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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 9, 2019	2019_505103_0012	033748-18, 000144-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the City of Kingston
216 Ontario Street KINGSTON ON K7L 2Z3

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

Rideaucrest Home
175 Rideau Street KINGSTON ON K7K 3H6

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

DARLENE MURPHY (103)

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 3-4, 8-11, 15-16, 18, 23-24, 2019.

Log #033748-18 (CIS #M569-000039-18), Log #000144-19 (CIS #M569-000001-19)- resident falls that resulted in transfer to hospital and significant change in condition,

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), a Registered Nurse (RN), the Nurse Practitioner (NP), the Registered Dietitian (RD), the Restorative care RPN, a Physiotherapist aide, the Physiotherapist (PT), the Assistant Directors of Care (ADOC's), the Director of Care (DOC) and the Administrator.

During the course of the inspection, this inspector made resident observations, reviewed resident health care records including progress notes, plans of care, physician orders and MDS assessments, and reviewed the home's Fall Prevention Policy, #RC-15-01-01.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Personal Support Services
Sufficient Staffing

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

Findings/Faits saillants :

1. The licensee has failed to ensure staff and others involved in the different aspects of resident #001's care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Resident #001 was admitted to the home on a specified date. A documented assessment was completed, on the date of admission, by Physiotherapist (PT) #102 and indicated resident #001 required the assist of one staff member for all transfers and mobility using a 2 wheeled walker.

Three days after admission, RPN #100 documented in both the resident's progress notes and plan of care the following:

Under "Walk in Room/Corridor": able to walk in room/corridor with supervision from staff; staff to provide oversight, encouragement and cuing but no physical support to assist resident to ambulate; ensure the following equipment (2 wheeled walker) is used.

Under "Locomotion on unit": resident will be able to walk on the unit with 2 wheeled walker with supervision from staff.

Under "Transfer": resident will be able to transfer with supervision from staff; staff cue the resident to self-transfer or provide verbal encouragement. Encourage use of 2 wheeled walker.

Resident #001's health care record was reviewed and no additional documented assessments were found during that three day period of time to reflect the changes in the resident's transfer and mobility status.

PT #102 was interviewed and indicated they assess all residents admitted to the home in regards to their transfer and mobility status. PT #102 recalled resident #001, upon admission to the home, was confused, had difficulty comprehending directions, had a past fall history and an unsteady gait. PT #102 further indicated resident #001 was also quite deconditioned and, upon the completion of their initial assessment, recommended resident #001 required a one person assist for all transfers and ambulation using the 2 wheeled walker. PT #102 stated their assessments are documented in the resident health care record and additionally the registered staff on the unit are verbally informed of the resident's transfer and mobility status following the assessment.

PT assistant #115 was interviewed and stated they recalled resident #001 was high risk for falls at the time of their admission to the home. PT assistant #115 stated the resident was unsteady on their feet, moved quickly and would make sudden turns which contributed to their risk of falling. PT assistant #115 stated resident #001's cognitive impairment further placed the resident at risk of falling. PT assistant #115 stated upon the completion of the PT's admission assessment, the PT chooses the appropriate transfer logo for placement in the resident's room and that the PT assistant is responsible for ensuring this logo is in place in the resident room for staff as a reference. PT #115 recalled that resident #001 had the "extensive assistance" logo placed in their room and explained this logo was used for residents that needed physical help from staff to transfer and to mobilize. PT assistant #115 stated residents with "extensive assistance" logos would have a staff member walking beside them when mobilizing and this logo would be used for residents with an unsteady gait or at risk for falls.

RPN #100 was interviewed in regards to resident #001's plan of care related to transfer and mobility. RPN #100 stated the resident's transfer and mobility is assessed by physiotherapy upon admission and that the assessment would be verbally passed along to the registered staff as well as documented in the resident health care record. RPN #100 was unable to account for the change to resident #001's transfer and mobility status, indicating it may have been a misunderstanding.

PSW #105, PSW #107, RPN #100 and RPN #101 were interviewed separately and indicated they were familiar with resident #001's transfer and mobility status at the time of the resident's admission. All indicated resident #001 had an unsteady gait, mobilized quickly and frequently forgot their walker. The staff indicated the resident required supervision only for transfers and mobility and all acknowledged the resident had a number of falls post admission. The staff members were unable to recall which transfer logo was posted in resident #001's room upon admission.

ADOC #111 and DOC #109 were interviewed separately and neither were able to account for the discrepancies between the PT's assessment and the resident's plan of care. Both indicated the physiotherapist documents their assessment and that the plan of care is to be developed based on the PT's assessment.

The licensee failed to ensure staff and others involved in the different aspects of resident #001's care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

2. The licensee has failed to ensure resident #001 was reassessed and the plan of care was reviewed and revised when the care in resident #001's plan of care was ineffective.

On a specified date, the home submitted a critical incident #M569-000039-18 to report resident #001 had a fall which resulted in transfer to hospital and a significant change in the resident's health status.

The resident's health care record was reviewed and indicated one day following resident #001's admission to the home, RN #103 documented resident #001 was observed walking by themselves and was noted to be unsteady. RN #103 further documented resident #001 required the assistance of one staff with the walker.

Three days following resident #001's admission, staff documented they observed resident #001 ambulating quickly throughout the halls with a two wheeled walker, had an unsteady gait and was prevented from falling as staff were able to intervene.

Later that same day, staff documented resident #001 was observed bending down to pick an item up off the floor, became off balance and fell. The resident was assessed for no injuries at that time.

Again, later that same day, resident #001 had another unwitnessed fall and was found lying on their back with the walker tipped over beside them. The resident was assessed and reported lower back pain, but continued to wander the unit.

On another identified date, resident #001 had another unwitnessed fall and the resident was assessed for no injuries.

On another identified date, resident #001 was observed by staff to become weak and required staff assistance to sit to avoid another fall.

On another identified date, resident #001 was found on the floor outside of the bathroom. The resident was assessed by RN #103 and found to have good range of motion (ROM), but the resident was unable to weight bear or walk and was having pain during the assessment. Nurse Practitioner #114 assessed the resident a few hours later and found resident #001 had increasing pain to an identified area, was having difficulty walking and was unable to weight bear with the assist of two staff. Resident #001 was sent to hospital at that time. The home followed up with the hospital and were advised the resident's testing results were not yet available, but were told resident #001 was up and walking. Resident #001 returned to the home in the early evening and once again required analgesics for complaints of pain. The following day RPN #101 documented resident #001 was having pain in a specified area. On an identified date, RN #104 was asked to assess resident #001 as the resident had been unable to get out of bed for three days. RN #104 noted resident #001 had increased pain with weight bearing . RN #104 advised staff to limit the resident's movement and to utilize a wheelchair for all mobility using two staff for pivot transfers.

The resident's plan of care was updated on two identified dates indicating the resident was not to be left unattended on the toilet and to reflect the resident was high risk for falls and would utilize a wheelchair for long distances. A bed alarm was also applied to the bed.

PT #102 reassessed the resident post injury and assessed resident #001 as a two person assist with pivot transfers, resident not to ambulate at this time and to utilize a wheelchair for all mobility. PT #102 was interviewed and indicated they did not receive a referral to reassess the resident's mobility status between the initial assessment completed on the resident's admission to the home and the post injury assessment. PT #102 indicated referrals should be sent when resident's are having falls such that their

mobility and transfer status can be reassessed. On a specified date, the home was informed by the hospital that resident #001's testing results indicated an injury.

Resident #001's plan of care from date of admission until the date of the significant injury indicated the following:

Under "Walk in Room/Corridor": able to walk in room/corridor with supervision from staff; staff to provide oversight, encouragement and cuing but no physical support to assist resident to ambulate; ensure the following equipment (2 wheeled walker) is used.

Under "Locomotion on unit": resident will be able to walk on the unit with 2 wheeled walker with supervision from staff.

Under "Transfer": resident will be able to transfer with supervision from staff; staff cue the resident to self-transfer or provide verbal encouragement. Encourage use of 2 wheeled walker.

RN #103 was interviewed and recalled resident #001 was very unsteady on their feet. The RN indicated shortly after the resident's admission to the home they had recommended to the staff that the resident required the assistance of a staff member for mobilization with their walker due to the resident's level of cognition and inability to safely mobilize on their own.

PSW #105, PSW #107, RPN #100 and RPN #101 were interviewed separately and indicated they were familiar with resident #001's transfer and mobility status at the time of the resident's admission. All indicated resident #001 had an unsteady gait, mobilized quickly and frequently forgot their walker. The staff members indicated the resident's ambulation status was supervision only and they tried to monitor the resident as closely as possible. The staff indicated they were not aware of any changes made to the resident's level of assistance for mobility and transfer until after the injury on the specified date.

ADOC #108 was interviewed and stated resident falls are discussed during morning management meetings and residents are assessed for a number of interventions when identified as high risk for falls including toileting routine, hip protectors, helmet, bed/chair alarms, foot wear, fall mats, low bed, physiotherapy/restorative care referrals, increased monitoring/1:1 and medication reviews in an attempt to reduce falls and mitigate risk of injury.

ADOC #111 was interviewed in regards to the interventions taken in response to resident #001's falls and near misses. ADOC #111 stated they recalled discussing the resident's falls during the morning management meetings and that a toileting routine had been discussed with staff, but it was believed this would have been ineffective and therefore was never implemented. ADOC #111 was unable to identify documented revisions made to resident #001's plan of care to mitigate the risk of falls/injuries prior to the injury on the specified date.

The Administrator was interviewed and also indicated falls are discussed in the morning management meeting and there is an expectation to reassess the resident in an attempt to prevent falls/injuries.The Administrator indicated resident #001's falls occurred during a short period time and felt this may have contributed to the lack of reassessment.

The licensee has failed to ensure resident #001 was reassessed and the plan of care was reviewed and revised when the care in resident #001's plan of care was ineffective. [s. 6. (10) (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 to ensure staff involved in the different aspects of the resident's care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent and complement each other and to ensure the resident is reassessed and the plan of care reviewed and revised when the care in the resident's plan of care was ineffective, to be implemented voluntarily.

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 :

1. The licensee has failed to ensure where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg 79/10, s. 49 (1), the licensee failed to ensure the written strategies to reduce or mitigate falls, including the monitoring of residents, the review of resident drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids were utilized.

Specifically, staff failed to comply with the home's "Fall Prevention and Management Program- RC-15-01-01" which states:

Under "Policy": ensure falls and fall injuries are promptly investigated, tracked and trended and root causes identified and addressed to prevent recurrence.

Under "Procedure": flag residents at high risk of fall injury for additional monitoring, precautionary measures and protective equipment. Clearly communicate responsibilities of all parties in prevention of falls and injury. Refer to physiotherapy as appropriate for further assessment and interventions.

As outlined in WN #1, resident #001 had a series of three near miss falls and three falls between two identified dates. The injury resulted in resident #001 experiencing pain and altered the resident's mobility status.

Resident #001's plan of care did identify the resident as high risk for falls, however, during that period of time, resident #001 was not assessed for additional monitoring, a change in the level of assistance required for transfer and mobility, precautionary measures or protective equipment to mitigate the risk of injury.

The licensee failed to ensure the strategies outlined in the falls policy were complied with. [s. 8. (1) (a),s. 8. (1) (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 to ensure the home's "Fall Prevention and Management Program-#RC-15-01-01" is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission.

Resident #001 was admitted to the home on a specified date. During a review of the resident's health care record, it was noted the resident's six week care conference was held eleven weeks after the resident's admission to the home.

Resident #003 was admitted to the home on a specified date. During a review of the resident's health care record, it was noted that the resident's six week care conference was held ten weeks after the resident's admission to the home.

Resident #004 was admitted to the home on a specified date. During a review of the resident's health care record, it was noted that the resident's six week care conference had yet to be held to date of this inspection. Registered Dietitian (RD) #106 was identified as the person currently responsible for the scheduling of the resident care conferences and was interviewed. They indicated resident #004's care conference was scheduled to be completed on a specified date, twelve weeks after the resident's admission to the home. RD #106 indicated the six week care conferences are often completed beyond the six week time frame as a result of the number of care conferences that are required to be completed including annual conferences. RD #106 indicated there can be as many as six care conferences scheduled each week.

Administrator #110 was interviewed and indicated they were unaware the six week care conferences were being completed outside of the six week time frame. Administrator #110 stated the person responsible for scheduling care conferences had changed within the past several months as a result of staffing changes. Administrator #110 indicated they recognized the importance of completing the six week care conferences within the legislated time frame of six weeks. [s. 27. (1)]

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 a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission, to be implemented voluntarily.

Issued on this 9th day of May, 2019

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

Original report signed by the inspector.