Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 31, 2018 | 2017_597655_0020 | 017301-17, 023091-17, 026683-17 | Critical Incident System |

### Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

GARRY J. ARMSTRONG HOME
200 ISLAND LODGE ROAD OTTAWA ON K1N 5M2

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

MICHELLE EDWARDS (655)

### 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): December 6, 7, 8, 11, 12, 13, 14, 15, and, 18, 2017.**

**The following logs were inspected concurrently: 017301-17, 023091-17, 026683-17, each related to falls.**

**During the course of the inspection, the inspector(s) spoke with Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Physiotherapy Assistant (PTA), a Physiotherapist, the Program Manager of Recreation and Leisure, the Program Manager of Resident Care, and the Program Manager of Personal Care.**

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

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 :**

The licensee failed to ensure that the policies – "Falls Prevention Program: Resident Assessment for Falls Tool (RAFT)", and "Assessment: Head Injury" –were followed. Inspector #655 reviewed the above-noted policies.

As per the policy titled "Falls Prevention Program: Resident Assessment for Falls Tool (RAFT)", registered nursing staff are to host a post-fall meeting (huddle) and complete the "Huddle Form" (also referred to as Appendix D, or the "post-fall screen") on the shift when the fall occurred. In the event of an unwitnessed fall, neuro vitals are to be taken. As per the policy titled "Assessment: Head Injury", a head injury assessment and neuro-checks shall be completed on residents with actual or suspected head injury for a period of 72 hours. The assessment includes: vital signs (blood pressure, pulse, respiratory rate), an assessment of the resident's level of consciousness, assessment of grips, size and reactions of pupils to light, best motor response, and the best verbal response. The assessment is to be documented on the "Neurological Flow Sheet" hourly for four hours, then, if stable, every four hours for 24 hours; and then, if stable, every shift for two days.

i. A Critical Incident Report (CIR) was submitted to the Director under the Long-term Care Homes Act (LTCHA), 2007, related to the unexpected death of resident #002 on a specified date.

According to the CIR, resident #002 also had a fall on the same day. In the CIR, it indicates that the following staff members were present and/or discovered the incident: RPN #133 and RN#132. A specific cause of death was identified on the CIR.

During an interview, PSW #130 indicated to Inspector #655 that on the day of the incident, the PSW went to go find resident #002 when the resident was found not to have come to the dining room for lunch on a specified date. PSW #130 indicated to Inspector #655 that at that time, resident #002 was found on the floor. The fall was unwitnessed. PSW #130 indicated to Inspector #655 that RN #132 was notified, and then attended to the resident.

During an interview, RPN #113 indicated to Inspector #655 that on the day of the above-noted incident, resident #002 had an unwitnessed fall. According to RPN #113, resident #002's cognitive status tended to fluctuate. According to RPN #113, however, whenever a fall is unwitnessed, a head injury routine is expected to be initiated, regardless of the resident's cognitive status.

Inspector #655 reviewed the health care record belonging to resident #002. Inspector #655 found a Neurological Flow Sheet for resident #002, dated the same date of the above-described incident. There were two entries on that day. Both entries were made within a period of 15 minutes. There were no other entries on the Neurological Flow sheet.

Inspector #655 reviewed the progress notes for resident #002. In a progress note entered by RN #132 one day after the incident (a late entry), resident #002's vital signs, including blood pressure, pulse, temperature, oxygen saturation, and respiration rate, were recorded. There was no record of a neurological assessment in the progress note. That is, there was no assessment data related to the Glasgow Coma Scale, pupils, or motor responses of the arms or legs.

During an interview, RN #132 recalled that resident #002 had fallen on a specified date; and that it was an unwitnessed fall. RN #132 indicated to Inspector #655 that after the initial assessment of the resident, the physician was called. According to RN #132, the physician advised at that time that the HIR for resident #002 be initiated. RN #132 indicated to Inspector #655 that for the first two hours, he/she had assessed resident #002, as per the HIR. At the same time, RN #132 indicated to Inspector #655 that the assessment results for the last hour had not been documented that day.

During an interview, the Program Manager of Resident Care, indicated to Inspector #655, that an investigation was conducted into the incident involving resident #002, including the resident's fall and unexpected death. According to the Program Manager of Resident Care, as a result of the investigation, it was determined that RN #132 had conducted additional sets of vitals (blood pressure, pulse, temperature, oximeter, respiration rate) – not captured on the Neurological Flow Sheet; however, the HIR was not completed correctly or in accordance with the licensee's policy, as there was no indication that the resident's motor response or pupils were assessed, as per the HIR.

ii. A Critical Incident Report (CIR) was submitted to the Director under the Long-term Care Homes Act (LTCHA), 2007, related to a fall. The incident described in the CIR involved resident #003.

According to the CIR, resident #003 was found lying on the floor on a specified date after having fallen. At that time, resident #003, refused to move a specific extremity. According to the CIR, on a specified date, resident #003 was experiencing increased pain. Resident

#003 was then transferred to the hospital and was diagnosed with a specific injury. In the CIR, it indicates that RPN #134 was present at the time of the incident; and that RN #111, and RN #135 also responded to the incident.

According to a progress note dated the same date of the above-described incident, it is indicated that resident #003 was observed to be walking in a specified location of the home by RPN #134. In the same note, it is indicated that RPN #134 "heard" resident #003 fall. In the same progress note, resident #003 was described as being confused. There was no indication in this progress note that a head injury routine had been initiated at the time of resident #003's fall.

Over the course of the inspection, Inspector #655 spoke to RN #123. According to RN #123, there was no HIR initiated for resident #003 when resident #003 fell on a specified date because it was a witnessed fall. RN #123 was also unable to locate a post-fall screen. According to RN #123, the post-fall screen was not indicated at the time of the fall for resident #003 because the resident, at that time, had no known history of falls.

During an interview on December 12, 2017, RPN #134 – the nurse identified in the CIR and in the progress notes as being present at the time of the fall - indicated to Inspector #655 that he/she heard the resident fall that day, but had not witnessed it. RPN #134 indicated to Inspector #655 that at that time, a critical incident report was completed; and that another nurse (RPN #127) was expected to complete the required post-fall assessments, including the post-fall "huddle" (Appendix D, or the "post-fall screen") and the HIR.

According to a progress note dated the same day of the incident, a head injury routine (HIR) was initiated and done twice on the same day – four, and then five hours, post-fall. The progress note contained no additional information related to the assessment of the resident at those times. Inspector #655 was unable to locate any other documentation to demonstrate that resident #003 had been assessed in accordance with the HIR.

During an interview, RPN #127 – the nurse who was working on the resident's home area at the time of the incident - indicated to Inspector #655 that he/she was not sure if a HIR was initiated for resident #003 when the resident fell on the specified date.

Progress notes on the following day, and the day after, indicated that resident #003 remained on the HIR. However, with the exception of one progress note, there was no documentation to indicate that the resident was assessed in accordance with the HIR.

On review of resident #003's health care record, Inspector #655 was unable to locate a Neurological Flow sheet (Form 315.11) for resident #003. Inspector #655 was also unable to locate a post-fall screening tool.

During an interview, RPN #106 confirmed that there was no other electronic documentation to demonstrate that either resident had been assessed in accordance with the HIR.

During an interview, the Program Manager of Personal Care, indicated to Inspector #655 that when a fall is not witnessed, the HIR is to be initiated; and, that when the HIR is initiated, the assessment is to be documented on the Neurological Flow Sheet. At the same time, the Program Manager of Personal Care, clarified that the post-fall "huddle" consists of the form titled "Appendix D: Post Fall Screen for Resident/Environmental Factors". According to the Program Manager of Personal Care, this form is expected to be completed after every fall, for every resident.

The licensee failed to ensure that the Post Fall Screen was completed for resident #003; and that the Head Injury Routine was completed for both resident #002 and #003, as per the licensee's policies: "Falls Prevention Program: Resident Assessment for Falls Tool (RAFT)", and "Assessment: Head Injury".

***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 policies, "Falls Prevention Program: Resident Assessment for Falls Tool (RAFT)", and "Assessment: Head Injury", are followed, to be implemented voluntarily.***

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**WN #2: 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. (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 :**

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

A critical incident report was submitted to the Director under the Long Term Care Homes Act (LTCHA), 2007, on a specified date, related to a fall. The incident involved resident #001. According to the CIR, resident #001 fell twice, on two consecutive days. Resident #001 is described in the CIR as experiencing a change in condition a number of days after the falls had occurred. According to the CIR, resident #001 also had a prior history of falls, with six falls occurring within a five week period.

Inspector #655 reviewed the health care record belonging to resident #001. On review of the health care record, Inspector #655 located a pink version of an internal referral sheet, dated approximately four weeks prior to the most recent fall, described in the CIR that was submitted to the Director under the LTCHA, 2007. On the referral sheet, it was indicated that resident #001 had had multiple falls, and was to be assessed to determine the appropriateness of a specified intervention.

During an interview, PSW #100 indicated to Inspector #655 that resident #001 was unsteady at times; and had a history of falls.

During an interview, Inspector #655 reviewed the health care record of resident #001 with RN #110, including the above-noted internal referral form. RN #110 was unable to speak to whether there had been any follow-up in response to the referral. At the same time, RN #110 reviewed the progress notes for the date that the referral form was completed; and for a period of one month afterwards. RN #110 was unable to locate any documentation related to the internal referral form or an assessment of resident #001 by a member of the health care team for the appropriateness of a specified intervention.

During an interview, Staff member #108 was unable to confirm whether resident #001 had been assessed in response to the above-noted referral.

During an interview on the same day, PT #109 could not recall the referral of resident #001 outlining a request to assess. PT #109 indicated to Inspector #655 that he/she "always documents" on the referral form itself; and that if there was no documentation on the referral form, then there had been no follow-up. At the same time, PT #109 recalled receiving a referral for resident #001 approximately one month later, at which time resident #001 was then assessed, and a specified intervention was implemented. According to PT #109, resident #001 was, at the time of the inspection, now at a lower risk for falls.

During an interview, the Program Manager of Resident Care, reviewed the internal referral process with Inspector #655. According to the Program Manager of Resident Care, when only the pink copy of the internal referral form is found in the resident's health care record, it is indicative of action taken by the nurse - specifically, that the nurse has taken the white copy of the same internal referral form and placed it in the appropriate mailbox. The Program Manager of Resident Care, confirmed that what Inspector #655 had found in resident #001's health care record was a referral.

The licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

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**Issued on this 31st day of January, 2018**

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

**Original report signed by the inspector.**