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
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
Aug 22, 2019	2019_640601_0016	013181-18, 016923-18, 029057-18, 012578-19, 013704-19	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Taunton Mills
3800 Brock Street North WHITBY ON L1R 3A5

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

KARYN WOOD (601), JENNIFER BATTEN (672)

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): July 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, 24 and 25, 2019.

Log #029057-18; Log #013181-18; Log #016923-18 and Log #012578-19 related to a fall resulting in an injury.

Log #013704-19 related to an incident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Kinesiologist, RAI-MDS Coordinator, Personal Support Workers (PSW) and residents.

The inspectors also reviewed residents health care records, the licensee's relevant policies and procedures, observed the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Pain

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 licensee has failed to ensure that there was a written plan of care for resident #003 that set out clear directions to staff and others who provided direct care to the resident.

Related to Log #016923-18:

A review of a Critical Incident Report (CIR) that was submitted to the Director on a specified date and time for an injury to a resident that resulted in an identified injury following a fall on a specified date and time. The Physician assessed resident #003 on a specified date following a change in the resident's condition and mobility. Resident #003's Physician ordered a specified test and the resident was transferred to an identified facility on a specified date.

A review of resident #003's clinical health record, by Inspector #601 identified that resident #003 was a high risk for falls.

A review of resident #003's progress notes, by Inspector #601 during a specified time,

identified that resident #003 had fallen on eight occasions. Resident #003 was assessed following each fall and there were three occasions when the resident had sustained a minor injury. Resident #003 sustained the identified injury after an identified number of falls and was transferred to the identified facility on a specified date.

A review of resident #003's transfer assessment documented by Kinesiologist #118 on two specified dates identified that resident #003's mobility had declined and the residents level of staff assistance required had changed which included the use of a transfer device following the specified injury.

A review of resident #003's care plan interventions that were in place from a specified period of time identified that resident#003's written interventions related to falls prevention and mobility included identified interventions. Inspector #601 identified that the written care plan interventions did not include the interventions that Kinesiologist #118 documented on the two specified dates when resident #003's mobility had declined and the residents level of staff assistance required had changed which included the use of a transfer device following the specified injury.

A review of resident #003's progress notes, by Inspector #601 for a specified period of time, identified that on three specified dates, Occupational Therapist (OT) #117 and the Kinesiologist had documented that resident #003 was being assessed to use a specified mobility device for locomotion and that staff assistance for transfers had changed. Inspector #601 identified that the specified mobility device for locomotion and the change in number of staff assistance required for transfers was not included in resident #003's written plan of care.

During an interview on a specified date, Physiotherapist #119 indicated to Inspector #601 that resident #003 was not on the physio program prior to their specified injury. Physiotherapist #119 indicated to Inspector #601 that resident #003 was ambulating with a specified mobility device prior to the specified injury and required a different specified mobility device for locomotion when they returned from the identified facility.

During separate interviews on a specified date, the RAI-MDS Coordinator #107, RN #120 and PSW #124 reported to Inspector #601 that resident #003 was at high risk for falls, was not aware of their limitations in relation to ambulation and the use of their specified mobility device.

During separate interviews on a specified date, the RAI-MDS Coordinator #107, RN

#120 and PSW #124 and review of resident #003's progress notes for a specified period of time by Inspector #601, identified that specific falls interventions had been utilized by staff to manage resident #003's risk for falls and these interventions were not included in the resident's written plan of care.

During an interview on a specified date, the Administrator indicated to Inspector #601 that the resident's care plans were to be updated by the registered staff immediately following each fall, if required. The Administrator further indicated that the interventions implemented to decrease resident #003's risk for falls were not documented in the resident's written care plan to provide clear direction to staff providing the resident's care.

A review of resident #003's written care plan in place at the time of the specified injury did not provide clear direction to staff for the type of mobility device required for locomotion, staff assistance required for transfers and the specific falls interventions that had been put into place. The written care plan following the fall with the specified injury did not include the changes to the plan of care to use the transfer device when transferring the resident.

The licensee failed to ensure the written plan of care for resident #003 set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care for resident #007 set out clear directions to staff and others who provided direct care to the resident.

Related to Logs #012578-19 and #013704-19:

A Critical Incident Report (CIR) was submitted to the Director on a specified date, regarding a fall sustained by resident #007 on a specified date and time. The fall resulted in the resident being transferred to an identified facility where they received a specified diagnosis. While in the identified facility, resident #007 was also diagnosed with another specified condition and the resident was sent back to the Long Term Care Home (LTCH) on a specified date. A second CIR was submitted to the Director on a specified date related to an incident involving resident #007.

A review of resident #007's health care record following their return from the identified facility on the specified date, Inspector #672 observed the written plan of care and Kardex both indicated that resident #007 was able to mobilize independently with the assistance of an identified mobility device and was able to toilet themselves

independently. The resident required no assistance with repositioning while in bed or with meal set up and feeding as the resident took all meals in the dining room setting and only had concerns with pain control related to periodic discomfort. Inspector #672 reviewed resident #007's progress notes for a specified period of time, and observed a progress note by Kinesiologist #113 documented the day resident #007 returned from the identified facility, which stated that resident #007 was provided with specified falls interventions and was placed on increased observation due to the resident attempting to get up from the bed independently. These interventions were not listed within the resident's written plan of care or Kardex.

During an interview, RPN #110 indicated that prior to the fall sustained on a specified date, resident #007 utilized the specified mobility device for very short distances, such as from the bed to the bathroom, otherwise utilized a specified mobility device for their locomotion needs throughout the resident home area and the LTC home and grounds. RPN #110 further indicated that following the resident's return from the identified facility, resident #007 had required an identified number of staff members to assist with bed mobility and repositioning, required a specified transfer device for transfers to and from the mobility device for locomotion, which was required for all mobility needs and had been mostly bed bound following their return to the home as a result of the identified injury and discomfort. Due to resident #007 remaining in bed following their return from the identified facility, they had received assistance with meal service while they remained in bed. Inspector #672 reviewed resident #007's written plan of care in place for a specified period of time, with RPN #110 and they indicated the plan of care did not reflect resident #007's health status or care needs during that time and did not provide clear directions to the staff who provided direct care to the resident related to their care requirements. RPN #110 further indicated it was the responsibility of all of the registered staff who worked on resident #007's home area to ensure that the written plan of care was updated as required to ensure it reflected each resident's care needs and provided clear instructions to the staff who provided direct care to the resident.

During an interview, Kinesiologist #113 indicated that upon resident #007's return from the identified facility on a specified date, they were provided with identified falls interventions and were placed on increased observation due to attempting to get up from the bed independently. Kinesiologist #113 further indicated that information had been shared with the registered staff on duty at the time the interventions were implemented so that the nurse could record the interventions into the resident's written plan of care.

During separate interviews, the RAI Coordinator and DOC indicated that it was the

expectation in the home that every resident's plan of care was updated as required by the registered staff on duty to ensure it reflected the resident's current health condition and care requirements, so that it provided clear directions to the staff who were providing direct care to the resident.

The licensee failed to ensure that the plan of care for resident #007 set out clear directions to staff and others who provided direct care to the resident following a fall sustained on a specified date, as it did not indicate that the resident was no longer able to utilize a specified mobility device for mobility purposes; required a specified transfer device for all transfers to and from the specified mobility device which was needed for all locomotion on and off the resident home area; required a specified number of staff members to assist with bed mobility and repositioning; was no longer independent with activities of daily living such as toileting; had specified falls interventions implemented; was placed on increased observation due to attempting to get up from the bed independently; and had comfort control issues related to the specified injury. [s. 6. (1) (c)]

3. The licensee has failed to ensure that there was a written plan of care for resident #002 that set out clear directions to staff and others who provided direct care to the resident.

Related to Log #013181-18:

A review of a Critical Incident Report (CIR) that was submitted to the Director on a specified date and time for an injury to a resident that resulted in an identified injury following a fall on a specified date and time. The resident was not able to communicate where they were having discomfort. The Physician assessed the resident on a specified date and ordered an identified medical assessment due to the resident having discomfort in an identified area. Resident #002 was sent to an identified facility and was diagnosed with a specified medical condition.

A review of resident #002's clinical health records, by Inspector #601 identified that resident #002 was identified as being a high risk for falls.

A review of resident #002's progress notes, by Inspector #601 for a specified period of time, identified that resident #003 had fallen on an identified number of occasions. Resident #002 was assessed following each fall and there were an identified number of occasions when the resident had sustained a minor injury. Resident #002 sustained the specified injury after an identified number of falls and was transferred to the identified

facility on a specified date.

A review of resident #002's care plan interventions that were in place for a specified period of time identified that resident#002's had specified written interventions related to falls prevention and mobility.

A review of resident #002's transfer assessment completed on a specified date after they had returned from the identified facility by Kinesiologist #113. Kinesiologist #113 had assessed resident #002 to require an identified number of staff assistance for transfers due to an identified gait. Resident #002 returned from the identified facility with a specified diagnosis. The resident lacks insight into safety, may attempt to self transfer and was provided a specified mobility device for locomotion and specified falls interventions were put into place.

During separate interviews on specified dates, Physiotherapist #119, RN #120 and RPN #131 indicated to Inspector #601 that resident #002 was at risk for falls and had been using a specified mobility device for locomotion. The Physiotherapist further indicated that resident #002 required the assistance of an identified number of staff for transferring and was refusing to participate in the physio program.

During separate interviews on a specified date, PSW #132 and PSW #133 indicated to Inspector #601 that resident #002 was at risk for falls and was currently transferring with the assistance of a specified number of staff that was different then specified by the Physiotherapist. PSW #132 and PSW #133 both indicated that resident #002 was able to walk with their identified mobility device with the assistance of staff on some days and on other days the resident would choose to use the specified mobility device for locomotion. PSW #132 and PSW #133 further indicated that resident #002 falls prevention measures currently in place included that resident #002 was to have the specified falls prevention interventions that were put into place by Kinesiologist #113 when the resident returned from the identified facility.

During an interview on a specified date, Kinesiologist #113 indicated to Inspector #601 that resident #002 was at risk for falls and the falls prevention measures in place at this time included that resident #002 was to have the specified falls prevention interventions that were put into place by Kinesiologist #113 when the resident returned from the identified facility.

During an interview on a specified date, the Administrator indicated to Inspector #601

that resident care plans were to be updated by the registered staff immediately following each fall, if required. The Administrator further indicated the interventions implemented to decrease resident #002's risk for falls were not documented in the resident's written care plan to provide clear direction to staff providing the resident's care.

A review of resident #002's written care plan did not provide clear direction whether the resident required a specified mobility device for ambulation or a specified mobility device for locomotion or that their specified falls prevention interventions that were put into place after the resident returned from the identified facility.

The licensee failed to ensure the written plan of care for resident #002 set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan related to a specified safety device.

Related to log #029057-18:

A review of a Critical Incident Report (CIR) that was submitted to the Director on a specified date and time for an injury to a resident that resulted in an identified injury following a fall on a specified date and time. Resident #001 was sent to an identified facility on a specified date and had an identified diagnosis.

A review of resident #001's current care plan by Inspector #601 identified that resident #001 was to have a specified safety device in place while in their mobility device for locomotion, as a falls prevention measure.

On a specified date and time, Inspector #601 observed resident #001 sitting in their specified mobility device for locomotion and their specified safety device was not set up properly.

During an interview on a specified date, Kinesiologist #113 indicated to Inspector #601 that resident #001 had been identified as a high risk for falls and the resident would attempt to self transfer. Kinesiologist #113 further indicated that resident #001 required the specified safety device to be set up a certain way in order for the device to function properly.

On specified date and time, Inspector #601 observed resident #001 lying in bed with their head facing the foot of the bed. Resident #001's specified mobility device for locomotion was next to their bed and the safety device was not set up properly.

During an interview on a specified date, RN #120 and PSW #125 indicated to Inspector #601 that resident #001 had been identified as a high risk for falls and the resident would attempt to self transfer. According to RN #120, resident #001's specified safety device had not functioned properly when the resident self transferred back to bed as the safety device was not set up properly.

During an interview on a specified date, the Administrator indicated to Inspector #601 that resident #001's plan of care was not followed when the safety device was not set up properly on the two specified dates.

The licensee did not ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan as the safety device was not set up properly, as a falls prevention measure on the two specified dates. [s. 6. (7)]

5. The licensee has failed to ensure when resident #007 was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, that different approaches were considered in the revision of the plan of care.

Related to Logs #012578-19 and #013704-19:

A Critical Incident Report (CIR) was submitted to the Director on a specified date, regarding a fall sustained by resident #007 on a specified date and time. The fall resulted in the resident being transferred to an identified facility where they received a specified diagnosis. While in the identified facility, resident #007 was also diagnosed with another identified diagnosis and the resident was sent back to the LTCH on a specified date. A second CIR was submitted to the Director on a specified date related to an incident involving resident #007.

Inspector #672 reviewed resident #007's health care record for a specified period of time and observed that resident #007 sustained an identified number of falls during that time period.

Inspector #672 reviewed the plans of care for resident #007 for the same specified period of time, which stated that resident #007 was independent with a specified mobility device.

The plan of care further indicated that resident #007 required staff to keep routines and care givers consistent as much as possible. The Falls Risk Assessments completed between the same specified time, all indicated that resident #007 was at moderate risk for falls. The falls prevention interventions were listed within resident #007's plan of care in place at the time of resident #007's fall on a specified date.

Inspector #672 reviewed resident #007's plan of care after each of the six falls sustained between the specified period of time, and no evidence was observed that different approaches were considered for the resident, following any of the falls sustained. All of the interventions listed in resident #007's written plan of care were created on a specified date, with the exception of the intervention to remind the resident to use their mobility device which was created on a different specified date.

The post fall assessments indicated that resident #007 would frequently attempt to self-transfer, which resulted in the resident falling due to a specified reason, related to the resident not having the ability to recall that assistance was required and to use the call bell. The post fall interventions listed within the post fall assessments in an attempt to prevent further falls from occurring following the falls sustained by resident #007 were implemented on three occasions.

During separate interviews, RPNs #110 and #126 and RN #127 indicated that the expectation in the home was that following every resident fall, the falls prevention interventions listed in the resident's plan of care were to be reviewed and revised. RPN #110 further indicated that the only time changes would not be made to the interventions listed in the resident's plan of care would be if the resident had the falls prevention intervention already in place, such as alarms, floor mats, etc. In that situation, RPN #110 indicated that a progress note should be written to indicate that the interventions were reviewed, but no revisions were made due to the resident already having all available interventions in place but would continue to be closely monitored by staff.

During separate interviews, the RAI Coordinator and the DOC indicated the expectation in the home was for the registered staff on duty following a resident fall to immediately review and revise the interventions listed in the resident's plan of care following each fall sustained by the resident.

The licensee failed to ensure that when resident #007's plan of care was reviewed following each of the falls sustained between an identified period of time, and that different approaches were considered in the revision of the plan of care in an attempt to

prevent further falls from occurring. [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 that resident care plans provide clear directions, the care set out in the plan of care for resident #001 is provided to the resident as specified in the plan related to the identified falls prevention intervention and ensure when a resident is being reassessed and the plan of care is revised because care set out in the plan has not been effective, that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #007's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

Related to Logs #012578-19 and #013704-19:

A Critical Incident Report (CIR) was submitted to the Director on a specified date, regarding a fall sustained by resident #007 on a specified date and time. The fall resulted in the resident being transferred to an identified facility where they received a specified diagnosis. While in the identified facility, resident #007 was also diagnosed with another specified condition and the resident was sent back to the Long Term Care Home (LTCH) on a specified date. A second CIR was submitted to the Director on a specified date

related to an incident involving resident #007.

A review of resident #007's health care record following their return from the hospital on a specified date, Inspector #672 observed that resident #007 had struggled with pain control, especially during the tasks of toileting and repositioning. The progress notes stated resident #007 exhibited symptoms of pain. Due to resident #007's pain, registered staff contacted the physician on a specified date, and received new analgesic orders, along with attempting to implement pain reduction interventions and to keep resident #007 on identified interventions.

Inspector #672 reviewed resident #007's physician's orders and medication list, and observed resident #007 had physician's orders for specific analgesics to assist with pain control upon return from the identified facility. Resident #007's physician orders for analgesic medication was increased with a specified analgesic, a identified number of days after they had returned from the identified facility.

Inspector #672 reviewed the internal policy entitled "Pain Management Program", tab: 04 -48, from the care section of the nursing manual, which stated the following:

"2) Complete and document an assessment using the Pain assessment found in the UDA tab in PCC (DO NOT USE – either the supplementary documentation in eMAR or the Pain in the vitals tab as neither of these are acceptable) when:

a) On initiation of a pain medication or PRN analgesic
b) When there are personal expressions exhibited by resident that may be an indicator for the onset of pain
c) When there is a change in condition with pain onset
d) With diagnosis of a painful disease where pain is expressed, or symptoms exhibited by the resident
g) when receiving pain medication for greater than 72 hours
h) with distress-related personal expressions or facial grimacing

4) Conduct a Pain Assessment when:

-A scheduled pain medication does not relieve the pain.
-Pain remains regardless of the support strategies.
-Pain medication is changed.
-An empiric trial of analgesics is started.

Inspector #672 then reviewed resident #007's health care record and observed that when resident #007's pain was not relieved by initial interventions between an identified seven day period, no clinically appropriate pain assessment instruments were observed to have been completed. Further review of resident #007's health care record showed that the last pain assessment had been completed upon the resident's return from the identified facility on a specified date. The pain assessment record indicated resident #007 did not exhibit any evidence of any complaints of pain which was documented as a one out of ten.

During an interview, RPN #110 indicated that following resident #007's return from the identified facility on a specified date and resident #007 had exhibited signs and symptoms of pain. RPN #110 further indicated that resident #007 had mostly remained in an identified location for a specified number of days, and the physician had been contacted to increase the resident's analgesic medications. RPN #110 indicated that the expectation in the home was for clinically appropriate assessment instruments specifically designed for the purpose of assessing a resident's pain were to be completed upon a resident's return from an identified facility, when the resident's pain was not well controlled, when a new analgesic was initiated or changed and when breakthrough medications were administered. RPN #110 indicated they did not complete pain assessments for resident #007 according to the expectations in the home.

During an interview, the DOC indicated that it was the expectation in the home that clinically appropriate assessment instruments specifically designed for the purpose as assessing a resident's pain were to be completed according to the internal pain management policy. The DOC further indicated that registered staff in the home had received education on the internal internal pain management policy.

The licensee failed to ensure that when resident #007's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose. [s. 52. (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 residents are assessed using a clinically appropriate assessment instrument specifically designed for that purpose and when a residents pain is not relieved, to be implemented voluntarily.

Issued on this 4th day of September, 2019

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

Original report signed by the inspector.