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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Licensee Copy/Copie du titulaire de permis

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection/ Genre d'inspection
Apr 15, 2019	2019_670571_0006	013448-18, 015289-18, 016501-18, 019735-18, 020509-18, 023642-18, 024489-18	Critical Incident System

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South WHITBY ON L1N 9W2

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

Glen Hill Strathaven
264 King Street East Bowmanville ON L1C 1P9

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

PATRICIA MATA (571), LYNDA BROWN (111)

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): March 4, 14, 15, 18, 19, 21, 2019.

The following CIS intakes were related to falls:
Log #013448-19, CIS #2605-000016-18
Log #020509-18, CIS #2605-000022-18
Log #023642-18, CIS #2605-000025-18
Log #024489-18, CIS #2605-000026-18

The following CIS intake was related to a missing resident:
Log #019735-18, CIS #2605-000021-18

The following CIS intakes were related to allegation of abuse:
Log #015289-18, CIS #2605-000017-18
Log #016501-18, CIS #2605-000019-18

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered staff, PSW's and residents

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

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

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

s. 6. (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 has failed to ensure that if the resident when being reassessed and the plan of care

is being revised because care set out in the plan has not been effective, that different approaches had been considered in the revision of the plan of care.

Related to Log # 013448-18:

A critical incident report (CIR # 2605-000016-18) was submitted to the Director on June 11, 2018 for a fall that caused an injury for which the resident was taken to hospital and which resulted in a significant change in the residents health status. The CIR indicated on June 9, 2018 at 2215 hours, resident #001 was found on the floor beside their bed. The resident sustained a laceration to their forehead. The resident was started on Head Injury Routine (HIR) monitoring. On June 10, 2018 the resident developed a large hematoma and bruising around the right eye and cheek, the resident was on an anticoagulant. The physician was contacted and instructed staff to transfer the resident to hospital for further assessment. The resident was diagnosed with acute subdural hematomas and returned to the home on comfort care. The CIR indicated the resident had sustained four falls. The CIR was completed by the DOC.

Review of the progress notes for resident #001 from January 1 to June 18, 2018, indicated the resident sustained four falls as follows:
-On April 20, 2018 at 1525 hours, the RN received a call from the RPN on the unit that the resident had a fall outside that Celebration Room in the hallway. The resident was found lying on their right side. The fall was unwitnessed. The physiotherapist was also present. The resident had a skin tear noted on right elbow. The causative factor was that the resident was not using their walker. The intervention that was put in place was the use of the walker. Post Fall Huddle Notes outlined to ensure that the walker was used at all times. The care plan was reviewed and updated.
-On April 29, 2018 at 1815 hours, the door to nursing station was closing behind the PSW, when the PSW heard a thump and found the resident lying on their back on the floor, on the other side of the door. The resident was unresponsive for a brief period of approximately 30 seconds and then responded as usual. There were no injuries were noted. A note was left for the Nurse Practitioner (NP) to assess the resident as the resident's pulse dropped to 40 and then increased up to 119. The causative factor was a possible episode of syncope. The Post Fall Huddle Notes indicate to monitor the resident and ensure that the resident is using walker.
-On June 2, 2018 at 1655 hours, the resident was pushed by resident #002 and fell backwards onto the floor and onto their back. The resident complained of pain in right hip and was grimacing. 911 was called and the resident was transferred to hospital for assessment. The resident returned from hospital on June 3, 2018 with a diagnosis of a small fractured left Pubic Ramus, two skin tears to the right elbow and a swollen right thumb
-On June 4, 2018 at 1149 hours, the Physiotherapist assessed the resident and indicated that the resident was currently ambulating using walker. The plans and recommendations were that the staff were to monitor the resident's ambulation using the walker for antalgic, unsteady or weak gait, encourage periods of rest and mobility, staff to remind the resident to use the walker all the time during ambulation, continue to monitor for pain and to seek the opinion of the MD/NP as required.

-On June 6, 2018 the resident was on increased monitoring every 30 minutes due to incident with a co-resident. On June 7, 2018 the staff noted the resident appeared to be more agitated and aggressive than usual, swearing and trying to hit staff. PRN Ativan and Dilaudid was given.
-On June 8, 2018 at 0242 hours, the resident has been up periodically throughout the night. PRN Dilaudid was given. At 0551 hours, a bed pad alarm was brought to unit. In discussion with night staff, it was reported that resident was often awake and sitting on edge of bed calmly. They were easily calmed and return to sleep. Staff felt that the alarm would be an irritant and upset resident #001 and prevent the resident from returning to sleep. It was decided that the bed alarm might do more harm than good.
-On June 9, 2018 at 2215 hours, the staff found the resident lying on their back on the floor at the bedside. The resident sustained a laceration to the right forehead. Staff attempted to put ice on the resident's forehead but resident resisted as the resident was agitated and difficult to assess. After the fall, HIR was initiated. The resident denied having pain. The interventions that were put into place or being used were proper footwear, side rails, bed/chair alarm, and falls mat. They became agitated with the bed alarm. Appropriate foot wear was on. Post fall Huddle Notes: as noted above, a pad alarm is not effective as it agitates the resident.
-On June 10, 2018, the Post Fall Huddle conducted with two RN supervisors and a RPN included the discussion of implementing the bed pad alarm and falls floor mat for safety when the resident was in bed. It was documented at 1217 hours that the resident had a laceration to forehead from fall the previous evening, a large hematoma was also developing and bruising noted around right eye and the down cheek. The resident was ambulating and agitated earlier in the shift and their left leg was noted to be externally rotated and limping on left side with ambulation. The resident was experiencing pain and was given Dilaudid. The physician was notified and instructions were given to notify the POA and to send the resident to the hospital for assessment. There was an updated falls logo above the resident's bed. At 2031 hours, the hospital was called for an update on the resident's condition and it was communicated that the resident was diagnosed with a brain bleed. The resident was to be sent back home on June 11, 2018 at 0010 hours, no treatment was provided at the hospital. At 1106 hours, the NP spoke with the family and a decision was made to provide the resident with palliative care. The resident passed away on June 17, 2018.

A review of the written plan of care (dated January 24, 2018, before the falls) for resident #001 indicated, risk for falls characterized by multiple risk factors related to: new environment, wandering, poor judgement, use of psychotropics, history of orthostatic hypotension. Interventions included: Transfer and change positions slowly, reinforce need to call for assistance, call bell within reach when in bed, resident to wear proper and non- slip footwear, encourage resident to use walker, sometimes forgets to use the walker and staff to provide walker when seen ambulating without walker.

Review of the written plan of care (dated June 11, 2018, after the last fall) for resident #001 indicated, risk for falls characterized by multiple risk factors related to: new environment, wandering, poor judgement, use of psychotropics, history of orthostatic hypotension, fall (April 20, 2018, June

2, 2018, fractured left Pubis Ramus, June 09, 2019, Subdural Hematoma). Interventions added included:
-Ensure resident remains in wheelchair at all times (Date Initiated: 06/11/2018);
-Use two person assist transfers and change positions slowly (Revision on: 06/12/2018)
-Encourage resident to stay in chair or bed. Increase monitoring if restless. Currently diagnosed with a Subdural Hematoma and is on sedative medication r/t comfort care (Revision on: 06/15/2018)
-Check q1h to ensure safety (Date Initiated: 06/10/2018)
-Resident in fall prevention program (Date Initiated: 06/10/2018).
-Adaptive equipment required to reduce fall risk: personal alarm, bed in lowest position, and falls mats on each side of bed when in bed for safety. (Compliance with equipment varies, depending on resident's mood, can become agitated by the alarm, which causes distress, therefore staff remove it when this occurs.) (Date Initiated: 06/10/2018).
-Dynamic tilt wheelchair provided. Kept in lowest position with a chair pad alarm. Staff to supervise closely. To be tilted.(Date Initiated: 06/13/2018)

During an interview with the DOC on March 04, 2019, the DOC indicated when a resident sustains a fall with injury, the registered nursing staff are to update the care plan as necessary to trial a new intervention, complete a referral to PT, implement HIR as per protocol. The DOC indicated if there is an acute injury call 911, call the physician or NP, notify the SDM, document the incident, complete a risk management report, post fall assessment, post fall huddle/analysis note and skin assessment. The DOC indicated if the fall was unwitnessed, do HIR and complete a pain assessment if the resident is experiencing pain. The DOC indicated they were in charge of the Resident Safety Committee, which includes a review of the falls. The DOC indicated the committee members meet quarterly and minutes of the meetings were kept. The DOC indicated during the meeting, the PT reviews the number of falls per unit, time of the falls, and creates a spread sheet to demonstrate/identify the problem areas for falls, day of the week and by unit. The DOC indicated the nurse is to update the Fall logo (ACES) above the residents bed after a fall, if there is a new intervention. The DOC indicated the home also has a Falling Star program which residents are placed on, if the resident sustains one or two falls in a month. The DOC indicated the committee does not specify the names of residents who have fallen, but the committee discusses interventions to reduce falls.

The licensee has failed to ensure that if 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.The resident sustained four falls, two in April and two in June 2018. The resident's care plan was not updated with new interventions until after the resident sustained the fourth fall, and upon return from hospital on palliation. [s. 6. (11) (b)] (111)

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 when resident #001 is reassessed and plan of care reviewed and 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, to be implemented voluntarily.

Issued on this 15th day of April, 2019

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

Original report signed by the inspector.