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 |
|---|---|---|---|
| Jul 24, 2019 | 2019_603194_0015 | 007775-17, 008026-17, 008873-17, 012019-17, 016367-17, 025837-17, 026604-17, 028391-17, 028947-17, 003860-18, 006540-18, 008064-18, 009567-18, 011576-18, 013382-18, 018540-18, 018560-18, 028817-18, 002579-19, 002712-19, 010673-19, 011985-19 | Critical Incident System |

## Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

Seven Oaks
9 Neilson Road SCARBOROUGH ON M1E 5E1

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

CHANTAL LAFRENIERE (194), CAROLINE TOMPKINS (166)

## 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): June 11, 12, 13, 14, 17, 18, 19, 20, 24, 25 and 26, 2019**

**The following logs were completed during the inspection:**

**Log #007775-17, related to allegations of resident to resident abuse**
**Log #008026-17, related to falls**
**Log #008873-17, related to falls**
**Log #012019-17, related to falls**
**Log #016367-17, related to falls**
**Log #025837-17, related to falls**
**Log #028947-17, related to falls**
**Log #003869-18, related to falls**
**Log #006540-18, related to falls**
**Log #008064-18, related to falls**
**Log #009567-18, related to falls**
**Log #011576-18, related to falls**
**Log #013382-18, related to falls**
**Log #018540-18, related to falls**
**Log #018560-18, related to falls**
**Log #028817-18, related to falls**
**Log #002579-19, related to falls**
**Log #002712-19, related to falls**
**Log #010673-19, related to falls**
**Log #011985-19, related to fall**
**Log #028391-17, related to medication administration**
**Log #026604-17, related to allegations staff to resident abuse**

**During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Residents, Manager of Resident Services, Nurse Managers (NM), Physician, Registered Physio Therapist, (PT), Rehab. Assistant, (RA), Occupational Therapist,**

**(OT), Behavioural Support Ontario (BSO)/RPN, Social Service Worker,(SSW) Registered Nurse,(RN), Registered Practical Nurse, (RPN) and Personal Support Worker (PSW)**

**Observed staff to resident interactions, reviewed relevant policies, identified clinical health records, internal abuse investigation and Falls Prevention Program,**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Hospitalization and Change in Condition**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **4 WN(s)**
- **2 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. (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. (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. (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).**

**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 failed to ensure that the staff and others involved in the different aspects of care for resident #012 and #014 collaborated with each other in the assessment of the residents so that their assessments are integrated and are consistent with and complement each other.

Related to Log # 002579-19:

A Critical Incident Report (CIR) was received on an identified date, related to a fall involving resident #014, Inspector #194 reviewed the clinical health record for the

resident during their stay at the home.

The Registered Physio Therapist (PT) completed the admission assessment for resident #014, indicating that resident #014 was confused but was functioning well, using an assistive aid to ambulate. PT had indicated in the progress note that resident #014 had refused to participate in the program and would not be placed on the Physio program at this time.

The Occupational Therapist (OT) completed the admission assessment for resident #014, indicating that the resident did not require any OT assistance at that time.

Review of resident #014 clinical health record for an identified period indicated that the resident had sustained a number of falls. The resident was noted to be found on the floor for all of the identified falls, with injury noted on the final fall.

An OT referral was completed by nursing staff on an identified date, indicating the need for two specific falls interventions as resident #014 was at risk for falls.

A Morse Falls Assessment completed on admission on an identified date, indicated resident #014 at high risk for falls.

The plan of care related to falls for resident #014, indicated several fall interventions.

During an interview with Inspector #194, the OT indicated that referrals do not always get to them. The OT indicated not remembering seeing the identified OT referral completed on the identified date, by Nursing department. The OT indicated that registered staff in the home have access to specific falls interventions, if required for resident safety and do not require an OT assessment to have them initiated.

The nursing staff and OT involved in the different aspects of care of resident #014 failed to collaborate with each other in the assessment of resident #012 so that their assessments were integrated and complemented each other, when specific falls interventions were not initiated for the resident on an identified date. (194)

Related to Log #009567-18:

On an identified date a CIR was submitted to the Director reporting an incident for which resident #012 was taken to the hospital for assessment and treatment. Review of the CIR

documentation indicated on an identified date, a Personal Support Worker (PSW) found resident #012 on the floor.

Review of the resident #012's clinical records related to the incident on an identified date, by Inspector #166, indicated resident #012 was assessed and had sustained an injury. Resident #012 was transferred to the hospital for further treatment and returned to the home after treatment was provided.

Review of the licensee's post huddle assessment on an identified date, related to the this fall incident, by Inspector #166, indicated the OT had received a referral to assess resident #012 for the use a specific falls intervention, due to frequent falls. The OT's recommendation included that the resident was at risk for increased falls, the bed was to be in lowest position, as well as two further falls interventions to be in place.

Review of the resident's plan of care indicated the intervention related to the bed to be in the lowest position was already in place. There is no evidence that the use of the specific falls intervention and the OT's recommendation for a further falls intervention were added in resident #012's plan of care until after resident #012 had fallen and sustained an injury.

Related to Log #011985-19:

On an identified date, an after hours call was received reporting that resident #012 was transferred to the hospital for further assessment and treatment after a fall. A CIR was submitted to the Director reporting that the previous day, resident #012 was found on the floor. The resident was transferred to the hospital and required further treatment.

Review of resident #012's clinical records, by Inspector #166, indicated that the resident had a number documented falls over an identified period. The Post Fall Assessment Huddle on an identified date, indicated a referral should have been forwarded to Occupational Therapy and to Physiotherapy. The referral also indicated preventative measures with new strategies for falls and injury prevention/reduction to include monitor closely and the use of a specific falls intervention.

On an identified date, during an interview with Inspector #166, the Physiotherapist reviewed their list of referrals and indicated that the referral was not received.

On an identified date, during an interview with Inspector #194 and #166, the Occupational Therapist (OT) indicated that referrals are not always received. The OT

indicated that registered staff in the home have access to specific falls interventions if required for resident safety and do not require an OT assessment to have them initiated.

The Nursing, Physio and Occupational departments involved in the different aspects of care of resident #012 failed to collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other, when specific falls interventions were not initiated for the resident until after the resident had fallen a number of times during the reviewed period, resulting injury.(166) [s. 6. (4) (a)] (194) [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care for resident #008 related to provision of care, was provided as specified.

Related to Log # 008026-17:

A CIR was received by the Director, related to an injury for which a resident is taken to hospital resulting in a significant change in the resident's health status. Inspector #194 reviewed the CIR, the nursing care plan related to provision of care and the home's incident report. Inspector #194 interviewed DOC and PSW #115 related to the incident involving resident #008 on an identified date, resulting in injury.

The CIR indicated that resident #008 was being provided care by staff, on an identified date, resulting in an injury with a transfer to hospital.

Plan of care for resident #008 was reviewed by Inspector #194 and indicated that on an identified date, prior to the incident, the provision of care for the resident was assessed to require total dependence, one person physical assist and another staff to stand by.

Review of the progress notes for resident #008 related to the incident, was completed by Inspector #194 on an identified date and indicated the following:

-On an identified date, RPN documented that resident #008 sustained an injury and was transferred to hospital for further assessment.

-The following day, RPN documented that resident #008 returned from hospital with restrictions related to mobility.

During an interview with Inspector #194, the DOC indicated that resident #008 was

assessed as a two staff assist for provision of care.

During an interview with Inspector #194 , PSW #115 indicated that they provided care to resident #008 unassisted and the resident sustained an injury.

The licensee failed to ensure that the care set out in the plan of care for resident #008 related to provision of care, when care was provided by one staff, when the plan of care directed two staff to assist.

Related to Log #011985-19:

On an identified date, an after hours call was received reporting that resident #012 was transferred to the hospital for further assessment and treatment after a fall. A CIR was submitted to the Director reported that on an identified date, resident #012 was found on the floor. The resident was transferred to the hospital and required treatment.

Review of resident #012's plan of care related to high risk for falls, by Inspector #166, indicated additional specific interventions post hospitalization:

Review of resident #012's clinical records, by Inspector #166, indicated resident #012 was transferred back to the home from the hospital on an identified date. Documentation indicated that on the same day, resident #012 was found sitting at the side of the bed, attempting to get up. The following day, resident #012 was attempting to climb out of bed and a specific falls interventions was requested. The Charge Nurse had indicated to the staff in the resident's home area that there were no specific falls interventions available. During an interview with Inspector #166, the day following the incident, Registered Practical Nurse (RPN) #126, indicated resident #012 had attempted to get out of bed that morning and the RPN had requested a specific falls intervention from the Nurse Manager.

On an identified date, Inspector #166 observed resident #012 asleep in their bed. The bed was in lowest position and a fall intervention was in place. There was no specific falls intervention in place as indicated in the resident's plan of care post hospitalization.

On an identified date during an observation of resident #012, Inspector #166 observed resident #012, asleep on their bed. The bed was in the lowest position, specific falls interventions were in place.

The specific fall intervention was written into the plan of care on an identified date and initiated a number of days after the resident had returned from the hospital. (166) [s. 6. (7)] (194) [s. 6. (7)]

3. The licensee failed to ensure that resident #015 was assessed and the plan of care reviewed and revised, post fall on several identified date, when the care set out in the plan was not effective.

Related to Log # 002712-19:

A CIR was received by the Director on an identified date, involving resident #015 for a fall resulting in injury. Inspector #194 noted that plan of care for resident #015 related to falls had not been reviewed or revised during the reviewed period where the resident had several falls.

The clinical health record for the reviewed period indicated that resident #015 was cognitively impaired with a history of falls. On an identified date resident #015 was found on the floor, was transferred to the hospital with an injury. The progress notes indicated that resident #015 fell but did not sustain an injury. On an other identified date, the progress notes indicated that resident #015 fell, but did not sustain any injury.

The plan of care related to falls for resident #015 on identified date, identified several fall interventions.

Inspector #194 reviewed resident #015's progress notes for the period of several months. The progress notes indicated that resident #015 was exhibiting responsive behaviours that placed the resident a risk for fall and medical interventions being used were not effective.

During an interview with Inspector #194, PSW #123 indicated that resident #015's was at risk for falls, describing the behaviours that placed the resident at risk for falls and fall interventions that the staff were implementing to minimized the resident's falls.

During interview with Inspector #194, RN #125 indicated that fall interventions for resident #015 not noted in the plan of care were used by staff. RN #125 indicated that the plan of care was not updated to reflect the interventions trialed and used for resident #015 related to falls prevention.

The licensee failed to ensure that resident #015 was assessed and the plan of care reviewed and revised post fall on the identified dates, when the care set out in the plan has not been effective. [s. 6. (10) (c)]

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

Related to Log #009567-18:

A CIR was submitted to the Director reporting an incident to which a resident was taken to the hospital for assessment and treatment. The CIR documentation indicated on an identified date, a Personal Support Worker (PSW) found resident #012 on the floor. Review of resident #012's clinical records related to the incident by Inspector #166, indicated resident #012 had sustained an injury. Resident #012 was assessed and transferred to the hospital for further treatment and returned to the home.

Review of resident #012's health care records by Inspector #166, indicated that resident #012 's judgement was impaired related to self safety.

Review of resident #012's clinical documentation and plan of care related to mobility and falls, indicated that the resident had several previous documented falls with no injuries reported as a results of these falls.

Review of resident #012's plan of care related to mobility and falls prior to the fall provided several interventions.

Review of resident #012's, plan of care the following month, indicated no change in interventions.

Review of resident #012's, plan of care the following month, indicated no change in interventions.  Resident had fallen during the identified month and sustained an injury.

Review of resident #012's plan of care related to mobility and falls the following month, indicated no change in interventions. Resident #012 had fallen during the identified month and sustained an injury.

Review of resident #012's clinical records related to all the documented falls during an

extensive period, indicated the resident continued to experience numerous falls, some with injuries:

The licensee has failed to ensure that when resident #012 was being reassessed and resident's plan of care was revised because care set out in the plan had not been effective, as the numerous documented incidents of falls with and without injury indicated, different approaches had not been considered in the revision of the plan of care.

Related to Log #011985-19:

On an identified date, an after hours call was received reporting that resident #012 had been transferred to the hospital for further assessment and treatment after a fall.

On another identified date, a CIR was submitted to the Director reporting that, resident #012 was found on the floor. The resident was transferred to the hospital, admitted and provided treatment.

Review of resident #012's clinical records for several months, indicated the resident continued to experience a number of falls, where the plan of care was not revised.

There is no evidence that resident #012's plan of care related to falls had been revised and different interventions put into place for several months, after resident had fallen and sustained an injury.

Review of resident #012's, plan of care related to mobility and falls, at the beginning of the review period provided several falls interventions.

Review of resident #012's plan of care related to high risk for falls, at the end of the reviewed period, indicated that new interventions were added to the resident's plan of care.

On an identified date, during an interview with Inspector #166, Nurse Manager (NM) #121, indicated not being aware that resident #012 had experienced several falls with injuries, during the reviewed period.

On an identified date, during an interview with Inspector #194 and #166, Rehab Assistant (RA) #122, indicated they were not aware that resident #012 had experienced several

falls with injuries, during the reviewed period.

On an identified date, during an interview with Inspector #166, Registered Nurse (RN) #125, indicated not being aware of the number of falls that resident #012 had sustained until the RN was completing the documentation required for the licensee's internal tracking of critical incidents.

Resident #012 had experienced numerous falls during the reviewed period and sustained injuries related to several of these falls.

There is no evidence that resident #012's plan of care related to mobility and high risk for falls had been revised and different interventions put into place to mitigate resident #012's potential for falls until after resident had fallen numerous time and sustained an other injury with the latest fall. [s. 6. (11) (b)] (166) [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 collaboration by staff and others, that care is provided as specified in the plan of care, and that the plan of care is reviewed and revised every six month, or when care needs have changed or no longer effective ensuring that different approaches to care are provided when developing the plan of care, to be implemented voluntarily.***

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**WN #2: 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 failed to ensure that the Falls Prevention Program was implemented in the home.

During discussion with the DOC, Inspector #194 was informed that Nurse Manager (NM) #122 was the lead for the Falls Team . The DOC indicated that the Falls Team role was to collaborate with the interdisciplinary team in reviewing and providing additional falls strategies for residents identified to be at high risk for falls.

Review of the Falls Prevention Binder – Falling Leaf, was completed by Inspector #194 on June 24, 2019. The Falls Prevention Binder indicated that a leaf logo would be placed outside the resident's room. The Morse Falls Scale Assessment tool was to be completed, Post Fall Huddle to be completed post fall, Referral forms to be completed as required. The program also identified a tracking sheet was to be completed post fall monthly.

Review of the home's "Falls Prevention and Management" RC-0518-21 dated 01-10-2016 indicated the following:

-The home shall develop and maintain an interdisciplinary Falls Prevention and Management Program
-to identify residents at risk for falls and establish individualized care plans for falls prevention and management

-to decrease the incident of falls through interdisciplinary falls prevention interventions.
-to reduce injuries related to falls without compromising mobility and functional independence
-to monitor and evaluate resident outcomes related to fall prevention and management.

Procedures:
A falls risk assessment:
1. screen all residents for risk for falling at time of admission using the Morse Scale.
2. if resident identified as high risk on the Morse Fall Scale at time of admission, develop interventions to prevent and manage the falls risk in the 24 hour care plan.
3. after each fall, convene the care team to identify root causes for the fall by completing the Post Fall Assessment Huddle.
4. based on root causes, follow up with referrals as indicated.
6. re assess resident for continued risk for falls using the RAI MDS assessment quarterly and when there is a significant change in health status. Complete a Morse Scale prior to each RAI MDS assessment.

Post fall management:

1. Initiate Head injury Routine q1hour x 24 hours or as ordered by physician (including through the night) and assess the resident's level of consciousness and any potential injury associated with the fall or symptoms of increased intracranial pressure.

7. Conduct Post fall assessment Huddle meeting with the interdisciplinary care team present on the unit at the time of the fall. Identify root causes for the fall and preventative strategies for future fall and injury prevention. Document the meeting on the post fall assessment huddle form and place in chronological order in the section of the health care record in the progress notes.

8. As part of the Post Fall Assessment Huddle review fall preventative strategies and modify plan of care when the evaluation of interventions demonstrates that the interventions are ineffective as indicated.

Log #009567-18 and Log #002712-19;

During inspections related to falls, Inspector #194 observed the rooms for residents #015 and #012 as well as the resident's clinical health record. There was no evidence of fall logos noted to be in place to identify the resident at being at high risk for falls.

During inspections of resident #014, #012 and #015's falls, by Inspector #194 and #166 post fall huddles were reviewed. Inspectors #194 and #166 were unable to obtain evidence that Post Fall Huddles had been completed for resident #014 on several identified date, resident #015 on an identified date and resident #012 on numerous identified dates.

Review of the fall tracking sheet on the secure unit was completed by Inspector #194 for the period of several months. The identified falls for resident #015 and resident #012 were not documented during the reviewed period.

Head Injury Routine in the policy indicated that vital signs were to be completed hourly for 24 hours. Interview with RN #125 indicated that staff were following a different time frame for vitals related to head injury routine in the home.

During Interview with Inspector #194, NM #121 indicated that they were the current lead for Falls Team in the home. NM #121 indicated that there was no formal program in the home for Falls Prevention. Inspector #194 inquired if the home was using the "Falling Leaf, Star or a similar program for falls prevention, NM #121 replied no. NM #121 indicated that the Falls Team, consisted of registered staff, PSW, OT, Rehab assistant, Restorative team, stating that PT only oversaw the team and would receive minutes. NM #121 indicated that the Falls Team met regularly at a specified time. NM #121 indicated that there had been several meetings over a specified period, none of which minutes were taken.

During interview with Inspector #194, on an identified date related to the role of the PT in the Falls Prevention Program, Registered Physio Therapists (PT) #111 and PT #110 indicated that they were not involved in the Falls Team. Both PTs interviewed indicated to Inspector #194 that the home did have a Falls Preventative Program in the home. PTs were unable to verbalize what this consisted of when asked to describe, stating that a Falls Team was active in the home, with Rehab PTA sitting on the team as well as OT.

During interview with Inspector #194, Rehab Assistant (RA) #122 indicated that their were part of the Falls Team in the home. RA #122 indicated during the interview that their had been no Falls Team meeting, for a specified period of time. RA #122 indicated to Inspector #194 that it had been several months since last Falls Team meeting. RA #122 indicated that currently there were no logos to identify residents at risk for falls in the home.

During interview with Inspector #194 and #166, the OT indicated that they were part of the Falls Team. The OT indicated during the interview that there had not been any Falls Team meetings in the home for an identified period of time. When the Falls Team meetings were taking place, the team would discuss residents at risk for falls, trying to develop strategies to minimize the risk of falls. The OT indicated that when they receive a referral, the resident would be assessed and recommendations would be provided. When the Falls Team was active, the team would meet at a specified time on each of the floors. The OT also indicated that the home currently does not post logos for residents at high risk for falls.

During interview with Inspector #194, NM #109 indicated that the home's Falls Prevention Program "Falling Leaf" kept documentation in a binder located on each home unit. NM #109 indicated that when a referral for the Falls Team was received, the team would review the environment and Post Fall Huddle to minimize the risks for the resident. Referral to Falls Team would then be completed with interventions and strategies forwarded to the registered staff on the unit, to update and implement any recommendations. If strategies were not effective, new strategies would be discussed, information documented and communicated to the registered staff.

Interview with RPN #126 was completed by Inspector #194, related to Falls Prevention Program. RPN #126 indicated that the fall tracking sheet was completed by the registered staff on the unit for all falls that occurred but stated that there are part-time staff that may not complete the tracking sheet. RPN #126 indicated that they were not aware of a falls champion on the unit, and that Morse Falls Assessment completed for all resident's post fall. A Morse Fall Assessment for the falls of Resident#015 for the identified period, could not be found.

During interview with Inspector #194, RN# 125 indicated that Head Injury Routine in the home was completed differently than indicated in the licensee's Falls Prevention and Management policy.

The licensee failed to ensure that the home's Fall Prevention Program was implemented by ensuring that the Falls Team was active, Post Fall Huddles were completed, logos were posted to identify resident at high risk for fall, falls tracking sheets on each unit were completed to include all the residents falls and a clear understanding of the Head injury routine was identified in the home. [s. 48. (1) 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 ensuring that the falls prevention and management program is implemented in the home, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

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

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Related to Log #026604-17:

During an inspection of staff to resident abuse, reported in CIR involving resident #010 on an identified date, Inspector #194 noted that the home did not immediately report an incident of abuse to the Director.

Review of the internal investigation notes for the allegations of abuse towards resident #010 by PSW #107 on an identified date, was completed by Inspector #194.

During review of the progress notes in the internal investigation it was discovered that RPN #112 reported to MRS #103 and NM #104 an allegation of abuse towards resident #010 by PSW #107 on an identified date. RPN #112 indicated in progress notes that during rounds with the physician, resident #010 reported abused by PSW #107. The progress notes also indicated that physician #106 had documented the allegations, reported by the resident #010 and indicated in the documentation that the allegations had been reported to NM #104 that day.

During interview with Manager Resident Services (MRS) #103 completed by Inspector #194, related to the incident documented by RPN #105. MRS #103 indicated that they had poor recall of the incident. MRS #103 indicated during interview that they recalled RPN #105 stating that an incident involving resident #010 who was upset had been reported during physician rounds. MRS #103 indicated that the incident was reported to the physician, Nurse Manager #104 and DOC.

The internal investigation into the allegation included a statement from NM #104, who was in charge at the time of the incident. The internal investigation statement from NM #104 indicated that the physician had mentioned, documenting in the resident's chart a concern they had received from the resident. NM #104 indicated in statement that the physician did not mention a resident's name nor an employee's name or that the concern was of abuse or neglect.

During interview with Inspector #194, DOC expressed that it was their expectation that all managers were to inquire about any concerns related to residents to determine if any further follow up was required. DOC indicated that they did not know why NM #104 had not asked any further questions to determine, if there were issues that required follow up after discussion with physician.

The licensee failed to ensure that NM #104 and MRS #103 reported allegations of staff to resident abuse immediately to the Director. [s. 24. (1)]

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

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

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).**
**2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,**
**i. a breakdown or failure of the security system,**
**ii. a breakdown of major equipment or a system in the home,**
**iii. a loss of essential services, or**
**iv. flooding.**
**O. Reg. 79/10, s. 107 (3).**
**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**
**4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.**
**5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of the incident involving resident #008, where an injury for which the resident was taken to a hospital resulted in a significant change in the resident's health condition.

Related to Log #008026-17:

A CIR was received by the Director, for a fall involving resident #008 resulting in injury and a significant change in condition. Inspector #194 reviewed the CIR, progress notes, nursing care plan related to provision of care and the incident report.

CIR indicated that resident #008 suffered a fall, resulting in a transfer to hospital, the CIR was submitted to the Director, six days after the incident.

Review of the progress notes for resident #008 related to fall on an identified date, was completed by Inspector #194 and indicated the following:

-On an identified date, RPN documented that resident #008 fell after the provision of care. Resident #008 was assessed and transferred to hospital for further assessment.

-The following day, RPN documented that resident #008 returned from hospital with mobility restrictions.

Plan of care for resident #008 was reviewed by Inspector #194, and indicated a significant change in the resident's health condition

The licensee failed to inform the Director, on the identified date, when resident #008 returned from the hospital with a significant change in the resident's health condition. [s. 107. (3)]

**Issued on this 25th day of July, 2019**

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

**Original report signed by the inspector.**