Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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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
May 6, 2019	2019_792659_0008	031714-18, 005352-19	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Cambridge Country Manor
3680 Speedsville Road, R.R. #1 CAMBRIDGE ON N3H 4R6

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

JANETM EVANS (659), NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 12, 13, 14, 15, 19 and 20, 2019.

**Intake # 005352-19\Critical Incident #2651-000003-19 related to a fall with injury.
Intake #031714-18\Critical Incident #2651-000013-18 related to a fall with injury.**

This inspection was completed concurrently with Follow up inspection #2019_792659_0007.

A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 6 (10) (b), identified in a concurrent inspection #2019_792659_0007 (Log #006679-19, CIS #261-000006-19) was issued in that report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered nurses (RN), Registered Practical Nurses (RPN), Behavioural Support lead/RAI Coordinator (BSO/RC), Food and Nutrition Service Manager, Dietary Aides (DA), Personal Support Workers(PSW), Ward clerk , Physiotherapy Aid (PA) and residents.

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

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. (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 failed to ensure that care set out in the plan of care was provided to resident #003 as specified in the plan.

A Critical Incident (CI) was submitted to the Ministry of Health and Long Term Care (MOHLTC) in relation to an identified resident's fall resulting in an injury.

The identified resident's fall history showed there were five falls in the last six months.

A review of the plan of care identified the resident as at risk for falls characterized by history of falls, injury, multiple risk factors related to cognitive impairment, impaired balance, and unsteady gait. Review of plan of care showed that under the interventions for fall prevention it stated that the resident was to use a protective device to minimize injury.

Resident observation showed that the resident was not using the protective device on two occasions. Staff acknowledged that the resident was not using the device.

Staff acknowledged that the device was part of the falls prevention strategy for the identified resident and that the care was not provided as specified in the plan.

The care set out in the plan of care was not provided to the identified resident as specified in the plan. [s. 6. (7)]

2. A CI reported to the MOHLTC stated that an identified resident sustained a fall with

injury for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

The clinical record showed the identified resident was at risk for falls. The resident had a history of falls since admission. The resident had been known to be unsafe with transfers. Interventions for fall prevention were documented to the safety plan and plan of care.

There were a number of falls recorded for a one month period, several of which were un-witnessed.

Review of the Safety plan/post fall investigations for these falls documented a safety device had been in place but had not alerted staff; in addition several other strategies identified in the plan of care to mitigate the risk of falls and injury were not in place.

Observations completed showed strategies identified in the plan of care for falls prevention were not implemented.

Three staff acknowledged that interventions for fall prevention documented to the safety plan and plan of care had not been in place at the time of the observations.

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. [s. 6. (7)]

3. A Critical Incident (CI) was submitted to the MOHLTC in relation to an identified resident's fall resulting in an injury.

A review of the physiotherapy assessment stated that a mechanical lift was to be used for transfers and a wheelchair for mobility.

The plan of care identified the resident as at risk for falls characterized by history of falls, injury, multiple risk factors related to cognitive impairment, impaired balance, and unsteady gait. Interventions for fall prevention documented the resident was ambulatory and should use non slip footwear.

Resident observation showed that the resident was in a wheelchair and did not ambulate.

resident's care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

4. On a specified date, it was reported to a PSW, by a resident, that they had witnessed an identified resident exhibit responsive behaviours toward a co-resident.

Review of the hard copy of the identified resident's chart and the online assessments showed a behavioural assessment had not been completed for the resident on or about the time of the alleged incident.

Review of the Resident Assessment Instrument Minimum Data Set 2.0, indicated that the identified resident exhibited responsive behaviours daily and the behaviours were not easily altered.

Review of the care plan for the identified resident, showed the resident had a history of responsive behaviours towards staff The care plan had not been updated to include responsive behaviours directed to residents.

Five staff acknowledged the identified resident exhibited responsive behaviour towards staff but stated they had not witnessed the resident exhibit responsive behaviours towards other residents. One staff stated that the identified resident had not been identified as at risk for responsive behaviours prior to this incident.

The licensee had failed to ensure that the identified resident was reassessed and the plan of care related to responsive behaviours was reviewed and revised when the identified resident's care needs changed or care set out in the plan was no longer necessary. [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 to ensure that care set out in the plan of care for resident #001 and #003 and all other residents, is provided as specified in the plan. The license will also ensure the plan of care for each resident is reviewed and revised, when the resident's care needs change or the 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 the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategies, the strategies were 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 provided for strategies which included the monitoring of residents.

Specifically, staff did not comply with the licensee's Head Injury Routine (HIR) reviewed May 2018, which stated when a resident sustained any trauma to the head or had an unwitnessed fall, staff were to follow the HIR as per the policy, using the Glasgow Coma Scale as a documentation tool and vital signs, assess the resident for 72 hours, with the

following frequency unless otherwise stated by the Attending Physician:
Every half hour for the first 2 hours following the injury
Every hour for the next 4 hours
Every 4 hours for the next 8 hours
Every shift for the remainder of the 72 hour monitoring.

1. A CI was reported to the MOHLTC which stated that an identified resident sustained a fall with injury.

In a specified one month period, the identified resident had a number of falls, several of which were unwitnessed.

Review of the HIR completed for the unwitnessed falls, showed for several of the falls there were instances where the resident was not roused to complete the HIR and it was documented the resident was sleeping. In addition to this, the scheduled timelines for the checks were not followed as per the policy.

2. The clinical record for an identified resident showed they were at risk for falls. The resident had sustained two falls in a specified time frame.

Review of the HIR completed for the two falls showed one completed HIR and one HIR was in progress. The HIR records showed instances where the resident was not roused to complete the HIR and it was documented the resident was sleeping. In addition to this, the scheduled timelines for the checks were not followed to as per the policy.

The clinical record did not show documented evidence from the Attending Physician related to alteration of either residents' HIR from the home's documented policy and procedure.

Staff stated that sometimes their peers would not rouse a resident to complete a HIR. They stated they should be completing the HIR in full. [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 strategy for Head Injury Routine (HIR) is complied with, to be implemented voluntarily.

Issued on this 9th day of May, 2019

[redacted]

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

Original report signed by the inspector.