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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Feb 24, 2015	2015_294555_0002	O-001289-14	Complaint

Licensee/Titulaire de permis

EXTENDICARE CENTRAL ONTARIO INC
82 Park Road North OSHAWA ON L1J 4L1

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

EXTENDICARE OSHAWA
82 PARK ROAD NORTH OSHAWA ON L1J 4L1

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

GWEN COLES (555)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 27 and 28, 2015.

This complaint inspection was in relation to Log #O-001289-14.

During the course of the inspection, the inspector(s) spoke with the Administrator; the Director of Care (DOC); the Assistant Director of Care (ADOC); Registered Nurses (RN); Registered Practical Nurses (RPN); Personal Support Workers (PSW); Physiotherapist; Residents; and Family Members.
The Inspector also made observations of residents, staff to resident interactions, and reviewed clinical records, policies, and procedures related to Falls Prevention.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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	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 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).

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 has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the Resident.

Resident #1:

Review of clinical records indicates that on five occasions over a two month period Resident #1 had unwitnessed falls, which on one occasion resulted in complaints of pain. Family and Physician were notified and the resident did not require transfer to hospital for treatment.

On January 27 and 28, 2015 Resident #1 was observed on multiple occasions with the following interventions in place: bed sensor, bed in the lowest position, two 1/4 side rails raised, call bell available, two floor mats on both sides of the bed, wheelchair with tab monitor, and a Falling Star logo on over-bed light, name plate, wrist band and wheelchair. Personal protective equipment was not observed on the resident or in the resident's room during the inspection.

Review of Resident #1 current plan of care found no evidence of floor mats and tab monitor for wheelchair as an intervention to prevent falls. The plan of care indicated "Resident has personal protective equipment for safety to be applied every night and removed in the morning".

An interview was conducted on January 28, 2015 with Staff #104 who reported Resident #1 is a falls risk and that the resident has the following interventions: the bed in the low position, bed sensor attached to call bell system, and was never left unattended when toileting. An interview was conducted on January 28, 2015 with Staff #109 who reported Resident #1 is high risk for falls and has the following interventions: two floor mats, bed monitor attached to call bell system, close visual monitoring, bed in lowest position and resident is never left alone when toileting. Both Staff #104 and #109 reported falls prevention interventions would be found in the care plan binder, electronic tasks and the physical chart. Interview with Staff #105 on January 28, 2015 who reported Resident #1 is a falls risk and has the following interventions: bed in lowest position, bed sensor connected to call bell, tab monitor on wheelchair, two fall mats, close visual monitoring, make sure call bell is available, and staff always present when toileting.

During an interview with the ADOC on January 28, 2015 who was aware that Resident #1 is a high risk for falls and had five unwitnessed falls in a two month period. The ADOC reports Resident #1 has falls interventions in place however reported that fall mats and tab monitor for wheelchair were not identified in the plan of care. The ADOC stated that the personal protective equipment is not being used for the resident as the resident refuses to wear it but aware that it continues to be noted on the care plan.

Resident #2:

During a one month period Resident #2 had three unwitnessed falls, one of which resulted in a scratch, one resulted in no injury and one resulted in a laceration that required transfer to hospital for treatment.

On January 27 and 28, 2015 Resident #2 was observed on multiple occasions and the following interventions were noted: Falling Star logo on the resident's wristband, nameplate, walker, and over-bed light; bed in mid position, one mat on the floor, two 1/4 side rails up and call bell available. Resident #2 was observed on two separate occasions walking without the walker, and as a result staff re-directing the resident back to the room to secure the walker or providing the walker to the resident.

An interview was conducted with Staff #105 on January 28, 2015 who reported Resident #2 was a falls risk as unsteady when walking, forgets to use walker and requires reminding. Staff #105 reported Resident #2 is on the Falling Stars program and that falls interventions for Resident #2 include staff to remind to use walker or walk beside, have call bell available and fall mats.

Review of clinical documentation during the period related to the falls found no evidence in the plan of care related to the Falling Stars program and requiring reminders related to walker use.

An interview conducted with the ADOC on January 28, 2015 who reports Resident #2 had three unwitnessed falls during the review period. The ADOC reported that Resident #2 is a falls risk and on the Falling Stars program, and requires reminders related to use of walker as often forgets to use. The ADOC found no reference to the Falling Stars program and reminders for resident to use walker identified in the plan of care. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided as specified in the plan.

Over a two month period Resident #3 had six falls, three of which were unwitnessed. Four of the falls resulted in injury that did not require transfer to hospital for treatment.

Review of the plan of care in place during the falls review period indicated Resident #3 was to have "Check q1h for safety during periods where risk for falls is increased. (evenings and nights)". Review of clinical records found no evidence of hourly safety checks during evening and nights documented.

An interview was conducted on January 28, 2015 with Staff #104 who reported that Resident #3 was on the Falling Stars Program which involved increase visual monitoring of the resident to ensure falls safety. Staff #104 reported documentation of interventions related to falls prevention would be done electronically through the Point of Care (POC) tasks system, which would include hourly safety checks. During an interview conducted on January 27, 2015 with Staff #102 who reported that information related to resident care would be found in the care plan binder and in the POC on the computer. An interview was conducted with the ADOC on January 28, 2015 who reported that hourly safety checks would be documented in the electronic record by the non-registered staff. The ADOC reported that as there is no documented evidence of hourly safety checks for

the Resident # 3's falls during the review period the safety checks were not done. [s. 6. (7)]

3. The licensee has failed to ensure that the plan of care is reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary.

Resident # 3 fell on six occasions in a two month period resulting in twice having no injuries, twice sustaining a laceration; once sustaining bruising, and once sustaining a hematoma. None of the injuries required transfer to hospital for treatment, and family and physician were notified.

On January 27 and 28, 2015 Resident #3 was observed multiple times to be in bed or sitting in a wheelchair, and was never observed ambulating. Resident #3 was observed to have a Falling Star logo on the wristband, on the wheelchair, nameplate and on the over-bed light. On January 28, 2015 it was observed in the resident's room that the resident was a sit to stand transfer as per the transfer logo, however the posted Kardex dated July 3, 2014 indicated that the resident was one person physical assist to transfer and walk in room/corridor.

During an interview conducted with Staff #104 and #105 on January 28, 2015 who reports Resident #3 is now a two person transfer as the resident's condition has changed. Both staff report that Resident #3 is now using a wheelchair and no longer ambulating, however prior to the recent change in condition the resident was walking but unsteady, was high risk for falls and on the Falling Stars Program. Both staff report that the resident had trialled using hip protectors but they are not required now due to the change in condition. Staff #105 confirmed that the plan of care indicates that Resident #3 is full weight bearing; two person to provide some physical assistance but resident performs part of the tasks; and to use hip protectors, and that the care plan needs to be revised.

An interview was conducted with the ADOC on January 28, 2015 who is responsible for the Falls Prevention (Falling Stars) Program. The ADOC reported that if a resident has had no falls in 6 weeks or a change in condition, then they would be removed from the Falling Stars Program. The ADOC reported that all interventions and transfer information would be found in the care plan, care plan binders, transfer logo and printed Kardex located in the resident's room. The ADOC reported that as Resident #3 is no longer ambulating, has not had a fall in six weeks, and the care needs of the resident related to hip protectors, transfers, ambulation and falls risk have changed, the plan of care needs

to be reviewed and revised. [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 the plan of care sets out clear direction to staff and others; that care is provided as identified in the plan of care; and that the plan of care is reviewed and revised when the care needs change or when 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. 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 has failed to ensure that when a resident has fallen a post-fall assessment had been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

On an identified date Resident #3 was found on the floor of the room as a result of a fall, having sustained a laceration. The resident was assessed and treated without transfer to hospital, and the family and physician was notified.

Review of clinical documentation for the falls review period found no evidence of a post-falls assessment being completed using a clinically appropriate assessment instrument.

Interview conducted with Staff #105 on January 28, 2015 who reported if a resident had any fall the registered staff would be required to document electronically under Risk Management a Post-Falls Assessment which is an clinical assessment tool for falls.

An interview was conducted with the ADOC on January 28, 2015 who reported that Resident #3 had an unwitnessed fall during the review period. The ADOC stated that the expectation for registered staff related to falls was to complete a risk management incident report which would trigger the completion of a "Post Falls Assessment" which is the clinical assessment tool for falls. The ADOC found no evidence of a Post Fall assessment being completed for Resident #3's fall during the falls review period. [s. 49. (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 when a resident has fallen a post-fall assessment has been conducted using a clinically appropriate assessment instrument specifically designed for falls, to be implemented voluntarily.

WN #3: 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 for the inspection period that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is: a) in compliance with and is implemented in accordance with all applicable requirements under the Act, and b) is complied with.

Under O. Reg. 79/10, s. 48 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Under O. Reg. 79/10, 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.

Review of the policy entitled "Falls Prevention and Management Program" RESI-10-20-01 dated April 2013 indicated under Registered Staff: "When a resident falls: 2. Immediately complete an initial physical and neurological assessment of the resident; 3. If a resident hits their head or is suspected of hitting their head (ie. an unwitnessed fall) clinical monitoring record needs to be completed."; "Appendices: Appendix II - Clinical Monitoring Record".

Review of the document entitled "Appendix II Clinical Monitoring Record" indicated "monitor the following every hour x 4 hours then every 8 hours x 72 hours: Neurovitals Signs (if head/brain injury suspected or the fall is unwitnessed); monitor vital signs; assess for pain; monitor for changes in behaviour."

1. On five occasions during a two month period Resident #1 had unwitnessed falls, which on one occasion resulted in complaints of pain. Family and Physician were notified and the resident did not require transfer to hospital for treatment.

Review of the clinical documentation for Resident #1 found no evidence of any document entitled "Clinical Monitoring Record" for the five falls in the two month period. Review of the clinical records for Resident #1 during the two month period found no evidence of documentation of neurovitals signs as per schedule indicated on the Clinical Monitoring Record despite falls being documented as unwitnessed.

2. On three occasions in a one month period Resident #2 had unwitnessed falls, which on one occasion resulted in no injury; one resulted in a scratch and one resulted in a laceration with transfer to hospital for treatment. Family and Physician were notified.

Review of the clinical documentation for Resident #2 found no evidence of any document entitled "Clinical Monitoring Record" for one fall in the review period. Review of the clinical records for Resident #2 found no evidence of any documentation of neurovitals signs as per the schedule indicated on the Clinical Monitoring Record despite all falls being documented as unwitnessed.

3. On six occasions during a two month period Resident #3 had three unwitnessed falls, one of which resulted in a laceration but no transfer to hospital was required.

Review of the clinical documentation for Resident #3 found no evidence of any document entitled "Clinical Monitoring Record" for the three unwitnessed falls in the review period. Review of the clinical records for Resident #3 found no evidence of documentation of neurovitals signs as per schedule indicated on the Clinical Monitoring Record despite three falls being documented as unwitnessed.

Interview conducted with Staff #105 on January 28, 2015 who reported if a resident had an unwitnessed fall or the resident was a unreliable source of information related to falls, then the resident would be started on a Head Injury Routine using the Clinical Monitoring Record and documented electronically.

Interview conducted with the ADOC on January 28, 2015 who indicated that an unwitnessed fall would require the completion of the Clinical Monitoring Record for monitoring of possible head/brain injury, which includes the documentation of neurovitals

as per the schedule noted on the document.

The ADOC reported that all five falls in the two month period for Resident #1 were unwitnessed and therefore required a Clinical Monitoring Record to be completed. The ADOC reported that there is no evidence of a Clinical Monitoring Record or evidence related to the documentation of the required neurovitals for Resident #1's falls and therefore did not comply with the Falls Prevention Policy.

The ADOC reported that Resident #2 had three unwitnessed falls during the review period and sustained a laceration that required transfer to hospital on one occasion. The ADOC reported that there is no evidence of a Clinical Monitoring Record or documentation related to neurovitals for one unwitnessed fall for Resident #2 during the review period, and incomplete documentation as per the schedule for the other two unwitnessed falls, and therefore did not comply with the Falls Prevention Policy.

The ADOC reported that all three falls for Resident #3 were unwitnessed and therefore required a Clinical Monitoring Record to be completed. The ADOC indicated that there is no evidence of a Clinical Monitoring Record or evidence of documentation related to neurovitals for Resident #3's three unwitnessed falls, and therefore did not comply with the Falls Prevention Policy. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 25th day of February, 2015

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

Original report signed by the inspector.