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
Jun 12, 2019	2019_745690_0012	006809-18, 013067-18, 017178-18, 030119-18, 033164-18, 005562-19, 008415-19	Critical Incident System

Licensee/Titulaire de permis

Friuli Long Term Care
7065 Islington Avenue Woodbridge ON L4L 1V9

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

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40 Friuli Court Woodbridge ON L4L 9T3

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

TRACY MUCHMAKER (690), AMANDA BELANGER (736), JENNIFER NICHOLLS (691)

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): May 27-31, 2019.

The Following intakes were inspected upon during this Critical Incident inspection:

-Two logs which were related to critical incident reports the home submitted to the Director regarding injuries that required a transfer to hospital;
-Two logs which were related to critical incident reports the home submitted to the Director regarding allegations of resident to resident abuse; and,
-Three logs which were critical incident reports the home submitted to the Director for falls that resulted in an injury and transfer to hospital.

A Complaint inspection #2019_745690_0011 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Maintenance Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapist Assistant (PTA), Personal Support Workers (PSWs), housekeepers and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, staff to resident interactions and resident to resident interactions, reviewed relevant health care records, internal investigation notes, personnel files, as well as numerous licensee policies, procedures and programs.

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

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
3 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

A Critical Incident (CI) report was submitted to the Director for an allegation of resident to resident abuse. The CI report indicated that resident #002 was walking in an identified area and exhibited an identified responsive behaviour towards resident #003. The CI report further indicated that resident #002 had a history of the identified responsive behaviour towards co-residents.

A review of progress notes by Inspector #690, for resident #002 indicated that the resident had a specified intervention in place for the resident's responsive behaviours which posed a risk to co-residents. The specified intervention was discontinued on an identified date, when resident #002 no longer posed a threat to co-residents.

A review of resident #002's current electronic care plan on Point Click Care (PCC) and the resident's kardex by Inspector #690 identified that the resident had the specified intervention in place at specified times.

A review of the home's policy titled "Documentation-Plan of Care and Care Plan Definitions", policy #VII-C-10.90(e), dated April 2019, indicated that the plan of care must include clear directions to team members and others who provided direct care to the resident. The policy further indicated that the kardex was a system used by the interprofessional care team, that communicated a summary of the resident's care needs as they change shift to shift.

In an interview with Inspector #690, Personal Support Worker (PSW) #105, indicated that resident #002 no longer had the specified intervention in place and that they hadn't for some time. In a separate interview with PSW #118, they indicated that they utilized both the care plan and the kardex to find information on residents. Inspector #690 and PSW #118 viewed resident #002's electronic care plan and kardex. The care plan did not indicate that the resident had the specified intervention in place, however the kardex indicated that resident #002 was to have the specified intervention in place at specified times. PSW #118 indicated that the information on the kardex and the care plan did not match, and that it should.

In an interview with Registered Nurse (RN) #116, they indicated that resident #002 no longer had the specified intervention in place as they no longer had a specifed responsive behaviour towards co-residents. Together, Inspector#690 and RN #116 viewed resident #002's care plan on PCC. The specified intervention was not visible on the care plan when RN #118 was logged into PCC. Inspector #690 showed RN #118 the care plan for resident #002 when the Inspector was logged into PCC, and the specified intervention was indicated on the care plan. RN #118 identified that there must have been a technical issue with PCC as the intervention was not identified when they were logged in to PCC. RN #118 and Inspector #690 viewed the kardex and identified that the kardex indicated that resident #002 had the specified intervention in place at specified times. RN #116 indicated to Inspector #690, that they had no idea how the specified intervention could be on the kardex if it was not on the care plan. RN #116 indicated that staff would utilize the kardex and the care plan on PCC to identify what interventions were in place for a resident and that the care plan and kardex for resident #002 did not provide clear direction and that it should have.

In an Interview with Inspector #690, the Director of Care (DOC) identified that the

resident's plan of care was comprised of many documents and included the care plan on PCC and the kardex on Point of Care (POC). The DOC indicated that staff would utilize the care plan and kardex to find out what responsive behaviours a resident had and what interventions were in place to manage the responsive behaviours. Together, the DOC and Inspector #690 viewed the electronic care plan and kardex for resident #002. The DOC identified that the kardex and care plan did not provide clear direction to staff related to the specified intervention for resident #002 and that it should have. [s. 6. (1) (c)]

2. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

A CI report was submitted to the Director on an identified date, related to resident #006 who sustained an injury of unknown cause. The CI report indicated that the resident was sent to hospital and was diagnosed with an identified injury. The CI report further indicated that the resident was at a specified risk level for falls, and the previous fall had occurred seven days prior to the date of the incident mentioned in the CI report, with no apparent injury at that time.

Inspector #736 reviewed the progress notes for resident #006, and noted that on an identified date, Registered Practical Nurse (RPN) #103 documented that the resident was found lying on the floor, and that the "physio" staff had not applied an identified intervention. The RPN further documented that the resident had needed assistance with an identified activity of daily living (ADL), and therefore the "physio" staff did not put the identified intervention back on.

Inspector #736 reviewed the plan of care for resident #006 at the time of the incident on the identified date and noted that the resident had an identified intervention to be applied at specified times.

In an interview with the Inspector, RPN #103 indicated that they responded to resident #006 being on the floor on the identified date. The RPN recalled that the resident had an identified intervention in place, as per the family's request to prevent falls. The RPN also recalled that the identified intervention had not been applied to the resident prior to their fall on the identified date, as the private care worker had told the physiotherapist that the staff would be there shortly to assist the resident with an identified ADL. RPN #103 indicated to the Inspector that the identified intervention should have been applied to resident #006 before the physiotherapist left the resident unattended.

In an interview with the Inspector, Physiotherapy Assistant (PTA) #115 indicated that they were aware that resident #006 had an identified intervention, however after the PTA had finished an specific treatment with resident #006 on the identified date they did not reapply the identified intervention at the request of the private care worker. The PTA stated that the identified intervention should have been applied to the resident after the PTA had finished the specific treatment with resident #006.

A review of the policy titled "Documentation- Plan of Care", VII-C-10.90, last reviewed April 2019, indicated that staff would provide care as specified in the resident's plan of care.

In an interview with the Inspector, the DOC indicated that according to the report in PCC, resident #006 had the identified intervention for three months prior to the date of the incident, as part of their plan of care. The DOC indicated to the Inspector that care was not provided to resident #006 on the date of the incident when the identified intervention was not applied after the PTA had finished the specific treatment with the resident. [s. 6. (7)]

3. A CI report was submitted to the Director on an identified date, related to resident #008 who sustained an injury for which the resident was taken to hospital and that resulted in a significant change in the resident's health status. The CI report indicated that resident #008 was found on the floor and had pain. The resident was sent to the hospital and was diagnosed with an identified injury. The CI report further indicated that the resident was at a specified level of risk for falls, and was to have a specified falls prevention intervention in place.

Inspector #691 reviewed the progress notes for resident #008 and noted that on the date identified in the CI report, RPN #126 documented that the resident sustained a fall in an identified area. A further review of progress notes documented by RPN #126, identified that a specified intervention been malfunctioning.

Inspector #691 reviewed the electronic care plan for resident #008 at the time of the incident, and noted that the resident had identified falls prevention interventions in place. A further review of the care plan indicated that the resident was at risk for falls at specified times.

During interviews with PSW's #105, #106 and #124, they indicated to Inspector# 691,

that resident #008 had a specified level of risk of falling, and their support actions included the use of the specified intervention.

During an interview with RPN #103, they indicated that resident #008 had an identified responsive behaviour and and staff would observe them closely. RPN #103 further indicated that the resident required monitoring and had a specified intervention in place to prevent falls. RPN #103 indicated that they did recall the resident's fall and that the specified intervention had malfunctioned.

In an interview with Inspector #691, RN #116 indicated that they recalled the incident when resident #008 fell and indicated that the specified intervention had malfunctioned. They further indicated that staff members had left the resident in the identified area of the home as the resident had been restless and the staff members felt resident #008 would be safer in the identified area while they were providing care.

A review of the home's internal investigation notes by Inspector #691, indicated that RPN #126 was made aware of the malfunctioning intervention, but thought it had already been replaced by the previous shift. The Inspector reviewed a document, from an identified date, given to RPN #126 for not following the homes policy, specifically the Falls Prevention policy.

In an interview with Inspector #691, the DOC identified that after the home's internal investigation regarding resident's #008 fall was completed, they determined that the specified intervention was malfunctioning. The DOC indicated that RPN #126 was aware of the specified intervention malfunctioning but they thought that by keeping the resident closely monitored, the resident would be okay. The DOC further indicated to the Inspector that the expectation would be that staff would follow the internal process of replacing malfunctioning interventions, including falls prevention interventions, they were readily available at all times. Together, Inspector#691, and the DOC viewed resident #008's care plan and identified that resident #008 had the specified intervention in place as a fall prevention intervention. The DOC indicated to the Inspector that staff were aware of malfunctioning intervention prior to the fall and that resident #008's care was not provided as specified in the plan of care as they did not have a functioning intervention in place at the time of the fall on the identified date. [s. 6. (7)]

4. The licensee has failed to ensure that the resident was reassessed and the plan reviewed and revised at least every six months and at any other time when, the residents care needs changed.

A CI report was submitted to the Director on an identified date for an injury that required a resident to be transferred to the hospital that resulted in a significant change in the resident's health status. The CI report identified that resident #007 sustained a fall resulting in an identified injury. A further review of the CI report identified that a specified intervention was to be in place.

Inspector #691 reviewed resident #007's progress notes that identified that the resident sustained a fall the day before the CI report was submitted, in an identified area. During an identified assessment of resident #007, it was identified that the resident complained of pain in an identified area. Resident #007 was transferred to hospital for further assessment. A further review of progress noted identified a progress documented the day after the fall, that indicated that resident #007 was provided with a specified intervention.

A review of the electronic care plan on PCC identified the following focus " I'm at (specify level) of risk for falls". A further review of the care plan described resident #007’s biggest risk of falling. The care plan included specified support actions to prevent falls, however Inspector #691 could not locate a support action to indicate that resident #007 was to have the specified intervention in place.

During an initial observation by Inspector #691 of resident #007 on an identified date, Inspector #691 identified that resident #007 did not have the specified intervention in place.

In an interview with Inspector #691, PSW #108 identified that they reviewed the kardex, the care plan and received shift report from registered staff to find information about what falls prevention interventions a resident had in place. They further identified that a resident's risk level for falls should be identified in the care plan. PSW #108 indicated that resident #007 was a specified level for risk for falls and required the specified intervention.

At conclusion of the interview, PSW #108 offered to show Inspector #691 resident #007's specified intervention. Together, the Inspector and PSW#108 observed resident #007 in an identified area and the resident did not have the specified intervention in place. PSW #108 stated to the Inspector “Oh, the new person is on, they must have forgot”. Inspector # 691 observed PSW #108 obtain the specified device apply the specified intervention to resident #007.

In an interview with Inspector #691, RPN #107 identified that resident #007 was at a specified risk level for falls, and had the specified intervention in place. RPN #107 identified that the care plan would be revised after a fall or when there is a change in status. Together Inspector #691 and RPN #107 reviewed the current care plan. It was identified by RPN #107 that the current care plan did not indicate that resident #007 was to have the specified intervention in place and that it should have.

In an interview with Inspector #691, RN #120, identified that resident #007 was at a specified risk level for falls, and that the resident should have the specified intervention in place. RN #120 indicated that a care plan would be revised quarterly, and when there were changes to care, such as after a resident sustained a fall. Together, with the Inspector, they reviewed the current care plan and RN #120 identified that the care plan did not include the use of the specified intervention and that it should have.

A review of the policy entitled "Documentation- Plan of care", VII-C-10.90, last revised: April 2019, identified " the care plan was a documentation tool that communicated and directed the plan to team members for specific care approaches not established in standard operating procedures." Further review of the policy indicated that staff were to reassess each resident's plan of care as required when the resident's care needs changed.

In an interview with Resident Assessment Instrument (RAI) Coordinator #117, they identified to Inspector #691 that resident #007 was at a specified level of falls risk and required the specified intervention. Together, Inspector #691and RAI coordinator #117 reviewed care plan, and RAI Coordinator #117 identified that resident #007's specified fall risk level and the specified intervention were not indicated on the care plan, should have been.

In an interview with Inspector #691, the DOC indicated that the plan of care encompassed many documents, which included, the care plan, kardex, progress notes, and assessments. The DOC indicated that it was the expectation that the plan of care identified a resident's fall risk level and that resident #007's care plan did not identify the risk level. The DOC further indicated that the specified intervention for resident #007 was not required to be on the care plan, as it was noted in the progress notes and that it would be the expectation that staff review progress notes, and assessments to identify what interventions were in place for residents on a daily process as per the home's policy. [s. 6. (10) (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 ensure that there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident, that the care set out in the plan of care is provided to the resident as specified in the plan and, that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, 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 has failed to ensure that where this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy was complied with.

In accordance with O.Reg 79/10, s.49 (1), the licensee was required to ensure that the falls prevention and management program, at a minimum, provided for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the section of the licensee's policy, "Falls Preventior and Management #VII-G-30.10, last revised April 2019, which was part of the licensee’s

Falls Prevention and Management Program, that stated the fall risk assessment was to be completed on PCC on return from hospital, or with a significant change in status.

Inspector #691 and #736 reviewed the home's policy titled “Falls Prevention and Management” policy #VII-G-30.10, last revised April 2019. The policy indicated that a falls risk assessment was to be completed on PCC within 24 hours of admission, as triggered by the Minimum Data Set (MDS) Resident Assessment Protocol, upon return from hospital, or with a significant change in health status.

A CI report was submitted to the Director on an identified date, related to resident #006 who sustained an injury of unknown cause. The CI report indicated that the resident was sent to the hospital and diagnosed with an identified injury.

Please see WN #1, finding 2, for details.

Inspector #736 reviewed progress notes for resident #006 and identified a progress note that indicated that the resident was transferred to hospital on an identified date, and was diagnosed with an identified injury The progress notes indicated that the resident returned from hospital seven days later.

Inspector #736 conducted a review of resident #006’s electronic health records and identified a falls risk assessment completed approximately six weeks prior to the incident mentioned in the CI report, as a quarterly assessment and could not locate any other falls risk assessments completed for resident #006.

In an interview with Inspector #736, RN #116 indicated that resident #006 should have had a falls risk assessment completed at the time of the incident, after the resident returned from the hospital. Together, the Inspector and the RN reviewed the electronic assessments for the resident and were unable to locate a fall risk assessment; the RN indicated that there were no other locations that it may have been documented.

In an interview with the DOC, they indicated that a fall risk assessment was to be completed upon return from the hospital and with any significant change in health status. Together, Inspector #736 and the DOC reviewed the electronic assessments and the progress notes for resident #006. The DOC indicated that resident #006 did not have a falls risk assessment completed at the time of the incident, when they returned from hospital, and that they should have. The DOC confirmed to the Inspector that the home’s fall policy was not complied with in relation to resident #008 having a fall risk assessment

completed upon return from hospital. [s. 8. (1) (a),s. 8. (1) (b)]

2. A CI report was submitted to the Director on an identified date, for an injury that required a resident to be transferred to hospital that resulted in a significant change in the resident's health status. The CI report identified that resident #007 sustained a fall that resulted in an identified injury.

Please see WN #1, finding 4, for details.

Inspector #691 conducted a review of resident #007's progress notes and identified a progress note that indicated that resident #007 had fallen the day before the CI report was submitted and was transferred to hospital. The resident returned from the hospital the day after the fall occurred.

Inspector #691 conducted a review of resident #007's electronic assessments and could not locate a fall risk assessment that was completed upon resident #007's return from hospital.

In an interview with Inspector #691, RN #116 indicated that resident #007 should have had a falls risk assessment completed after the resident returned from hospital on the identified date. Together, the Inspector and RN#116 reviewed the electronic assessments for resident #007 and were unable to locate a fall risk assessment that was completed after the residents return from hospital. The RN indicated that there should have been a fall risk assessment completed after the resident's return from hospital.

In an interview with Inspector #736, RAI Coordinator #117 indicated that the falls risk assessment was to be completed on admission, upon return from hospital, or any time there was a significant change in health status for a resident.

In an interview with Inspector #691, the DOC indicated that a fall risk assessment would be completed upon any return from the hospital. Together, Inspector #736 and the DOC reviewed the electronic assessments and the progress notes for resident #007. The DOC indicated that resident #007 did not have a falls risk assessment completed, after they returned from hospital, however stated that they felt the policy was unclear for hospital transfers less than 24 hours in duration. [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 that the home's fall prevention and management strategy, specifically completing the falls risk assessment upon a resident's return from hospital, or with a significant change in status is complied with, to be implemented voluntarily.

WN #3: 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 the resident had fallen, the resident had been reassessed and, if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A CI report was submitted to the Director on an identified date, related to resident #006 who sustained an injury of unknown cause. The CI report indicated that the resident was sent to hospital and was diagnosed with an identified injury.

Please see WN #1, finding 2, for details.

Inspector #736 reviewed resident #006’s electronic health records and noted that RPN #103 documented a progress note dated seven days prior to the CI report being submitted, that indicated that they had responded to the resident being found on the floor. The progress note further indicated that the RPN completed an assessment of resident #006. The Inspector was unable to locate a post fall assessment that was

specifically designed for falls for resident #006's fall that occurred on the identified date.

In an interview with Inspector #736, RPN #103 indicated that any time a resident was found on the floor, even if they had been lowered to the ground by a staff member, it was considered to be a fall, and a post fall assessment on PCC was to be completed. RPN #103 further indicated that they were the staff member to respond to resident #006 being found on the floor on the identified date. RPN #103 indicated that they did not complete a post fall assessment of the resident, as they had not considered it a fall at the time. The RPN further stated that they should have completed the post fall assessment for resident #006.

A review of the Falls Policy titled “Falls Prevention & Management”, policy #VII-G-30.10, last revised April 2019, indicated that when a resident had fallen, the nurse would complete a post fall assessment as required. The policy further indicated that the post fall assessment was to include the level of consciousness, evidence of gross injury, vital signs, assessment of damage to joints, signs and symptoms of shock and pain level.

In an interview with Inspector #736, the DOC indicated that a post fall assessment would be completed for each resident, after they had sustained a fall. The post fall assessment was to be completed on PCC under the assessments tab. Together, the Inspector and the DOC reviewed the assessments under the assessment tab for resident #006, and were unable to locate a post fall assessment for the fall that the resident sustained on the identified date. The DOC indicated that there was no other location that the assessment would have been documented. The DOC further indicated, that based on the home's definition of a fall, resident #006 sustained a fall on the identified date, and that staff should have completed a post fall assessment and that they did not complete one. [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 the resident has fallen, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any identified responsive behaviours.

A CI report was submitted to the Director on an identified date, for an allegation of resident to resident abuse. The CI report indicated that resident #002 was walking in an identified area of the home when they exhibited an identified responsive behaviour towards resident #003. The CI report further indicated that resident #002 had a history of exhibiting the identified responsive behaviour towards co-residents.

Please see WN #1, finding 1, for details.

A review of resident #002's electronic progress notes indicated that the resident had on-going identified responsive behaviours towards staff and co-residents following the above mentioned incident. Progress notes identified that resident #002 had an identified intervention in place and that it had been discontinued three months prior as resident

#002 no longer posed a risk to co-residents. The progress notes further identified that resident #002 continued to have on-going identified responsive behaviours towards staff.

A review of documentation on POC identified an identified Support Action for staff to document when resident #002 had the identified responsive behaviours towards staff. Inspector #690 identified documentation by PSW staff that indicated that resident #002 exhibited the identified responsive behaviours several times in the five month period prior to the date of the inspection.

A review of resident #002's electronic care plan on PCC in place at the time of the inspection identified that the resident had identified responsive behaviours. Inspector #690 could not find any information in the care plan to identify that resident #002 had the specified responsive behaviours towards staff that were documented in the support actions.

In an interview with Inspector #690, PSW #125, indicated that resident #002 had ongoing identified responsive behaviours towards staff. PSW #125 indicated that they utilized an identified intervention during care but that resident #002 could be unpredictable at times. PSW #125 indicated that they would obtain information from other staff and refer to the care plan on PCC or the kardex on POC to find out what behaviours a resident had and what interventions were in place to manage the responsive behaviours.

In an interview with Inspector #690, RN #116 indicated that the resident's plan of care was comprised of many documents and included the care plan on PCC and the kardex on POC. RN #116 indicated that a resident's care plan and kardex would indicate if a resident had identified responsive behaviours and that the PSW's would utilize the care plan and kardex to find out what responsive behaviours a resident had and what interventions were in place to manage the responsive behaviours. RN #116 indicated that although resident #002's identified responsive behaviour had improved in the last several months, they continued to have the identified responsive behaviours towards staff. Together, Inspector #690 and RN #116 viewed resident #002's care plan and kardex and RN #116 indicated that the care plan and kardex did not identify that resident #002 had the identified responsive behaviours, and that it should have.

In an Interview with Inspector #690, the DOC indicated that the resident's plan of care was comprised of many documents and included the care plan on PCC and the kardex on POC. The DOC indicated that PSW staff would utilize the care plan and kardex as part of the plan of care to find out what responsive behaviours a resident had and what

interventions were in place to manage the responsive behaviours. The DOC further indicated that resident #002 continued to have the identified responsive behaviours towards staff. Together, Inspector#690 and the DOC reviewed resident #002's current care plan and kardex and the DOC indicated that the care plan and kardex did not identify that resident #002 had the identified responsive behaviours and that it should have. [s. 26. (3) 5.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that any report to the Director included the names of any staff members or other persons who were present at, or discovered the incident.

a) A CI report was submitted to the Director on an identified date, for an injury to a resident, for which the resident was taken to hospital and resulted in a significant change in health status for the resident. The CI report indicated that resident #008 sustained an identified injury as a PSW was assisting the resident with an ADL. The CI report did not include the name of the staff member who was present or discovered the incident.

Please see WN #1, finding 3, for details.

Inspector #736 reviewed the home's internal investigation notes related to the incident, which indicated that the involved staff member was PSW #106.

b) A CI report was submitted to the Director on an identified date, for an allegation of abuse of a resident by the licensee or staff that resulted in harm or risk of harm to the resident. The CI report indicated that resident #005 was noted by a PSW to have an identified injury. The CI report did not include the name of the staff member who discovered the incident.

Inspector #736 reviewed the home's internal investigate notes related to the incident, which indicated that PSW #113 had discovered the identified injury and reported it to RPN #112.

In an interview with Inspector #736, the DOC indicated that a CI report was to include the names of any staff members that were present at or that discovered the incident. Together, the Inspector and the DOC reviewed the CI reports submitted for resident #008 and #005, and the DOC indicated that the CI report did not include the name of the staff members that discovered the incidents. The DOC indicated to the Inspector that they felt it was not necessary to list the staff member who discovered the injury in the CI report. [s. 107. (4) 2. iii.]

2. The licensee has failed to ensure that any report submitted to the Director included the outcome or current status of the individual or individuals that were involved in the incident.

a) A CI report was submitted to the Director on an identified date, as a result of resident #006 having sustained an injury with significant change in health status and was transferred to hospital. The CI report indicated that the resident had sustained an identified injury, and that the cause of the injury was unknown.

Please see WN #1, finding 2, for details.

On an identified date, four days after the home submitted the CI report, the Director requested an amendment to the CI report to include the resident's date of return from hospital, the status of the resident upon return from the hospital, the resident's transfer

and ambulation status prior to the incident, as well as the cause of injury if it was determined.

Inspector #736 reviewed an amended CI report dated four days after the report was first submitted, that indicated that the resident was still in the hospital and had had an identified procedure. The CI report indicated that there was no current plan for discharge on the day the report was amended. The Inspector was unable to locate any further amended CI reports related to resident #006 that indicated when the resident had returned from the hospital, or their status upon return from hospital.

Inspector #736 reviewed resident #006's health records and identified that the resident had returned from hospital seven days after the CI report was first submitted. The records indicated that the resident had received an identified treatment and had an identified device in place.

A review of the home's policy titled "MOHLTC- Critical Incident Reporting", policy #XXIII-C-10.90, last revised August 2018, indicated that the DOC was responsible to ensure that all required documentation was completed within the expected timelines in the Critical Incident System (CIS) portal as per the Ministry of Health and Long Term Care (MOHLTC) standards.

In an interview with Inspector #736, the DOC indicated that they were responsible to submit and update CI reports for the home. Together, the Inspector and the DOC reviewed the information requested by the Director and the amended report. The DOC indicated that the information related to the date of the resident's return from hospital and status upon return from hospital were not included in the CI report and that they should have been. The DOC further indicated that the home's internal investigation of the incident identified that the resident's private care worker had lied to the RPN on shift that day, and the RPN had not considered the resident to have had a fall. Together, the Inspector and the DOC reviewed the CI report, and were unable to locate any description of the events leading up to the incident. The DOC stated that the home had completed an internal investigation, but did not feel it necessary to update the CI report.

b) A CI report was submitted to the Director on an identified date as a result of resident #008 having sustained an injury with significant change in health status and was transferred to hospital. The CI report indicated that the resident had a fall and sustained an identified injury.

Please see WN #1, finding 3, for details.

On an identified date, two days after the CI report was first submitted, the Director requested an amendment to the CI report to include the date and time of resident's date of return from hospital, health status of resident upon return.

The Inspector reviewed the CI reports submitted to the Director from the licensee and located an amended CI report dated the same day the amendment requested, that indicated that the resident was still currently in hospital and awaiting an identified treatment. The CI report indicated that there was no current plan for discharge. The Inspector was unable to locate any amended CI reports related to resident #008 that indicated when the resident had returned from the hospital, or their status upon return from hospital.

Inspector #691 reviewed resident #008's health records and noted that the resident had returned from hospital five days after the date that the home amended the CI report, and had received an identified treatment and was to have an identified intervention in place upon return from hospital.

In an interview with Inspector #691, the DOC indicated that they were responsible to submit and update CI reports within the home. Together, the Inspector and the DOC reviewed the information requested by the Director and the amendments to the report. The DOC confirmed that the information related to the date of the resident's return from hospital and status upon return from hospital were not included in the CI report and should have been. [s. 107. (4) 3. v.]

Issued on this 13th day of June, 2019

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

Original report signed by the inspector.