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 sions de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 26, 2016	2016_189120_0021	009040-16	Critical Incident System

Licensee/Titulaire de permis

WATERDOWN LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

ALEXANDER PLACE
329 Parkside Drive P. O. Box 50 Waterdown ON L0R 2H0

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 6, 2016

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Co-Director of Care, Physiotherapist and registered nurse.

During the course of the inspection, the inspector observed the resident's bed system, reviewed the resident's clinical record, the Personal Support Worker's task flow sheets and the licensee's falls prevention policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The plan of care for an identified resident was not based on, at a minimum, an interdisciplinary assessment of special treatments and interventions or safety risks associated with the resident's therapeutic air surface.

Staff determined that resident #101 required a therapeutic air surface as an intervention to manage their pressure ulcers. A therapeutic air surface was installed on the resident's bed frame on a specified date in 2016. The plan of care was revised on the same date. Two days later, the resident fell off the surface and onto the floor sustaining an injury that was confirmed by x-ray completed at the home. The injury was treated and as a result of the fall, the resident experienced pain and decreased independent mobility.

Based on written documentation reviewed at the home dated post fall in 2016, the registered staff attributed the resident's fall to several factors. Notes included statements such as "has sores so possibly trying to move", "the bed was slippery as it is an air mattress" and "the resident was not known to be restless in bed but this is a new behaviour recently displayed". According to the Director of Care and Administrator, a clinical safety assessment of the resident on the therapeutic surface was not completed prior to its implementation to determine if the resident required additional interventions to minimize any potential risks, especially falling risks. On the days leading up to the implementation of the surface, the registered staff described the resident as being immobile in bed and required assistance to reposition and they therefore did not believe any risks were likely. According to records reviewed, the resident was a high risk for falls, could independently move their arms and legs with some limitations and could bear some weight when transferred with a sit-to-stand lift. Post fall, the interventions that were implemented included falls arrest mattresses on the floor on either side of the bed, the bed in the lowest position and a bed alarm.

Discussion was held with the Director of Care and Administrator that in general, some therapeutic surface styles were well known for being unstable due to air flow movement and the soft nature of the mattress while inflated. The resident in this case had an air mattress with a cover that was made of a quilted nylon with a polyurethane coating finish was known to be slightly slippery. The licensee had not considered the various risk factors associated with the intervention of the therapeutic surface and the types of movements that the resident was reported to have exhibited. The plan of care was therefore not based on an interdisciplinary assessment of interventions and any safety risks and as a result, the resident suffered actual harm. [s. 26. (3) 18.]

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 plan of care is based on an interdisciplinary assessment of special treatments and interventions such as therapeutic air surfaces and safety risks with respect to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. Resident #101 was reported to have fallen out of a non-tilt wheelchair on a specified date in 2016 and from a different wheelchair (tilt-wheelchair) two days later. Progress notes made by registered staff on the date of the first fall described that the resident slid from their wheelchair unwitnessed but was suspected of sliding out of their non-tilt wheelchair due to discomfort of their pressure sores and was suspected of trying to reposition themselves. Progress notes made by registered staff on the same date of the second fall indicated that the resident was uncomfortable in the chair due to pressure sores and the resident sustained minor facial injuries when they fell from their chair.

The resident's plan of care was updated on 7 days prior to the first fall and included directions to staff providing care that the resident be repositioned while in wheelchair every two hours to promote wound healing. Progress notes made by registered staff prior to and post fall and confirmation by registered staff #100 confirmed that the resident was not able to reposition themselves and needed the assistance of staff to reposition while sitting in the wheelchair.

According to records completed by various personal support workers for care provided to the resident between the week prior to and up to the date of the second fall, the resident was not repositioned every 2 hours. Records of care dated 4 days prior to the first fall indicated that staff did not reposition the resident from 14:19 to 21:16, 3 days prior from 13:15 to 18:28, on the date of the first fall from 14:49 to 21:47, the day after the first fall from 05:33 to 22:31 and on the date of the second fall from 05:29 to 16:21. Between these dates, the documentation revealed repositioning occurred on average every 3 hours. Due to the resident's condition related to their pressure sores, not being repositioned every two hours would have contributed to the resident's discomfort and subsequent fall from their wheelchair. [s. 50. (2) (d)]

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Issued on this 29th day of April, 2016

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

Original report signed by the inspector.