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

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

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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
Dec 18, 2018	2018_618211_0003	029215-18, 029893-18	Critical Incident System

Licensee/Titulaire de permis

Dundas Manor Limited
533 Clarence Street P.O. Box 970 WINCHESTER ON K0C 2K0

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

Dundas Manor Nursing Home
533 Clarence Street P.O. Box 970 WINCHESTER ON K0C 2K0

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

JOELLE TAILLEFER (211)

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 4, 5, 10, 11, 12, 2018.

The following Critical Incident System intake(s) related to falls were completed during this inspection:
Log # 029215-18,
Log # 029893-18.

A finding of non-compliance was found under Log # 022751-18 and included in this report.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Associate Director of Care, Maintenance Supervisor, Resident Assessment Instrument (RAI) Coordinator, Registered Practical Nurses (RPN), Personal Support Workers and the residents.

The Inspectors toured residential home areas, observed the residents' care areas, reviewed health care records and select policies and procedures related to the above identified critical incidents for falls prevention and management, including the documentation.

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

This finding of non-compliance is related to Log # 029893-18.

Resident #005 was admitted to the home on an identified date, with a diagnosis of cognitive impairment and other medical health conditions. The resident's specific test taken on an identified date indicated that the resident sustained an identified injury.

Review of the resident's post-fall assessment completed on an identified date, indicated that the staff needed to keep the resident up later, out of the bed to prevent future falls during a specific shift.

Interview with RPN #122 on December 11, 2018, stated that the resident was put in bed at a certain time by a PSW. RPN #122 discovered after a conversation with the regular staff during the post-fall assessment on the identified date, that resident #005 should not be put in bed before a specific time to prevent falls.

As confirmed by the DOC, the most recent plan of care for resident #005 reviewed on

December 12, 2018, doesn't reflect the post-fall assessment completed on an identified date, stating that the resident should not be put in bed before a specific time.

The licensee has failed to ensure that the staff and others involved with the post-fall assessment completed on an identified date, collaborated with each other in the development and implementation of the resident's plan of care so that the different aspects of care are integrated and are consistent with and complement each other. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

This finding of non-compliance is related to Log # 029215-18.

Resident #004 was admitted to the home on an identified date, with a diagnosis of cognitive impairment, multiple previous identified injuries and other health medical condition.

Resident #004 sustained an injury after a fall on an identified date. Hourly rounding was initiated for resident #004 after returning from the hospital.

The resident's most recent plan of care indicated that hourly rounding was put in place on an identified date to prevent falls. The goal is to decrease the number of falls and prevent an injury from falls. The hourly rounding sheets showed that on an identified date for specific hours there were no signed initials for those times.

Interview with PSW #115 on December 10, 2018, stated that they did not complete the hourly rounding as per the plan of care since they forgot to sign off the hourly rounding on the identified date for specific hours.

Interview with the ADOC on December 11, 2018, indicated that the hourly rounding sheets are to be initialed by staff when rounding is completed. [s. 6. (9) 1.]

3. This finding of non-compliance is related to Log # 029893-18

Resident #005 was admitted to the home on an identified date, with a diagnosis of cognitive impairment and other medical health conditions.

The resident's progress notes indicated that the resident had numerous falls within a period of two months. Resident #005 was sent to the hospital on an identified date, due to severe pain and rule out an injury. The resident returned to the home on the same day. The resident's specific test taken on an identified date, indicated that the resident sustained an injury.

The resident's most recent plan of care indicated that hourly rounding was initiated on an identified date, in the intent to be proactive in meeting resident 005's needs and to prevent falls.

The hourly rounding sheets reviewed on the identified date, for specific months, showed that numerous shifts and times were not initialed.

Interview with PSW #130 on December 12, 2018, stated they did not document the hourly rounding sheet on the identified date for specific hours.

Interview with PSW #129 on December 12, 2018, indicated that they forgot to initial their names on the hourly rounding sheet on an identified date during specific hours.

Interview with PSW #128 on December 12, 2018, stated that they don't remember if the resident was on hourly rounding during that period of time and the sheet was not documented on two identified dates during specific hours.

Interview with PSW #131 on December 13, 2018, stated that they must have forgotten to sign the sheet on the identified date during specific hours.

Interview with PSW #124 on December 13, 2018, indicated that they forgot to sign the sheet on an identified date during specific hours.

Interview with PSW #132 on December 13, 2018, stated that the resident #005 was monitored hourly on an identified date during specific times, but they forgot to sign the hourly rounding sheet.

Interview with the DOC on December 12, 2018, indicated that the licensee's expectation from the staff was to put an initial on the hourly rounding sheets to show that resident #005 was monitored hourly. [s. 6. (9) 1.]

4. This finding of non-compliance is related to Log # 022751-18.

Resident #002 had a fall on an identified date, resulting in a specific injury. Resident #002 has a lengthy falls history, with numerous falls documented in Point Click Care in the 6 months prior. Resident #002 is categorized as high risk for falls and had hourly rounding in place at the time of the fall on an identified date.

It is documented on resident #002 care plan, completed on an identified date, that hourly rounding is in place to prevent falls. Intent is to be proactive in meeting residents needs. Icon has been placed above as a visual cue for staff.

In an interview with PSW #115 on December 11, 2018, at 1410, PSW #115 confirmed that resident #002 was on hourly checks at the time and that these hourly rounding sheets were found on resident #002's door. PSW#115 confirmed this is the only place to document hourly rounds.

In an interview with PSW #103 on December 5, 2018, at 1200, PSW #103 told Inspector #732 that resident #002 has hourly rounding and believes it had been in place for a while.

On December 10, 2018, at 0925, Inspector #732 obtained resident #002 hourly rounding sheet for the identified month from ADOC #109. The document had 4 areas highlighted in pink. These areas contain no staff initials. The dates and times that were highlighted include multiple different hours during that identified month.

ADOC #109 informed Inspector #732 that the highlighted areas represented holes in documentation by staff members. In a separate interview with ADOC #109 on December 11, 2018, at 1115 hours, Inspector #732 asked ADOC #109 if they could confirm that hourly rounding was completed, but just not documented. ADOC #109 was unable to confirm if hourly rounding was completed or not completed, but was able to confirm that the highlighted areas represented a lack of documentation by staff.

The licensee failed to ensure that the provision of the care set out in the plan of care was documented as indicated in the residents #002, #004 and #005's plan of care. [s. 6. (9) 1.]

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 provision of the care set out in the hourly rounding sheets are documented for residents #002, #004, and #005.
To ensure that the staff and others involved with the post-fall assessment collaborated with each other in the development and implementation of the resident's plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: 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. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the falls prevention and management program must, at a minimum provide strategies to reduce or mitigate falls, including the monitoring of residents and the use of devices.

This finding of non-compliance is related to Log # 029893-18.

Resident #005 was admitted to the home on an identified date, with a diagnosis of cognitive impairment and other medical health conditions.

Review of the resident #005's current plan of care identified the resident has a high risk for falls and required a specific equipment for mobility, one person constant supervision and physical assist for safety.

Review of the progress notes indicated that the resident sustained numerous falls in the identified month.

Review of the resident's post-fall assessment completed on an identified date, indicated that the resident suffered from a fall due to the increase of clutter and congestion surrounding a specific area in the home. The resident ambulated and tripped.

Interview with RPN #127 on December 12, 2018, stated that resident #005 was sitting in a specific equipment in an identified area in the home. RPN #127 indicated that all staff were busy with other residents and others were taking their break for dinner. During that time, the resident stood up from the specific equipment and walked from one area to another area in the home. The area was occupied by many residents sitting in their wheelchair and resident #005 tripped over somebodies feet. RPN #127 stated that the resident was found on the floor in the specific area in the home.

RPN #127 indicated that if a specific device would have been placed on the identified equipment and attached to the resident, the fall may have been prevented.

The DOC stated that a identified device attached to resident #005 may have prevented this fall when the resident was not closely monitored.

The licensee has failed to ensure that resident #005 was monitored and provided with a device as a strategies to reduce or mitigate a fall on the identified date during the precised shift. [s. 49. (1)]

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 falls prevention and management program must, at a minimum provide strategies to reduce or mitigate falls, including the monitoring of residents and the use of devices, to be implemented voluntarily.

Issued on this 18th day of December, 2018

[redacted]

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

Original report signed by the inspector.