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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 13, 2018	2018_570528_0004	006534-18, 028371-18	Resident Quality Inspection

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

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

CYNTHIA DITOMASSO (528), LESLEY EDWARDS (506), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 23, 24, 25, 26, 29, 30, 31 and November 1, 2, 7, 2018

The following inspections were completed concurrently with this Resident Quality Inspection, and findings of non-compliance are included in this report.
i. Critical Incident System (CIS) log #010766-18 for CIS #1056-0000010-18 and CIS log #011574-18 for CIS # 1056-000012-18, related to fall with injury
ii. Critical Incident System (CIS) log #010282-18 for CIS #0156-000009-18 and CIS log #011043-18 for CIS #1056-000011-18, related to resident to resident altercation with injury and,
iii. Follow up inspection log #006534-18, related to 24 hour registered nursing staff

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Assistant Director of Care (ADOC), Staff Educator, Programs Manager/Volunteer Services Coordinator, the Physiotherpist (PT), Behavioural Support Ontario (BSO) staff, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), health care aids (HCA), residents and families.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed documents including but not limited to: staffing schedules, medical records, complaints and concerns logs, meeting minutes, and policies and procedures.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.
0 AMP(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2018_558123_0005	168

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order AMP – Administrative Monetary Penalty	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

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 the care set out in the plan of care was provided to the resident as specified in the plan.

A. Resident #024 sustained a fall.
As a result of this fall a referral was made to the physiotherapist (PT), for a consultation for a post fall assessment.
A review of the clinical record did not include any documentation from the PT following the fall related to a post fall assessment.
Interview with the PT, following a review of the clinical record, identified that they "missed" the referral and that they were not able to locate documentation of an assessment of the resident post fall for the referral request.
The PT identified that they did not recall previous awareness of this request and that an assessment was not completed.

Care was not provided to the resident as specified in the plan of care. (168)

B. During the Resident Quality Inspection stage one interview with resident #020, identified that they felt rushed with care. Review of the plan of care revealed that the resident required a specified level of assistance for activities of daily living. In a follow up interview with the resident, during the course of the inspection, they reported feeling rushed with care and detailed that they were provided an alternative level of assistance

with activities of daily living. Interview with PSW #101 confirmed that they provided an alternative level of assistance for the resident that day. Interview with PSW #107 confirmed that resident #020 was provided assistance with care. Resident #020 was not provided with the care as specified in their plan during the course of the inspection. (528)

C. Review of CIS #1056-000012-18 revealed that in May 2018, resident #014 required hospital admission after sustaining a fall and injury.

Review of medical records revealed resident #014 was readmitted to the home. A progress note on the date of readmission identified that the resident required, but was not limited to, safety devices. Review of the plan of care revealed that the following day the resident sustained a fall with no injuries. The Risk Management Report for the fall identified that the resident fell and the safety device was applied but not in working order. Interview with the DOC confirmed that the device would have to be in working order when applied. The plan of care was not provided to the resident as specified in the plan of care, related to a falls prevention intervention. [s. 6. (7)]

2. The licensee has failed to ensure that the resident 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.

A. Review of CIS #1056-000012-18 revealed that resident #014 had a fall with injury.

i. Review of the plan of care identified that the resident returned back to the home and required safety devices.
a. Review of the written plan of care did not include the safety devices after the resident had sustained a specified number of falls. Interview with the DOC confirmed that the plan of care was not updated to include the devices until after the resident had fallen a specified number of times. Interview with the ADOC confirmed that the expectation would be that staff should have updated the written plan of care on readmission.
ii. In addition, after the specified number of falls, the DOC confirmed that they updated the plan of care to clarify that the resident did not have one of the specific interventions listed on the written plan of care.

The plan of care was not updated to include resident's #014 falls prevention interventions on readmission until after the resident had three falls. (528)

B. Review of CIS #1056-000009-18, revealed that resident #014 had had an altercation with a co-resident.

i. Review of the medical record identified that resident #014 with multiple co-morbidities however, no history of physical responsive behaviours
ii. Review of progress notes revealed that the resident had altercations with co-residents causing injury on several occasions over a four week period. Review of the written plan of care included a goal that the resident exhibited the behaviours but it had not been updated to include what type of behaviours after the incidents had occurred.
iii. Interview with the Responsible Behaviour Program Lead staff #111 confirmed that the plan of care had not been updated to include that resident #014 had specified behaviours until seven weeks after the change in behaviours were initially identified. (528) [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 following:
i. that the care set out in the plan of care is provided to the resident as specified in the plan,
ii. 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #014 had a physician's order for routine administration of an identified medication. During the course of the inspection, RPN #123 gave resident #014 an additional dose of the identified medication. An interview with RPN #123, confirmed that they gave the resident an extra dose of the medication. An interview with the ED and DOC confirmed that the medication was not administered to the resident in accordance with the directions for use as specified by the prescriber. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A. During the course of the inspection, resident #023 was observed by the LTC Homes Inspector to have treatment applied. A review of the resident’s clinical record did not include an assessment of the area being treated, or was the area identified on the resident's treatment assessment record. Interview with RPN #113 confirmed that the resident had an area requiring treatment but there was no documentation of this area in the resident’s clinical record. An interview with the ADOC confirmed that the resident had a procedure which should have been assessed when the resident returned from their appointment using a clinically appropriate assessment. (506) On an identified day in October 2018, the ADOC verified that the expectation was that all areas of skin integrity would be recorded in the resident’s clinical record in Point Click Care (PCC), under progress notes when the area of altered skin integrity was discovered.

B. During the course of the inspection, resident #016 was observed by the LTC Homes Inspector to have an area of altered skin integrity. A review of the resident’s clinical record did not include an assessment of this area, or was it identified on the resident's treatment assessment record. Interview with RPN #113 confirmed that the resident did have an area of altered skin integrity of an unknown origin and that there was no documentation of this area in the resident’s clinical record. Interview with the ADOC confirmed that it would be the expectation that the resident’s area of altered skin integrity be assessed when identified using a clinically appropriate assessment. (506)

C. During the course of the inspection, resident #021 was observed to have an area of altered skin integrity.
Interview with the resident verified the presence of the area and that to their recall it had been present for a few months. Interview with RN #105 verified the presence of the area and that the area was checked daily when they were working. However, a review of the electronic clinical record and paper chart did not include an assessment of the area by a member of the registered nursing staff.
Interview with the ADOC, following a review of the clinical record, verified that the resident who exhibited altered skin integrity did not have an skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment

instrument that was specifically designed for skin and wound assessment. (168) [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident, who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was been assessed by a registered dietitian who was a member of the staff of the home.

During the course of the inspection, resident #021 to have an area of altered skin integrity.
A review of the clinical record did not include an assessment of the resident, related to the area of altered skin integrity, by the registered dietitian (RD).
Interview with the ADOC, following a review of the clinical record, verified that the resident was not assessed by the RD related to the area of altered skin integrity.
Interview with the FSM, following a review of the clinical record, verified that the resident did not have a referral request submitted for the RD, for the resident related to the area of altered skin integrity.

The resident who exhibited altered skin integrity was not assessed by a RD who was a member of the staff of the home. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure that the resident who exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During the course of the inspection, resident #021 was observed to have an area of altered skin integrity.
A review of the clinical record included a referral written by the physician for the area, documenting that it had changed. A review of the clinical record did not include a reassessment of this area at least weekly. The documented assessments in the clinical record were recorded by the physician.
Interview with RN #105 identified that they monitored the area each shift that they work.
Interview with the ADOC, following a review of the clinical record verified that the resident did not have at least a weekly reassessment for the area of altered skin integrity by the registered nursing staff as required. [s. 50. (2) (b) (iv)]

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 resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receivs a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #4: 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, that the procedure was complied with.

A. In accordance with LTCHA, 2007 s. 21, the licensee was required to ensure that, the long term care home had written procedures that complied with the regulations for initiating complaints to the licensee and for how the licensee dealt with complaints. Specifically, staff did not comply with the licensee's procedure 'Complaint Management, ADMIN3-O10.01', modified date June 2018, which was part of the licensee's Administration Manual.

i. The Complaint Management procedure identified that "If concerns cannot be resolved

immediately at point of service, the individual who is first aware of a concern will initiate the Client Service Response Form. A copy of the initial form will be forwarded to the Executive Director. The original form will be forwarded to the member of the team who will be responsible for the resolution of the concern."

ii. During the course of the inspeciton, the substitute decision maker (SDM) of resident #018 reported that the resident had missing personal property, which they communicated to the home earlier in the month.

iii. Interview with the ED, identified that missing items, other than clothing, would be managed as a complaint. The ED reported that they were not aware of missing item for the resident and a review of the Complaints Binder, which included initiated Client Service Response forms did not include a form for the item.

iv. In a follow up discussion with the SDM of resident #018, they provided a description of the missing item, confirmed it was not labelled and identified that RPN #103 was notified of the loss during an event at the home.

v. An interview with RPN #103 confirmed that they were aware of the Complaint Management procedure and the need to complete a Client Service Response form for missing items. It was also confirmed that they were notified of the missing item by the SDM, during the event; however, that they had not initiated a Client Service Response form as required in the procedure.
vi. The missing item, which was in the Montessori Cupboard, as it was not labelled, was located by the ED on during the course of the inspection, labelled and returned to the resident.

The procedure was not complied with by RPN #103.

B. In accordance with O. Reg. 79/10 s. 30(1), the licensee was required to ensure that, in respect of each of the interdisciplinary programs required under section 48 of the Regulation: there must be a written description of the program that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10 s. 48(1)(1) includes "a falls prevention and management program to reduce the incidence of falls and the risk of injury" as a required interdisciplinary program.

i. The licensee had a written procedure that complied with the regulations for a falls prevention and management program. Specifically, staff did not comply with the licensee's 'Post-Fall Management procedure, CARE5-O10.05', with a reviewed date March 31, 2018, which was part of the licensee's Care Manual.

ii. The Post-Fall Management procedure identified that "upon discovering a resident who has fallen call for the nurse immediately and stay with the resident to provide comfort until the nurse arrives", that "a post fall assessment is completed by the nurse immediately following the fall, including vital signs every shift for a minimum of 72 hours" and "an interdisciplinary team huddle is conducted on the same shift that the fall occurred, follow the Post-Fall Huddle Questions to collect the information needed to conduct a root cause analysis of the fall".

iii. According to the clinical record resident #024 sustained a fall. The resident notified the PSW that they refused assessment.
iv. During the course of the inspection, a telephone interview with RN #122 who worked the specified shift, identified that to their recall they were not informed of the fall immediately, only when they arrived to the unit for other activities and that they completed all of the required activities/assessments regarding the incident with the limited assessment that they were able to complete due to the refusal of the resident. The Staff Educator/Nursing Assistant identified the PSW who worked the identified shift was PSW #124.

v. Telephone interview with PSW #124 identified that they had no recall of the incident or actions taken.

vi. The clinical record included a Post Fall Assessment, the followign shift, by RN #105 for the incident which occurred on their previous shift. Interview with the ADOC, following a review for the clinical record, identified that if RN #122 initiated the Post Fall Assessment their name would have appeared on the form and not just the name of RN #105. The Post Fall Assessment was not initiated or completed by RN #122 immediately.

vii. A request was made of the ED, for the interdisciplinary team Post-Fall Huddle that was conducted on the same shift as the fall. The ED was able to provide notes from the twice daily, whole home huddle, for the "Falls Follow Up" for the resident; however, was not able to produce an immediate Post-Fall Huddle.

viii. A copy of Registered Staff Shift Report, included hand written notes of the fall but did

not include documentation to identify that the required tasks such as "complete post fall assessment" and "ensure interdisciplinary Post Fall Huddle is completed with immediate interventions to prevent another fall" were completed.

Staff did not comply with the licensee's Post-Fall Management procedure for the fall of June 25, 2018. [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 that where the Act of this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure in place that the procedure is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Review of CIS 1056-000009-18, revealed that resident #014 was in an altercation with a co-resident.

Review of the progress notes for resident #014 identified that, several days after the incident, the physician ordered new interventions as a result of escalating behaviours, including but not limited to, a laboratory test. Review of the medical records did not include any results from the test. Interview with the Responsive Behaviour Program Lead staff #111 and the ADOC confirmed that the sample was not collected and sent and therefore the intervnetion was not completed.

The intervention identified in response to a resident #014's escalating behaviours, was not implemented. [s. 53. (4) (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 for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents including identifying and implementing interventions.

Review of CIS #1056-000009-18 and CIS #1056-000011-18 revealed that resident #014 had an unwitnessed altercations with co-residents.

As a result of the first altercation, review of progress notes identified that resident #014 was provided an intervention to protect themselves and coresidents. Review of a progress note completed by the physician, several days after the incident, documented that the resident had exhibited escalating pattern of untriggered behavior. Review of Point of Care (POC) documentation revealed that behaviours continued from an identified time-frame in May 2018. A progress note on an identified day, identified that the intervention was effective; however, the intervention was stopped. That same day, resident #014 had an un-witnessed altercation with a co-resident #033 resulting in a superficial injury.
Interview with the Responsive Behaviour Lead confirmed that the intervention was stopped within a few hours of the second incident occurring. Interview with the ED confirmed that the incident was unprovoked and therefore the intervention was restarted.

The home did not take steps to minimize unprovoked altercations between resident #014 and coresidents when an effective intervention was stopped, resulting in a second incident with resident injury. (528) [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents including identifying and implementing interventions, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

According to the clinical record resident #011 had a referral submitted to physiotherapy (PT) for range of motion(ROM) exercises.
A review of the clinical record did not include an assessment of the resident by the PT for ROM in relation to this referral.
Interview with the PT, following a review of the clinical record, identified that to their recall they assessed the resident including an assessment for ROM; however, failed to document their assessment in the clinical record.

Actions taken with respect to a resident under a program, including assessments were not documented. [s. 30. (2)]

WN #8: 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 failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require; a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

'Post-Fall Management procedure, CARE5-O10.05', with a reviewed date March 2018, identified that "upon discovering a resident who has fallen call for the nurse immediately and stay with the resident to provide comfort until the nurse arrives", that "a post fall assessment is completed by the nurse immediately following the fall, including vital signs every shift for a minimum of 72 hours" and "an interdisciplinary team huddle is conducted on the same shift that the fall occurred, follow the Post-Fall Huddle Questions to collect the information needed to conduct a root cause analysis of the fall".

During the course of the inspection, resident #020 reported that they had sustained a fall a few months ago resulting in an injury. Review of the residents plan of care did not include a post falls assessment, as required in the home's 'Post Falls Management Procedure'. Review of a risk management report confirmed that the resident had fallen and sustained a superficial injury. A post fall assessment dated two days after the fall, directed the reader to the progress notes for falls description and post fall treatment. However, review of the progress notes did not include the details required in the post falls assessment. Interview with the ADOC confirmed that when resident #020 had fallen registered staff did not assess the resident using the post falls assessment tool on PCC, and two days later registered staff had initiated the post fall assessment tool, but it was not completed. [s. 49. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident’s written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was created and maintained for each resident of the home.

Review of CIS #1056-000009-18 and #1056-000011-16, revealed that resident #014 had altercations with co-residents resulting in superficial injuries.

Review of resident #014's medical record revealed that an initial altercation occurred with with a co-resident causing superficial injury. Review of the progress notes identified that as a result of the injury, dementia observation system (DOS) monitoring was initiated. The progress notes also indicated that the resident had ongoing behaviours and DOS continued. Review of the medical record did not include DOS documentation for approximately four weeks. Interview with staff #111 and registered staff #119 confirmed that the DOS documentation was completed but not maintained as part of the resident #014's medical record. [s. 231. (b)]

Issued on this 19th day of November, 2018

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

Original report signed by the inspector.