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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 29, 2016	2016_330573_0017	020483-16, 020861-16 / 020863-16	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

CARLETON LODGE
55 LODGE ROAD R. R. #2 NEPEAN ON K2C 3H1

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

ANANDRAJ NATARAJAN (573)

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 25, 26, 27 and 28, 2016.

The following critical incident logs were inspected: Log# 020861-16 and Log# 020863-16 related to a resident to resident alleged abuse; Log# 020483-16 related to an incident that causes an injury to a resident for which resident was transferred to hospital.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Manager of Resident Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers and Residents.

The inspector reviewed Critical Incident (CI) reports, reviewed residents health record (including care plans, progress notes, medication administration records, PSW flow sheets and Geriatric Psychiatry Outreach reports), home's internal investigation report and the home's written program for Fall Prevention and Management. In addition, the inspector also observed resident care and resident rooms.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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. 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 failed to ensure that the home's policy "Falls Prevention and Management" was complied with.

According to O.Reg 79/10, s. 48 (1) 2, every licensee of a long-term care home shall ensure that the following interdisciplinary programs is developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury, and s. 48 (2) whereby each program must, in addition to meeting the requirements set out in section 30, (a) provide for screening protocols; and (b) provide for assessment and reassessment instruments.

A review of the home's Falls Prevention Program, March 2016, including the Falls Prevention Program: Resident Assessment for Falls Tool (RAFT), AP & OP No: 315.08, September 2013, items 2 and 3, under section Operational Procedure, indicate that the registered staff will:

Item 2: In the event of an unwitnessed fall, head injury will be assessed and neuro vital signs will be taken (AP&OP 315.11). A review of Home's assessment for Head Injury AP&OP 315.11 indicates Head injury assessment and neuro-checks shall be completed on residents with actual or suspected head injury for a period of 72-hours from the time of injury using the appended neurological assessment tool. Further it indicated that residents who have a previous subdural haematoma will continue with full neuro checks including level of consciousness for 72 Hours.

Item 3: Complete the RAFT when the condition or circumstances of the resident require: upon admission, where there is an injury from falling requiring hospitalization and if the resident has more than two (2) falls in a one (1) week (7 days) period. A review of Home's RAFT identifies the residents fall risk level as Moderate, High and Very High based on the total scores.

During this Inspection, Inspector #573 spoke with Manager of Resident Care, who indicated that if a resident had more than two (2) falls in a one (1) week period registered nursing staff were expected to complete an RAFT tool to identify the resident's fall risk level, which helps in the implementation of fall prevention interventions. Further she indicated that in the event of an unwitnessed fall, head injury will be assessed and neuro vital signs for the resident will be taken as per the home's policy.

Critical Incident Report (CIR) on a specified date indicated that an incident that caused an injury to resident # 001 for which the resident was taken to hospital and that resulted in a significant change in the resident's health status.

Resident #001 was admitted in the home with multiple diagnoses including history of falls. On July 26, 2016, Inspector #573 reviewed resident #001's health care record (progress notes/ Resident Assessment for Falls Tool (RAFT)) for three specific months and observed that since the time of admission resident #001 has sustained 15 falls. The RAFT which was completed at the time of admission indicates resident #001 is at Moderate risk for falls, further the RAFT completed on a specified date after the resident first fall incident indicates that resident #001 is at High risk for falls.

A review of the resident #001's health record, four (4) falls were noted within a three (3) day period, the Resident Assessment for Falls Tool (RAFT) to reassess resident fall risk level was not found in resident health record as per the home's policy.

Resident #001's Neurosurgery consultation on a specified date, indicated that resident #001 had a specific diagnosis related to head injury. Recommendations and follow up were discussed with resident #001's family members. A review of resident #001's progress notes indicates that the resident had unwitnessed fall on two specific days. Further, the progress on a specified date and hours indicates PSW observed resident was vomiting in the bed. An assessment for Head Injury using the neurological assessment tool was not found for the above two (2) unwitnessed falls in the resident health record.

On July 26, 2016, Inspector spoke with RN #100, who indicated that for resident #001 with history of head injury, in the event of any unwitnessed fall, head injury assessment should be completed for resident #001 with the neuro vital signs.

On July 26, 2016, Inspector #573 reviewed resident #001's health care record in the presence of Manager of Resident Care. Upon review, the assessment for the head Injury using the neurological assessment tool for resident #001's fall on two (2) specified dates was not found in resident record health record. Further the Manager of Resident Care was unable to find the documented Resident Assessment for Falls Tool (RAFT) showing reassessment of fall risks for resident #001, as per the policy.(Log# 020483-16) [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 policy for "Falls Prevention and Management" is complied with specifically: (a) the screening protocols (Resident Assessment for Falls Tool) (b) the assessment for Head Injury (AP&OP 315.11), to be implemented voluntarily.

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. (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).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (1) (a), whereby the licensee failed to ensure that the written plan of care for each resident sets out the planned care for the resident.

Resident #001 Critical Incident Report (CIR) indicated that an incident that caused injury to resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health status. Further the CIR indicated that resident #001 deceased on a specified date, at the hospital.

Resident #001 was admitted in the home with multiple diagnoses including history of falls. On July 26, 2016, Inspector #573 reviewed resident #001's health care record (Progress notes/ Post Fall Huddle form/ Resident Assessment for Falls Tool (RAFT)) for three (3) specific months and observed that since the time of admission resident #001 has sustained 15 falls.

Inspector #573 reviewed resident's post fall screen (Huddle form) which indicates registered staff to document the actions in the care plan that were taken to prevent falls, to determine if they have been effective in preventing further falls.

On July 26, 2016, Inspector #573 reviewed resident #001's written plan of care for fall prevention at the time of fall incident on a specified date. Upon review, Inspector #573 observed that resident #001's written plan of care does not have any specific individualized interventions for the staff regarding how to manage resident's falls, including the need for heightened monitoring for falls.

On July 26, 2016, Inspector #573 spoke with Manager of Resident Care, who indicated that fall prevention interventions such as low bed, floor mats and frequent resident monitoring for falls were in place for resident #001. Further after review of resident #001's written plan of care, revised on a specified date, the Manager of Resident Care agreed with the inspector that resident #014's written plan of care does not include any of those above specified interventions for staff regarding the management of resident #001's falls.

The written plan of care does not set out the planned care for the resident #001, specifically related to the resident's fall prevention interventions.(Log# 020483-16) [s. 6. (1) (a)]

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

---

Issued on this 29th day of July, 2016

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

Original report signed by the inspector.