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
Apr 17, 2019	2019_795735_0006	007329-18, 015314-18, 017916-18, 002148-19	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Stirling Heights
200 Stirling Macgregor Drive CAMBRIDGE ON N1S 5B7

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

KRISTAL PITTER (735), MARIA MCGILL (728)

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 1-5, 2019.

The following intakes were completed in this Critical Incident System inspection:

Log # 017916-18 related to falls prevention.
Log # 007329-18 related to medication.
Log # 002148-19 related to prevention of abuse and neglect.
Log # 015314-18 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Interim Director of Care, a Dietary Aide, the Resident Assessment Instrument (RAI) Coordinator/Falls Lead, Registered Nurses, a Registered Nursing Student, Registered Practical Nurses, Personal Support Workers, a former Personal Support Worker, a family member, and residents.

The inspectors also made observations of residents and care provided. Relevant reports, policies and procedures, the home's investigation notes, resident assessments, as well as clinical records and plans of care for the identified residents were reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), which documented that a resident sustained a fall which resulted in an injury.

There was no post-fall assessment documented for the identified fall.

A registered staff member and the RAI Coordinator / Falls Lead stated that a post-fall assessment was to be completed after every fall, and that there was no post-fall assessment completed for the identified resident.

The licensee has failed to ensure that when a resident fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from abuse by staff.

Ontario Regulation 79/10 defines financial abuse as the misappropriation or misuse of a resident's money or property.

A CI was submitted to the MOHLTC, which documented that the family of a resident had provided the home with video footage which identified a staff member taking money from a resident's room.

The home's documentation of the incident included an interview with the identified staff member that included confirmation from this staff member that they had taken a resident's money from their room.

The Executive Director (ED) said that they considered this incident to be financial abuse.

The licensee has failed to ensure that a resident was protected from financial abuse by staff. [s. 19. (1)]

Issued on this 18th day of April, 2019

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

Original report signed by the inspector.