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

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Inspection de soins 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
Jun 2, 2017	2017_590554_0012	028327-16, 033371-16, 005428-17, 007102-17, 007116-17, 007265-17	Critical Incident System

Licensee/Titulaire de permis

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

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

SPRINGDALE COUNTRY MANOR
2698 CLIFFORD LINE R. R. #5 PETERBOROUGH ON K9J 6X6

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): April 12-13, 19-21, and April 24-26, 2017

Intakes inspected include, #028327-16, 033371-16, 005428-17, 007265-17, 007102-17, and 007102-17

Summary of Intakes:
1) #28327-16 - Critical Incident Report (CIR) - related to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status;
2) #033371-16 - CIR - related to an incident of alleged abuse, resident to resident;
3) #005428-17 - CIR - Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status;
4) #007265-17 - CIR - Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status;
5) #007116-17 - CIR - Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status;
6) #007102-17- CIR - Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Environmental Services Manager, Maintenance Manager, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Housekeeping Aide(s), Physiotherapist, Physiotherapist Assistant, Family, and residents.

During the course of the inspection, the inspector toured the home observed staff to resident interactions, resident to resident interactions; reviewed clinical health records, licensee related investigations, Record of Falls (identified period), Multi-Disciplinary Monthly Falls Meeting Tracking Tool and Minutes, restraint records and monitoring tool, and reviewed licensee policies, specific to Falls Prevention and Management Program, including Lifts, Resident Transfers, and Falls Risk Assessments.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Responsive Behaviours

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 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The License failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Related to Intake #007265-17:

The Director of Care submitted a Critical Incident Report (CIR) to the Director, on an identified date, with regards to an incident that causes an injury to a resident for which the resident is taken to an acute care facility and which results in a significant change in the resident's health status. The CIR indicates that resident #005 had an incident on an identified date.

The clinical health record for resident #005 was reviewed, by the inspector, for the period of approximately two weeks, the following is documented:

Resident #005 has a history which includes cognitive impairment. Prior to the identified date, resident #005 required limited assistance for activities of daily living, and was ambulatory.

Resident #005 had an unwitnessed incident on an identified date, sustained injury and was transferred to an acute care facility for assessment and treatment. On an identified date, resident #005 was discharged from the acute care facility and returned to the long-

term care home.

Resident #005 was assessed by Physiotherapist, a contracted service provider for the long-term care home, the following was documented within a progress note upon resident's readmission to the long-term care home:

- Precautions: Resident is WBAT (weight bearing as tolerated),the identified area should not bend past an identified degree; no pillow under the identified areas while resident is in bed. Transfer resident using an identified transfer device. Resident was given a wheelchair from physiotherapy department; to have an identified degree of tilt for positioning in wheelchair, and to have a pillow under the identified area to keep the identified area straight and stabilized. Sensory alarm should be in place on resident at all times while in wheelchair and bed, fall mat down while resident is in bed, resident's bed to be in the lowest position and every fifteen minute checks are to be completed as a preventive measure.

The following was observed:

- On an identified date, and time, resident #005 was observed, by the inspector, to be seated in his/her wheelchair, with the tilt mechanism engaged, the tilt angle indicator on the wheelchair indicated that the tilt was positioned not at the identified tilt position/degree. Resident #005 was observed to have no pillow under the identified areas during this observation.

- On another identified date and during two separate observations, resident #005 was observed, by the inspector, to be seated in his/her wheelchair, with the tilt mechanism engaged, the tilt angle indicator on the wheelchair indicated that the tilt was positioned not at the identified tilt position/degree. Resident #005 was observed to have no pillow under the identified areas during this observation.

Personal Support Worker #051 was present during the observation on one of the identified dates, and verified that the tilt angle indicator was positioned not at the identified tilt position/degree marking on the indicator.

The Physiotherapist (PT) indicated what was observed by the inspector, on the identified dates above was not consistent with the plan of care for resident #005.

Director of Care indicated it would be an expectation, that care set out in the plan of care

is provided to the individual resident. [s. 6. (7)]

2. Related to Intake #007102-17:

The Director of Care submitted a Critical Incident Report (CIR) to the Director, on an identified date, with regards to an incident that causes an injury to a resident for which the resident is taken to an acute care facility and which results in a significant change in the resident’s health status.

The clinical health record for resident #007 was reviewed, by the inspector, for the period of approximately two weeks, the following is documented:

Resident #007 has a history which includes cognitive impairment. Prior to an identified date, resident #007 required extensive assistance for activities of daily living, used a wheelchair, but was able to ambulate with the assistance of two staff.

Resident #007 had an unwitnessed incident on an identified date, sustained injury and was transferred to an acute care facility for assessment and treatment. On an identified date, resident #007 was discharged from the acute care facility, and returned to the long-term care home.

Resident #007 was assessed by the Physiotherapist, a contracted service provider for the long-term care home, the following was documented within a progress note upon resident's readmission to the long-term care home:

- Precautions: Resident is not to weight bear; the identified area should not bend past an identified degree for at least three weeks. An identified transfer device was to be used. Resident was provided a wheelchair from physiotherapy department, tilt positioning is to be at an identified degree. Resident is to have a pillow under an identified area while tilted in the wheelchair, and a pillow under another identified area to keep this area straight and stabilized. A picture has been posted above the resident’s bed to show proper positioning while in his/her wheelchair. Resident to have a sensory alarm on at all times, fall mat on floor while in bed, bed at the lowest position and to be on every fifteen minute safety checks as a preventive measure.

The following was observed:

- On an identified date and time, resident #007 was observed, by the inspector, to be

seated in his/her wheelchair, with the tilt mechanism not engaged. Resident #007 was observed to have no pillow under the identified areas during this observation, identified areas were not positioned on the positioning rests of the wheelchair, he/she had one shoe on and one shoe off.
- On another identified date, resident #007 was observed, by the inspector, to be seated in his/her wheelchair, with the tilt mechanism not engaged. Resident #007 was observed to have no pillow under the identified areas during this observation, and had both lower extremities extended over and beyond the foot rests of the wheelchair.

Physiotherapist (PT) indicated what was observed by the inspector, on the identified dates above were not consistent with the plan of care for resident #007.

The Director of Care indicated, to the inspector, that it would be an expectation that residents are provided care as set out in the plan of care. [s. 6. (7)]

3. The licensee failed to ensure that a resident was reassessed, that the care set out in the plan had been revised or that different approaches had been considered in the revision of the plan of care, when such had not been effective.

Related to Intake #007102-17:

Resident #007 was admitted to the long-term care home on an identified date. Resident has a history which includes cognitive impairment.

The admission progress note (identified date), indicates that resident #007 requires extensive assistance for activities of daily living, his/her primary mode of locomotion and transportation was a wheelchair, and that he/she was at known risk for falls. Interventions in place on admission, were that a personal alarm was to be utilized while resident was in bed or in his/her wheelchair. Resident #007 had a PASD in place while in his/her wheelchair, resident could unfasten the PASD.

The clinical health record was reviewed, by the inspector, for the period of approximately four months the following is documented.

Written Care Plan (identified date):

- Falls – identified risk, due to cognitive impairment; goals of care, was indicated as no falls. Interventions include, personal support workers to assist resident with all transfers;

resident to be provided a bed alarm, which is a pad under the bed sheets and will alert staff through an alarm triggered and connected to the nurse call system, alerting staff when resident attempted to get out of bed; personal alarm in wheelchair; resident to wear non-slip footwear; and has a PASD on wheelchair, that resident can unfasten.

Registered Nurse #050, Personal Support Worker #051 and the Physiotherapist indicated to the inspector, that resident #007 did have a personal bed alarm, but the alarm was not the type of alarm with a sensor pad under the bed sheets; all indicated that the alarm was a "clippable" type of alarm which staff manually moved from chair to bed and vice versa.

Progress Notes (all separate dates) documented, the following:

- on an identified date – resident is climbing out of bed;
- on an identified date – resident is climbing out of bed, has been resettled by staff;
- on an identified date – resident is in bed, found by staff taking his/her personal bed alarm apart;
- on an identified date – resident very upset with personal alarm on his/her wheelchair, and wants alarm removed. Staff trialed the personal wheelchair alarm off;
- on an identified date – contracted service provider documented, that resident's personal alarm should be applied while in wheelchair and bed at all the time as a preventive measure.
- on an identified date - resident exhibiting an identified responsive behaviour, and playing with his/her PASD. RN #050 indicated in the progress note, that staff fastened resident's PASD. Approximately fifteen minutes later, resident #007 was found on floor, by his/her wheelchair; RN #050 indicated that it appeared as if resident had unbuckled the PASD.

Registered Nurse #050 indicated to the inspector, that resident #007 did not have a personal alarm on his/her wheelchair as the personal alarm had been removed on an identified date as a trial.

A progress note (identified date), indicates that resident climbed out of bed and into his/her wheelchair, came to the nursing station to ask the time; staff told him/her the time, said good-night and redirected resident back to his/her room.

Registered Nurse #073 indicated, to the inspector, that resident #007 appeared at the nursing station on the identified date, when staff returned resident to his/her room, the

personal bed alarm was not sounding. RN #073 indicated that he/she was unaware if resident had unclipped the personal alarm or if the batteries in the personal alarm were not functioning.

Inspector continued review of the progress notes, such is documented:

- On an identified date, resident was found, by personal support workers, sitting on the floor beside his/her bed; there is no mention, in the progress note, if personal bed alarm was in place at the time of this fall. Resident was assisted into his/her wheelchair and taken to the dining area by the nursing station, given a snack and was monitored by staff.

- On another date, resident was found, by staff, on the floor in his/her room; RN documented in his/her progress note, that resident had self-transferred from bed, and had unclipped the personal bed alarm. Resident was complaining of discomfort, and was transferred to an acute care facility for assessment and treatment.

A review of the clinical health record, by the inspector, as well as interviews with personal support workers, registered nursing staff, and the contracted service provider; all indicated, to the inspector, that resident #007 was cognitively impaired, was at known risk for falls, and known to self-transfer from bed or wheelchair. Documentation reviewed, identifies that resident #007 fell three times during this review period, with the third fall resulting in resident #007 sustaining injury and subsequently transferred to an acute care facility for assessment and treatment.

There is no indication to support that the care set out in the plan was revised or that different approaches were considered in the revision of the plan of care when such had not been effective, specific to Falls Prevention for resident #007. [s. 6. (11) (b)]

4. Related to Intake #005428-17:

The Director of Care submitted a Critical Incident Report (CIR) to the Director on an identified date, with regards to an incident that causes an injury for which the resident is taken to an acute care facility and which results in a significant change in the resident's health status.

Resident #004 has history which includes cognitive impairment. Prior to the identified date, resident #004 required limited assistance with activities of daily living, ambulated utilizing a walker, and would at times use a wheelchair for longer distances.

Registered Nurse #050 and Personal Support Worker #051 indicated that resident #004 was a falls risk.

The clinical health record was reviewed by the inspector, for the period of six months, the following is documented:

Written Care Plan: (identified date)

Falls – risk of falls related to cognitive impairment; goal of care is identified as, to decrease the number of falls. Interventions include, is fully-independent with mobility device; staff to ensure that resident's walker is available; ensure resident is wearing non-skid shoes; staff to monitor that the basket on the front of resident's walker has not been overloaded with personal belongings; staff to be aware that resident will walk independently against the advice of staff; ensure resident is wearing his/her glasses; ensure call bell in reach, and remind resident to use it; bed and chair alarm in place as resident will self-transfer.

Registered Nurse #050 and Personal Support Worker #051 indicated to the inspector, that resident was known to self-transfer, despite reminders from staff to call for assistance. Both staff indicated, that resident #004 did not have personal alarms prior to the identified date.

Progress Notes indicate:

- On an identified date – resident was found on floor in resident's room, appeared that resident had been self-transferring. Resident was assessed by registered nursing staff to have no injury.
- On another date – resident was found on floor in resident's room, resident was not wearing shoes at the time of this fall. Resident was assessed by registered nursing staff to have no injury.
- On another date – resident was found on floor in resident's room, was self-transferring at the time. Resident was assessed by registered nursing staff to have no injury.
- On another date – personal support worker heard resident yelling for help. Resident #004 was found on the floor beside the bed. Resident was assessed by registered nursing staff to have no injury. Resident was placed on every fifteen minute safety checks.
- On another date– Resident is not participating in physiotherapy. Resident has own

walker and wheelchair; please ensure his/her wheelchair is close to residents bed with breaks on. Ensure resident is wearing proper footwear.
- On another date - resident #004 found on the floor between chair and bed, yelling for assistance; resident seemed to be self-transferring. Resident was assessed by registered nursing staff and found to have no injuries. Safety checks, every fifteen minutes, remains in place.
- On another date (above CIR) - resident #004 was observed walking in hallway with his/her walker. Two personal support workers assisted resident back to his/her room; while being assisted by staff, resident lost his/her balance and fell to the floor. Resident was assessed by registered nursing staff and deemed to have sustained injury. Resident was transferred an acute care facility for assessment and treatment.

RN #050 and PSW #051 indicated to the inspector, that personal bed and or chair alarms, and or other interventions, such as a fall mat, were not initiated as a falls prevention intervention until after resident's incident on the identified date.

Based on interviews with personal support workers, and registered nursing staff, as well as a review of the clinical health record, resident #004 had six unwitnessed incidents during a six month period, all incidents were documented as resident had no injury. On an identified date, resident #004 fell, sustaining injury, and was transferred to an acute care facility for assessment and treatment.There is no documentation to support that the licensee ensured that the plan of care for resident #004 had been revised when the care set out in the plan had not been effective, and that different approaches were considered in the revision of the plan of care, specific to falls prevention and management for resident #004. [s. 6. (11) (b)]

5. Related to Intake #028327-16:

The Director of Care submitted a Critical Incident Report (CIR) to the Director on an identified date, for an incident that causes an injury to a resident for which the resident is taken to an acute care facility and which results in a significant change in the resident's health status. Resident #001 had an incident on an identified date, sustained injury, and was transferred to an acute care facility for assessment and treatment. Resident was subsequently transported to a secondary site for further treatment.

Resident #001 has a history which includes, cognitive and physical impairment. Resident is dependent on staff for activities of daily living, his/her primary mode of locomotion is a wheelchair.

Registered Nurse #050 and Personal Support Worker #051, both indicated to the inspector, that resident #001 is at known risk for falls. Both staff indicated, that resident #001 forgets he/she can't walk. RN #050, and PSW #051 both indicated interventions in place to mitigate falls risk, include, personal alarms,and restraints to be utilized. RN and PSW indicated that the personal alarms were the 'clippable' type.

The clinical health record for resident #001 was reviewed, by the inspector, for the period of approximately three months, the following is documented:

Written Care Plan: (identified date)

- Falls – resident is at high risk for falls, related to cognitive impairment. Goal of care indicated as "minimize falls". Interventions include, restraint utilized on bed and on wheelchair, and personal alarms are to be used; interventions further detail that resident #001 forgets that he/she can not walk, and that staff are to remind resident not to stand.
- Aids to Daily Living – Interventions include, wheelchair with restraint; ensure that safety devices are up on bed; and to ensure resident is wearing his/her glasses at all times.
- Toileting – Self-care deficit related to cognitive and mobility impairment. Interventions include, total dependence; requires the use of a transfer device with two staff to get onto and off of the toilet; scheduled toileting plan.

Progress Notes:

- Identified date - staff heard resident calling for help from down the hallway, entered resident #001's room, and observed resident on the floor. Resident #001 indicated to staff that he/she had climbed over the bed rails. Resident complained of discomfort.
- Identified date - personal support worker reported finding resident #001 standing at the sink in his/her washroom, the call bell in the washroom was ringing. Staff observed that restraint was still attached to the wheelchair, but had been turned to the side of the wheelchair; the personal chair alarm was attached, but not alarming.
- Identified date- resident found climbing x2. Was resettled by staff.
- Identified date - staff heard resident #001 shouting for help, and found resident on floor in his/her room. Resident stated he/she was trying to get to the washroom at the time of the incident. Registered nursing staff documented that resident is to have personal alarms in place (bed and wheelchair) but the personal bed alarm was not sounding when resident was discovered on the floor. Monitoring was initiated.

- Identified date - registered nurse (RN) heard resident #001 yelling for help; upon arrival to the resident's room, RN found resident #001 lying on the floor against the edge of the dresser. Registered Nurse indicated in his/her documentation that it appeared as if resident #001 had unclipped the personal bed alarm and climbed out of bed. Resident #001 was assessed by RN, resident indicated that he/she hit an identified area on the dresser; resident complained of specific symptoms. Resident was assessed to have injury, which RN described in the progress note and indicated that resident did not appear him/herself.

Registered Nurses #050, and #073, as well as the Director of Care, all indicated that resident #001 was known to be at risk for falls, was known to turn off his/her personal alarms, remove restraint(s), and was known to climb out of bed.

RN's #050 and #073, Personal Support Worker #051, as well as the Physiotherapist, all indicated to the inspector that the "sensor style-infer red" bed pad alarm and mat was not initiated as a new intervention until after resident #001 returned from the acute care facility on an identified date. All indicated there were no new interventions initiated during the identified three month period for resident #001. [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 to ensure there is a process in place and monitored, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan; and to ensure that a resident was reassessed, that the care set out in the plan had been revised or that different approaches had been considered in the revision of the plan of care, when such had not been effective, 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specifically Falls Prevention and Management.

Under O. Reg. 79/10, s. 48 (1) 1 - Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home, specifically, 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee's policy, MORSE Falls Risk Assessment and Treatment Plan (#HLHS-TP-4.8) directs the following:
- All residents on admission will be assessed for falls risk using the MORSE Falls Risk Assessment Tool, as well as at significant change of status and post fall.
- All residents who are deemed to be at risk shall be assessed for compliance to wear a hip protector and if compliant will be ordered a minimum of two pairs of approved hip protectors for use in the prevention for trauma related to the potential for falls and fractures.
- The physiotherapy team will do their assessment to determine an appropriate exercise and transfer regime.
- Registered (Nursing) Staff shall communicate the outcome of each assessment to nursing and personal care in the home and again at the next shift to shift report.
- It is the responsibility of the Director of Care to monitor compliance.

Related to Intake #007265-17, for Resident #005:

Resident #005 was admitted to the long-term care home on an identified date. Resident

#005 has a history which includes cognitive impairment. On admission, resident #005 was identified as a falls risk. Resident is ambulatory, and requires assistance with activities of daily living (ADLs).

A Falls Risk Assessment was completed by registered nursing staff, for resident #005 (on an identified date) and identifies resident as being at risk for falls.

On an identified date, resident #005 had an unwitnessed incident, sustained injury as a result, was assessed by registered nursing staff and transferred to an acute care facility for further assessment and treatment.

Resident #005 returned to the long-term care home on an identified date. On return from the acute care facility resident #005 was identified by registered nursing staff as having had significant change in his/her condition and required total assistance for all ADL's.

Registered Nurse #050, and the Director of Care both indicated (to the inspector) that a Falls Risk Assessment is to be completed on all residents on admission, and with a significant change in resident's condition.

A Falls Risk Assessment was not completed on re-admission to the long-term care home, noting resident #005 had a significant change in his/her condition. [s. 8. (1) (a),s. 8. (1) (b)]

2. Related to Intake #007102-17:

Resident #006 was admitted to the long-term care home on an identified date. Resident #006 has a history which includes cognitive impairment. Resident #006 is ambulatory with a mobility device, and requires minimal assistance with activities of daily living (ADLs).

A Falls Risk Assessment was completed by registered nursing staff, for resident #006 (on an identified date) and identifies resident as being at low risk, and has had no prior falls incidents.

On identified date, co-residents witnessed resident #006 falling. Resident #006 was assessed by registered nursing staff, deemed to have sustained injury and was transferred to an acute care facility for further assessment and treatment. A Critical Incident Report (CIR) was submitted by the Director of Care to the Director on an

identified date.

Resident #006 returned to the long-term care home on an identified date. On return from the acute care facility resident was identified by registered nursing staff as having had significant change in his/her condition, and required total assistance for all ADL's.

Registered Nurse #050, and the Director of Care both indicated (to the inspector) that a Falls Risk Assessment is to be completed on all residents on admission, and with a significant change in resident's condition.

A Falls Risk Assessment was not completed on re-admission to the long-term care home, noting resident #006 had a significant change in his/her condition. [s. 8. (1) (a),s. 8. (1) (b)]

3. Related to Intake #007116-17:

Resident #007 was admitted to the long-term care home on an identified date. Resident #007 has a history which includes cognitive impairment. Resident #007 required a wheelchair, but could ambulate with the assistance of two staff, and required assistance with activities of daily living (ADLs).

The admission progress note (identified date) identifies that resident has been known to self-transfer, and has a PASD which he/she can unfasten. On admission, a personal alarms were initiated.

The clinical health record, specifically the progress notes, identifies that resident #007 had identified responsive behaviours that pose safety risk.

A Falls Risk Assessment was not completed on admission for this resident. Registered Nurse #050 confirmed (with the inspector) that a Falls Risk Assessment was not completed, as per the licensee's policy, Falls Risk Assessment and Treatment Plan, which states that the assessment is to be completed on admission and if there is a significant change in resident's condition.

On an identified date, resident #007 was found on the floor in his/her room, complaining of discomfort. Resident #007 was assessed by registered nursing staff, deemed to have sustained injury and was transferred to an acute care facility for further assessment and treatment. A Critical Incident Report (CIR) was submitted by the Director of Care to the

Director on an identified date.

Resident #007 returned to the long-term care home on an identified date. On return from the acute care facility resident #007 was identified by registered nursing staff as having had significant change in his/her condition and required total assistance for all ADL's.

Registered Nurse #050, and the Director of Care both indicated (to the inspector) that a Falls Risk Assessment is to be completed on all residents on admission, and with a significant change in resident's condition.

A Falls Risk Assessment was not completed on re-admission to the long-term care home, noting resident #007 had a significant change in his/her condition. [s. 8. (1) (a),s. 8. (1) (b)]

4. Related to Intake #005428-17:

Resident #004 has a history which includes cognitive impairment. Resident #004 required assistance with activities of daily living (ADLs), utilized a walker, and occasionally used a wheelchair for transportation.

A Falls Risk Assessment (identified date), identifies that resident #004 was at risk for falls.

On an identified date, two personal support workers were assisting resident #004 to his/her room; resident #004 was walking with a mobility device, lost balance and fell to the floor. Resident #004 was assessed by registered nursing staff, deemed to have sustained injury and was transferred to an acute care facility for further assessment and treatment. A Critical Incident Report (CIR) was submitted by the Director of Care to the Director on an identified date, specific to this incident.

Resident #004 returned to the long-term care home within twenty-four hours. On return from hospital resident #004 was identified by registered nursing staff as having had significant change in his/her condition. On re-admission to the long-term care home, resident #004 required total assistance for all ADL's, was no longer ambulatory, required a wheelchair and had the identified area immobilized. Registered Nurse #050 indicated to the inspector that following the incident, resident became dependent on staff for all care and declined rapidly.

Registered Nurse #050, and the Director of Care both indicated to the inspector, that a Falls Risk Assessment is to be completed on all residents on admission, and with a significant change in resident's condition.

A Falls Risk Assessment was not completed on re-admission to the long-term care home, noting resident #004 had a significant change in his/her condition. Registered Nurse #050 indicated to the inspector that a Falls Risk Assessment was not completed, as per the licensee's policy, Falls Risk Assessment for resident #004 [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 there is a process in place and monitored, ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specifically Falls Prevention and Management, to be implemented voluntarily.

WN #3: 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 :

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

The licensee's policies, Lifting (#CS-6.8) and Resident Transfers (#CS-6.7), states that the purpose of these policies is provide a safe method of transfers and minimize the risk of injury for both the residents and staff. The policies direct that a lifting code diagram, specifying the type of lift or transfer is placed on the headboard of each resident's bed. Staff are to ensure that the proper lift is followed for that particular resident, and shall be adhered to without exception.

Registered Nurse #050, Physiotherapy Assistant (PTA), Physiotherapist (PT) and the Director of Care, all indicated to the inspector, that residents are assessed by the Physiotherapist for their transfer ability, and that the PT provides direction as to how a resident will be lifted and or transferred using the most appropriate device and or techniques to ensure residents are safely transferred and or positioned.

Registered Nurse #050 and the DOC indicated that staff are to follow the direction of PT when lifting and transferring a resident; both indicated that only the PT and or the DOC can change a resident's lift and transfer status.

Related to Intake #007265-17:

The Director of Care submitted a Critical Incident Report (CIR) to the Director, on an identified date, with regards to an incident that causes an injury to a resident for which the resident is taken to an acute care facility and which results in a significant change in the resident's health status.

Resident #005 had an unwitnessed incident on an identified date, sustained injury and was transferred to an acute care facility for assessment and treatment. Three days later, resident #005 was discharged from the acute care facility to the long-term care home.

The clinical health record for resident #005 was reviewed, by the inspector, for the period of approximately two weeks, the following is documented:
- Resident #005 was assessed by the Physiotherapist, a contracted service provider for the long-term care home, the following was documented within a progress note (upon readmission): "Precautions", the identified area should not bend past an identified degree; no pillow under the identified areas while in bed. Transfer resident using a mechanical transfer device.

Physiotherapist reiterated the plan of care for resident #005 in his/her subsequent assessment and progress notes two and three days later.

Registered Nurse (RN) #050, Physiotherapy Assistant (PTA), Physiotherapist (PT) and the Director of Care, all indicated to the inspector, that residents are assessed by the Physiotherapist for their transfer ability; and that the PT provides direction as to how a resident will be lifted and or transferred using the most appropriate device and or techniques to ensure residents are safely transferred and or positioned.

A progress note, documented by Registered Practical Nurse #070, indicated that Personal Support Worker reported that resident #005 was toileted using a sit to stand transfer device, on an identified date.

Registered Nurse #050 and the DOC indicated that staff are to follow the direction of PT when lifting and transferring a resident; both indicated that only the PT and or the DOC can change a resident's lift and transfer status.

Registered Nurse #050 and the Physiotherapist, both indicated to the inspector, that resident #005 should not have been transferred using the sit to stand transfer device until resident was reassessed by PT for weight bearing ability, noting that resident recently underwent an identified procedure.

Personal Support Workers failed to ensure that safe transferring and positioning devices or techniques were used on the identified date, when they transferred resident #005 using a sit to stand lifting device rather than the assessed mechanical transfer device. [s. 36.]

2. Related to Intake #007102-17:

The Director of Care submitted a Critical Incident Report (CIR) to the Director, on an identified date, with regards to an incident that causes an injury to a resident for which the resident is taken to an acute care facility and which results in a significant change in the resident's health status. The CIR indicates that resident #007 had an incident three days earlier.

The clinical health record for resident #007 was reviewed for the period of approximately one month, the following is documented:
- Resident #007 had an unwitnessed incident on an identified date, sustained injury and was transferred to acute care facility for assessment and treatment. Three days later, resident #007 was discharged from the acute care facility to the long-term care home.

Resident #007 was assessed by the Physiotherapist, a contracted service provider for the long-term care home, the following was documented within a progress notes:

- day following readmission - Precautions: Resident is not to weight bear at all, and the identified area should not bend past an identified degree for a least three weeks. Transfer using a mechanical transfer device.

- three days later – Resident was assessed today, PT tried to do a two person assist transfer into the washroom, resident #007 did not transfer well. Staff advised by PT to use a alternate mechanical transfer device and bedside commode for toileting. Transfer using a sit-stand transfer device with calf straps or alternate mechanical transfer device. Resident is NWB (non-weight bearing).

Physiotherapist reiterated the plan of care, specific to how resident #007 is to be lifted and or transferred, in his/her subsequent assessments and progress notes.

Registered Nurse #050, who was the assigned Charge Nurse on shift, indicated, in his/her progress note, that he/she and personal support workers toileted resident #007 manually using a two person transfer.

Registered Nurse #050 indicated to the inspector, that resident #007 indicated needing to use the washroom, and that resident #007 refused to use a bedside commode or a bedpan, and therefore staff transferred resident #007 using a two person transfer. RN #050 indicated being aware of resident #007's assessed transfer and lift status, but indicated that the resident refused to use a commode or bedpan, so he/she and the staff manually transferred resident.

The Physiotherapist indicated to the inspector, that resident #007 should not have been transferred using a two person manual transfer, until resident was reassessed by PT for weight bearing ability, noting that resident recently underwent a specific procedure.

Personal Support Workers, as well as RN #050 failed to ensure that safe transferring and positioning devices or techniques were used on the identified date, when they transferred resident #007 using a manual transfer rather than the assessed mechanical transfer device. [s. 36.]

3. Related to Intake #007116-17:

The Director of Care submitted a Critical Incident Report (CIR) to the Director, on identified date, with regards to an incident that causes an injury to a resident for which the resident is taken to acute care facility and which results in a significant change in the resident's health status.

Resident #006 had an incident on an identifed date, sustained injury and was transferred to acute care facility for assessment and treatment. Four days later, resident #006 was

discharged from the acute care facility to the long-term care home.

The clinical health record for resident #006 was reviewed, by the inspector, for the period of approximately two weeks, the following is documented.

The written care plan (in place on an identified date) directs staff as to the following:
- Transfers - Resident is unable to weight bear and stand unassisted. Interventions include, two personal support workers to transfer resident using an identified mechanical transfer device.
- Falls - Resident is at risk for falls. Interventions include, personal support workers to follow routine set up by physio for safe methods of transfers.

Progress Notes:
- Resident #006 was assessed by the Physiotherapist, a contracted service provider for the long-term care home, the following was documented within a progress note, dated on an identified date, which directs the following, "Precautions", resident #006's identified area should not bend past an identified degree; no pillow under identified areas while in bed. Transfer resident using the identified mechanical transfer device. Resident has been provided a wheelchair and is to have an identified degree of tilt for positioning while in wheelchair; a pillow is to be placed under an identified area, while in the wheelchair, to keep the identified area straight and stabilized.
- Physiotherapist assessed resident again (day later), indicating that resident was to be transferred using an identified mechanical transfer device).
- Physiotherapist reiterated this transfer status on two other dates, and PT indicated resident #006 is non-weight bearing.

On an identified date (and time) resident #006 was observed, by the inspector, sitting in a wheelchair in his/her room; Personal Support Worker (PSW) #053 was present in resident #006's room at the time of this observation. PSW #053 indicated that this morning, he/she, the PSW, sat resident up on the edge of the bed to provide morning care, indicated that resident attempted to stand on his/her own, so he/she, the PSW, helped him/her to stand at the side of the bed, and called for another PSW for assistance, and then they (PSW #053 and another PSW) did a two person pivot transfer from side of bed into resident's wheelchair.

Personal Support Worker #053 indicated awareness that resident #006 was to be lifted/transferred using a mechanical transfer device, but indicated resident attempted to stand and transfer, so I just went with it.

Registered Nurse #050 and the Physiotherapist, both indicated to the inspector, that resident #006 should not have been transferred using a two person pivot transfer until resident was reassessed by PT for weight bearing ability, noting that resident recently underwent an identified procedure.

Personal Support Workers failed to ensure that safe transferring and positioning devices or techniques were used on the identified date, when they transferred resident #006 using a two person pivot transfer rather than the assessed maxi-lift (mechanical device) [s. 36.]

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 there is a process in place and monitored, ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraint has been evaluated by a physician, or a registered

nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Related to Intake #028327-16:

The Director of Care submitted a Critical Incident Report (CIR) to the Director on an identified date, for an incident that causes an injury for which the resident is taken to an acute care facility and which results in a significant change in the resident's health status. Resident #001 had two incidents days earlier, sustained injury, and was placed on routine monitoring. Resident was subsequently transferred to an acute care facility was assessed and treated.

Resident #001 has a history which includes cognitive and physical impairment.

Registered Nursing Staff #050 indicated, to the inspector, that resident #001 is known to be at high risk for falls and requires the use of restraints while in his/her wheelchair or in bed.

The clinical health record, including progress notes, falls risk assessment and physiotherapy assessments all indicate resident #001 is a risk for falls. The physician's orders, Physician Medication Review (dated for the period of five months), as well as the Quarterly Non-Medicinal Review (dated over a five month period) all detail that resident #001 requires restraints to be utilized.

The Restraint Monitoring forms, for resident #001, were reviewed, by the inspector, for an identified two month period, documentation failed to identify that registered nursing staff had reassessed the condition of the resident, and the effectiveness of the restraints, during an identified period of time.

Registered Nursing Staff #050, and #071, as well as the Director of Care, all indicated to the inspector, that registered nursing staff are to review the Restraint Monitoring forms prior to their assigned shifts ending, and sign them.

The licensee failed to ensure that resident #001's condition had been reassessed and the effectiveness of the restraint has been evaluated by a physician, or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours. [s. 110. (2) 6.]

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 there is a process in place and monitored, ensuring that hat the resident's condition has been reassessed and the effectiveness of the restraint has been evaluated by a physician, or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances, to be implemented voluntarily.

Issued on this 12th day of June, 2017

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

Original report signed by the inspector.