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 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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 21, 2016	2016_327570_0009	005576-14, 003212-15, 020609-15, 006534-16	Critical Incident System

Licensee/Titulaire de permis

PROVIDENCE HEALTHCARE
3276 St. Clair Avenue East TORONTO ON M1L 1W1

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

PROVIDENCE HEALTHCARE
3276 ST. CLAIR AVENUE EAST SCARBOROUGH ON M1L 1W1

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

SAMI JAROUR (570)

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): April 04, 05, 06, 07, 08, 11, 12, 13, 14 & 15, 2016

Critical Incident Logs #005576-14 related to fall with injury; Log #003212-15 related to fall with injury; Log # 020609-15 related to fall with injury; and Log #0065634-16 related to fall with injury.

Non-compliance under O. Reg. 79/10, s. 107. (3) 4 was identified for Logs #003212-15 and #005576-14, and will be issued under inspection report # 2016_461552_0011.

Non-compliance under O. Reg. 79/10, s. 17. (1) (a) was identified for Log #003212-15 and will be issued under inspection report # 2016_327570_0008.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Care Manager (RCM), Resident Assistants (RA), Registered Nurse (RN), Registered Practical Nurses (RPN), Informatics Specialist (Restorative Care Lead), Physiotherapist (PT), Physiotherapy Assistants (PTA), and residents.

Also observed staff to resident interaction, reviewed clinical health records of identified residents, reviewed relevant policies related to falls prevention and staff-resident communication system.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 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 has failed to comply with O. Reg. 79/10, s. 49 (2), by not ensuring 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.

Related to Log # 003212-15 for resident #011

Review of clinical records for resident #011 indicates that the resident is at high risk of falling and the resident has a tendency to transfer self from bed and wheelchair.

A critical Incident Report (CIR) was received on an identified dated of 2015 for resident #011 who was transferred to hospital due to pain and was diagnosed with an injury.

Review of progress notes for resident #011 indicated, on an identified date, that RA staff witnessed the resident slip from wheelchair at an identified time with no injury noted. Later that day, the resident complained of pain and was assessed by physiotherapist and was sent to hospital on same day as per physician's orders.

Review of clinical records s for resident #011 indicated that RN #145 completed a post fall assessment on Point Click Care (PCC) electronic documentation on an identified date twelve days following the incident of fall.

Internal investigation on identified dates indicated that RN #145 did not complete a head to toe assessment of resident #011 post fall and that RA #144 transferred the resident to wheelchair prior to being assessed by the registered nurse.

Interview with RCM #103 indicated to the inspector that RN #145 should have assessed resident #011 and completed a post fall assessment and that RA #144 should have not

transferred resident #011 until a full assessment is completed by the registered nurse. [s. 49. (2)]

2. Related to log #020609-15 for resident #012

Review of the clinical health record for resident #012 indicated the resident was admitted with history of falls.

Review of clinical records for resident #012 indicated that the Morse Fall Risk assessment was completed on an identified date, fifteen days after admission date, indicating high risk of falls.

Review of progress notes for resident #012 for eleven months period from admission date indicated the resident sustained ten documented falls during this period.

Review of clinical records indicated post fall assessments were not completed as required by the home’s policy on Point Click Care (PCC) electronic documentation for six documented falls as follows: two falls on admission date, one fall two days post admission date, one fall two months post admission date, one fall seven months post admission date, and one fall ten months post admission date.

RPN #143 was unable to locate any records to indicate that the post fall assessment form was completed for the six documented falls.

Interview with the DOC indicated that for each fall a post fall assessment should have been completed on PCC as per policy and the Morse Fall Risk Assessment should have been completed within 24 hours of admission particularly when resident #012 sustained two falls on admission day. [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 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, to be implemented voluntarily.

Issued on this 21st day of April, 2016

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

Original report signed by the inspector.