101 walked past resident #004. At an identified hour the same day, resident #004 was observed coming out of a common area, the safety device was not attached to the mobility aid.

During an interview PSW #102 indicated to Inspector #554 that resident #004 was at risk for falls. The PSW indicated that falls prevention interventions in place for resident #004 included a safety device on the resident's mobility aid and the resident's bed. PSW #102 indicated that resident #004 is known to remove the safety device. PSW #102 indicated being aware that the safety device was not on resident's mobility aid or attached to the resident, the PSW indicated that resident had removed the safety device and that staff were not able to locate it.

On an identified date, resident #004 was observed seated on a commode at the bedside with no staff in attendance. Resident #004 did not have a call bell within reach or wearing an identified personal aid.

The plan of care for resident #004, specifically the written care plan, was reviewed by Inspector #554. The identified written care plan, identified that resident #004 was at risk for falls and indicated the following:

- Falls and Balance: Interventions included, ensure identified personal aids are clean and worn when up, safety device.
- Toileting: Inventions included, ensure call bell is within reach, resident is not to be left unattended on the toilet.

During an interview RN #100 indicated to Inspector #554 that resident #004 is at risk for falls. RN indicated that interventions in place to prevent falls include, a safety device on both resident's bed and mobility aid, call bell within reach, routine toileting and that resident was not to be left unattended while on the toilet. RN #100 indicated that resident #004 is known to remove the safety device but indicated that staff are to ensure that the safety device is always on the resident.

During an interview the CC indicated to Inspector #554 that interventions in place to prevent falls for resident #004 included assisted transfers, proper non-slip footwear, safety device on bed and mobility aid, call bell in reach and resident was not to be left unattended during toileting.

During an interview RN #100 and the CC indicated that staff are expected to follow the plan of care for each resident.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan, specifically the use of a safety device and attendance of staff during toileting.

Related to Log #010851-19:

A CIR was submitted to the Director on an identified date for a fall that caused an injury to resident #001 for which the resident was taken to hospital and resulted in a significant change in resident's health condition.

The plan of care for resident #001, including the written care plan, progress notes and post-fall assessments, was reviewed by Inspector #554 for the identified dates.

The plan of care, specifically an identified written care plan indicated that resident #001 required assistance with care and was at risk for falls and indicated the following interventions:
- Dressing: Interventions include, one-person physical assistance required.
- Toileting: Interventions include, two staff to toilet resident, resident is not to be left unattended during toileting.
- Falls and Balance: Resident removes safety device while in bed and in the mobility aid, rendering this intervention ineffective. Interventions include: encourage resident to ring for assistance, ensure call bell within reach, bed at knee level height, fall mat is not to be used, safety protectors to be worn at all times.

Resident #001 fell an identified number of times during an identified time period. The documentation in two progress notes identified that resident #001 fell and was not wearing safety protectors. The progress notes indicated the following:

- On an identified date documentation in a progress note indicated that resident was found sitting on the floor at resident's bedside. Resident #002 had been attempting to self-transfer. Resident was not wearing safety protectors at the time of the incident.

- On an identified date documentation in a progress note indicated resident was found sitting on the floor just outside the washroom door. Resident had been self-transferring and self-toileting. Resident #001 was wearing non-slip stockings but was not wearing

safety protectors at the time of the fall.

During interviews PSW #102 and PSW #105 indicated that resident #001 was at risk for falls. PSWs indicated resident #001 required assistance with dressing, which included the application of safety protectors. PSWs indicated that at times resident #001 would refuse to wear the safety protectors.

During an interview RPN #101and RN #100 indicated to Inspector #554 that resident #001 required extensive assistance with dressing and was always to wear safety protectors.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan, specifically related to safety protectors as a fall's prevention and management intervention.

***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 ensuring that plan of care set out clear directions to staff and others who provide direct care to the resident; and that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system that the licensee is required to ensure that the policy was complied with, specifically related to Falls Prevention and Management.

In accordance with O. Reg. 79/10, s. 48 every licensee of a long-term care home shall ensure that interdisciplinary programs are developed and implemented in the home, specially a falls prevention and management program to reduce the incidence of falls and the risk of injury. The program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments.

In accordance with O. Reg. 79/10, s. 49 (1) the falls prevention and management program must, at minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, did not comply with the licensee's policy, Morse Falls Risk Assessment and Treatment Plan.

The Morse Falls Risk Assessment and Treatment Plan policy indicated that purpose of the policy is for all residents to be assessed for falls risk and that an individualized program will be developed to prevent falls with and without injury for those at risk.

The Morse Falls Risk Assessment and Treatment Plan policy directs that all residents deemed to be at risk for falls will have a pictograph represented within their personal room or on their assistive device as cue for all staff in every department that the resident is a risk for falls. The pictograph could be a falling star strategically placed on the walker or wheelchair. The policy indicated that it is the responsibility of the Director of Care to monitor compliance.

Related to Log # #017676-19:

A CIR was submitted to the Director on an identified date regarding a fall that caused an injury to resident #002 for which the resident was taken to hospital and resulted in a significant change in the resident's health condition.

During interviews PSW #102, PSW #111, RPN #101 and RN #100 indicated to Inspector #554 that resident #002 was identified as being at risk for falls.

Resident #002 was observed by Inspector #554 on an identified date in a mobility aid, there was no pictograph on resident's mobility aid to identify that resident #002 was at risk for falls. There was no pictograph observed resident #002's room to identify resident's risk for falls.

During an interview PSW #102 and RPN #101 indicated that resident #002 has had falls as a result of self-transferring and the removal of the safety devices. PSW #102 and the RPN indicated that there is no pictograph used in the home to identify residents to be at risk of falls.

Housekeeping Aid (HSK) #110 indicated to Inspector #554 during an interview that resident #002 is known to self-transfer but indicated being unaware of resident's fall risk. The HSK indicated being unaware of a pictograph used by the long-term care home to identify residents at risk for falls.

The PT indicated to Inspector #554 during an interview that resident #002 would be at risk for falls. The PT indicated being unaware of a pictograph used within the long-term care home to identify residents at risk for falls.

During an interview PSW #102 and RN #100 indicated to Inspector #554 that resident #004 is at risk for falls. Inspector #554 failed to observe a pictograph identifying falls risk in resident's personal room and or on resident #004's mobility aid.

The DOC indicated to Inspector #554 in an interview that resident #002 and resident #004 would be at risk for falls. The DOC indicated there is no pictograph currently used by the long-term care home to identify residents at risk for falls.

The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system that is required, to ensure that the policy was complied with, specifically related to Falls Prevention and Management and the use of pictograph for those identified as being at risk for falls.

2. In accordance with O. Reg. 79/10, s. 48 every licensee of a long-term care home shall ensure that interdisciplinary programs are developed and implemented in the home,

specially a falls prevention and management program to reduce the incidence of falls and the risk of injury. The program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments.

In accordance with O. Reg. 79/10, s. 49 (2) every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and 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.

Specifically, did not comply with the licensee's policy, Morse Falls Risk Assessment and Treatment Plan.

The Morse Falls Risk Assessment and Treatment Plan policy indicated that purpose of the policy is for all residents to be assessed for falls risk and that an individualized program will be developed to prevent falls with and without injury for those at risk. The Morse Falls Risk Assessment and Treatment Plan policy directs that all residents on admission will be assessed for falls risk using the MORSE Falls Risk Assessment tool as well as when there is a significant change in status and post fall. The Morse Falls Risk Assessment and Treatment Plan policy further directs that registered staff shall communicate the outcome of each assessment to nursing and personal care staff in the home and again at the next shift to shift report with the use of a Falls Huddle. The registered staff will utilize a Falls Huddle Script to ensure all key points are captured during a Falls Huddle or shift report, using the Falls Huddle Script Form.

Related to Log #010851-19:

A Critical Incident Report was submitted to the Director on an identified date regarding a fall that caused an injury to resident #001 for which the resident was taken to hospital and resulted in a significant change in the resident's health condition.

The plan of care for resident #001, which includes the progress notes, written care plan, Morse Fall Risk Assessments, was reviewed by Inspector #554. Resident #001 was identified as being at risk for falls and had an identified number of falls during an identified period. The plan of care failed to document that at MORSE Fall Risk Assessment was completed following an identified fall. The plan of care further fails to document that a Falls Huddle or that a Falls Huddle Script was completed for any of

resident's falls.

RPN #101 and RN #100 indicated to Inspector #554 during an interview that a Morse Falls Risk Assessment is to be completed on admission, each time a resident has a fall and with a significant change in a resident's health condition. RPN #101 and RN #100 indicated that a Falls Huddle is not done when residents fall. Both registered nursing staff indicated being unaware that a Falls Huddle Script was to be completed.

The CC and the DOC indicated to Inspector #554 during an interview that a Morse Falls Risk Assessment was to be completed on admission, following a resident fall and with a significant change in a resident's health status. The CC indicated that a Morse Falls Risk Assessment was not completed for an identified date for resident #001. The DOC indicated that a Falls Huddle and Falls Huddle Script had not been completed following resident #001's falls.

3. Related to Log #017676-19 and #018458-19:

A CIR was submitted to the Director on an identified date, regarding a fall that caused an injury to resident #002 for which the resident was taken to the hospital and resulted in a significant change in the resident's health condition.

A CIR was submitted to the Director on an identified date regarding an incident that caused an injury to resident #003 for which the resident was taken to hospital and which resulted in a significant change in the resident's health condition.

Resident #002 and resident #003 were identified as having falls with injury and significant change in health status. The plan of care for resident #002 and resident #003 were reviewed by Inspector #554, documentation during the review failed to identify that a Falls Huddle and or a Falls Huddle Script had been completed following falls of resident #002 and resident #003.

The DOC indicated in an interview with Inspector #554 that the long-term care home is currently not completing a Falls Huddle or using the Falls Huddle Script as indicated in the Morse Falls Risk Assessment and Treatment Plan policy.

The Administrator indicated to Inspector #554 in an interview that staff are expected to follow licensee policies.

The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system that the licensee is required to ensure that the policy was complied with, specifically related to Falls Huddles and Falls Huddle Script being completed following the falls of resident #002 and resident #003.

***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 ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system that the licensee is required to ensure that such is complied with, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.**

**Findings/Faits saillants :**

The licensee failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions, specifically for an identified safety device.

Maplewood is a 49-bed licensed long-term care home. As part of their Falls Prevention and Management program the licensee utilizes the safety device as a Falls Prevention and Management intervention for residents identified as being at high risk for falls.

The Administrator provided Inspector #554 with a copy of the Instruction Manual for the safety device.

The instruction manual for the identified safety indicated that the device is an important part of the fall management protocols.

Page three of the instruction manual indicated that the device consists of a safety device with an adjustable cord and magnet and indicated that the device will activate when a resident attempts to rise and disconnects the magnet.

Page five of the instruction manual speaks to cord and magnet monitoring and indicated that the device will activate when the magnet is removed. The instruction manual indicated that the magnet pull cord adjusts to range of mobility and 'safety zone' best suited for each resident.

Page seventeen of the instruction manual indicated that the cord length selection will vary depending on resident needs, bed or chair mount position and other factors. The instruction manual indicated that is the caregivers duty to determine acceptable range of movement (safety zone) for each resident.

Connecting Magnet Cord to Patient: (on page 18)
- Use slider to adjust cord to desired length
- Attach clip near shoulder of clothing patient is not likely to remove and out of patient's reach
- Check that the attachment pint is in good condition and is not frayed or torn
- Secure clip lock by rotating it clockwise, this will reduce the risk that patient can remove clip.

Warning: For Safe Use – always follow these steps before leaving the resident unattended, check that: (on page 18)
- The device is on and in monitoring mode (monitoring indicator LED is flashing green)
- Cord clip is securely fastened to clothing out of the patient's reach
- Clip lock is engaged
- Magnet cord is not tangled, and is the right length for safe monitoring

Related to Log #017676-19:

A CIR was submitted to the Director on an identified date regarding a fall that caused an injury to resident #002 for which the resident was taken to hospital and resulted in a significant change in the resident's health condition.

During interviews PSW #102, PSW #111, RPN #101 and RN #100 indicated to Inspector #554 that resident #002 was identified as being at risk for falls. PSWs, RPN and the RN indicated that resident #002 was known to self-transfer and to remove the identified

manufacturers device (safety device).

The plan of care for resident #002 was reviewed by Inspector #554. Resident #002 was identified as being at risk for falls. Interventions in place to prevent falls included the use of a safety device. The plan of care reviewed for identified dates. The review identified that resident #002 had an identified number of falls and sustained injury in all the falls. Documentation by registered nursing staff identified that contributing factors in resident #002's falls were self-transferring and resident #002 removing the safety device.

Resident #002 was observed by Inspector #554 on dates during this inspection. Resident #002 was observed with a safety device attached to a mobility aid, the cord clip lock was not observed. A clothes pin was being used by staff instead of the manufactures cord clip lock. Resident #002 was observed without the safety device and clothes pin attached to the resident's clothing while in the dining room on identified an identified date and times. During one observation the safety device was not visible on the mobility aid or resident's clothing.

During interviews PSWs #102, #105, and #112, RPN #101, RN #100 and the DOC indicated to Inspector #554 that safety devices are utilized for residents that are identified as being at risk for falls. PSW's, RPN, RN and the DOC indicated that the safety device is supplied by the licensee and is part of the Falls Prevention and Management program.

During an interview PSW #101 and PSW #105 indicated to Inspector #554 that resident #002, resident #004 and other residents identified as being at risk for falls were able to remove the safety devices as the cord clip lock on the devices are broken or missing. PSW #105 indicated being unaware of how to assess the safety zone for an individual resident when using safety devices.

On an identified date, Inspector #554 observed resident #002, resident #003, resident #004 and five other residents in the dining room with safety devices in use. No cord clip lock was observed on the safety device in use for resident #002, a clothes pin was in use instead of the cord clip lock. Resident #003 and resident #004, both identified as at risk for falls, had a safety device attached to their mobility aids, but the cord clip did not have a lock to secure the device.

PSW #105 confirmed with Inspector #554 during an interview that the safety devices in use for resident #003 and resident #004 did not have a cord clip lock for use by staff as

the clip lock was broken. PSW #105 indicated that resident #002's safety device does not have a cord clip lock and indicated that staff were using a clothes pin to attach the safety device to resident #002's clothing.

During an interview RN #100 indicated to Inspector #554 that safety devices are used as a falls prevention intervention for residents identified as being at risk for falls. RN #100 indicated that registered nursing staff, the CC and the DOC assign safety devices to residents. RN #100 indicated being aware that the safety devices had cord clip locks as a safety feature but indicated being unaware of who's responsibility it was to ensure devices are used according to manufacturer instructions. RN #100 indicated being aware that there were a few safety devices being used for residents identified as falls risk without cord clip locks. RN #100 indicated being unaware of how to assess the 'safety zone' for an individual resident when using the safety device.

During an interview the DOC indicated to Inspector #554 being unaware that the safety devices used by the licensee had cord clip locks. The DOC indicated that manufacturers instructions should be followed when using equipment and devices.

The licensee has failed to ensure that staff use devices, specifically the identified safety devices, in accordance with manufacturers' instructions, specifically for residents #002, #003 and #004.

***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 ensuring that staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee policy, Osteoporosis Screening Tool and Treatment Plan directs that all residents shall be assessed by the physiotherapy team for an appropriate exercise and transfer regime.

Related to Log #018831-19:

A CIR was submitted to the Director on an identified date regarding a fall that caused an injury to resident #005 for which the resident was taken to the hospital and resulted in a significant change in the resident's health condition.

During the inspection of this CIR Inspector #554 reviewed the plan of care, including progress notes, written care plans and PT assessments, for resident #005. The plan of care was reviewed for specific dates.

Resident #005 was admitted to the long-term care home on an identified date, with specified medical conditions. A progress note, written by registered nursing staff on a specific date, indicated resident #005 was assessed at risk for falls, needing an identified lift and that resident used a mobility aid.

The written care plan indicated that resident #005 was assessed to need an identified lift for all transfers until assessed by the PT.

On an identified date, a progress note written by RPN #101 indicated that resident #005 had been assessed on admission and was determined to require an identified lift. RPN #101 indicated that a two-person transfer was attempted and successful. RPN documented that resident #005 had not been assessed by PT. RPN #101 indicated in the documentation advising PSWs that a two-person transfer would be allowed for resident #005.

During an interview RN #100 indicated to Inspector #554 that the admission package, as well as the admission progress note, indicated resident #005 needed an identified lift for transfers.

During an interview RN #100 and the CC indicated that residents are to be assessed by PT prior to any changes being made to a resident's transfer status. RN and the CC indicated that a resident's transfer status should never be down-graded prior to the PT assessing the resident for the safety of the resident and the staff.

The licensee has failed to ensure that staff used safe transferring techniques when assisting resident #005.

***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 ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.***

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**Issued on this 5th day of December, 2019**

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

**Original report signed by the inspector.**