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

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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
Jul 20, 2016	2016_219211_0014	012587-16, 012604-16	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE STARWOOD
114 STARWOOD ROAD NEPEAN ON K2G 3N5

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): July 5, 6, 7, 11, 12, 2016, on site.

The following inspection logs were completed during the time at the home: 012587-16 and 012604-16 related to resident's falls.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Assistant Director of Care, Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW) and a Resident.

The inspector also observed the resident's room, observed resident common areas, reviewed resident health care records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
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	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

The following finding is related to Log #012587-16.

Resident #001 was admitted on an specified and identified as a high risk level for fall due to unsteady gait and multiple medical issues.

The plan of care identified that resident #001 had eleven falls since the admission within a period of seven months.
At the time of admission, the resident was using a two-wheel walker with staff cueing and supervision.

The first fall happened twenty-seven days after the admission. The resident was found sitting on the floor with no visible injury.

The next day, the resident was found sitting in another room on a fall mattress beside a resident's bed. The resident did not report any pain and did not have any noticeable injuries.

The day after the second fall, a member of the falls committee was notified about the resident’s fall. A trial for a wireless bed pad alarm and a monitor magnetic bracket on the door frame was initiated.

Approximately, three weeks after the second fall, the resident was assessed for a four-wheel walker and received the new walker.

Five months after the resident's admission, the resident sustained an injury due to the third fall and sent to the hospital. The resident returned from the hospital to the home after eight days.
After returning from the hospital, the resident required a wheelchair or a two-wheel walker with extensive assistance from two people.

Four days after the resident returned from the hospital, the Post Fall Assessment report indicated Resident #001 attempted to stand up from the wheelchair and had a fourth fall. The resident was found sitting on the floor beside the wheelchair.

Interview with the ADOC revealed the resident became gradually more alert following the return from the hospital and was trying to get out of the wheelchair to walk.

On an identified date, the resident had his/her ninth fall. The progress notes indicated resident #001 was found lying on his/her back on the floor. The notes indicated “It can be assumed the resident was attempting to self-transfer as he/she has been known to do

this which results in falling".

Interview with RN #105 revealed the resident's ninth fall was unwitnessed with no injury. The resident attempted getting out of the wheelchair and had a fall. The tab alarm did not create any sound when the resident tried to get out of the wheelchair. The resident was found on the floor with the tab alarm clip still attached to his/her clothes. RN #105 reported to the inspector that the tab alarm's cord attached to the resident was too long.

Interview with the ADOC revealed the fall could have been prevented if the staff had shortened the tab alarm's cord.

Interview with the ADOC revealed the home's fall training included the tab alarm verification and monitoring. The staff should verify in the beginning and at the end of their shift that the tab alarm placed on the wheelchair is functioning properly as follow.
- The staff should verify that the resident's tab alarm cord is attached to the resident and shortened enough to alert the staff when the resident is trying to get up from the wheelchair.
-The staff should verify that the tab alarm monitor is functioning. [s. 5.]

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 is a safe and secure environment for its residents when using the tab alarm system, 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. (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. (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 had failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate 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.

The following finding is related to Log #012587-16.

On an identified date, the progress notes indicated the resident had a tenth fall with no injury. The resident likes to get up and walk. The resident has cognitive impairment and is not aware of his/her limitations.
On the same day, the progress notes indicated the Substitute Decision Maker (SDM) requested to have the resident wearing a seat belt as he/she has fallen frequently. Message was to be left with the DOC and the day RN.

Interview with RN #106 indicated that the resident was sitting in the wheelchair before the fall.
Interview with RN #103 revealed that the SDMs were told that he/she prefer not to restraint a resident.

The resident's Post Fall Assessment report indicated eleventh fall occurred on an identified date.

Interview with the ADOC and DOC revealed they were not aware that the SDM requested a seat belt for resident #001 and the intervention needs to be considered for the resident's safety. [s. 6. (4)]

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any time when the care set out in the plan has not been effective.

The following finding is related to Log #012587-16.

On an identified date, the resident's progress notes and the Risk Management Incident report indicated the resident had a 5th fall near the bed when he/she tried to ambulate without assistance. The fall was unwitnessed. The call bell was not accessible.

Interview with RN#106 revealed the bed alarm did create a sound when the resident tried to get up from the bed on the 6th fall, but the staff did not have time to enter the room before the resident fell.

Interview with the ADOC revealed the bed alarm is an intervention to prevent resident from falling but the system is not always preventing each and every fall.

Interview with the ADOC revealed that many interventions to prevent falls were implemented when resident #001 returned from the hospital. However, the resident's plan of care does not indicate when the tab alarm monitoring was started after the resident returned from the hospital. The tab alarm should have been applied when the resident fell from his /her wheelchair after the 4th fall for safety. On another identified date related to the 6th fall, the progress notes indicated resident #001 was lying on the floor in the dining room beside the wheelchair away from the direct vision of staff. The tab alarm did not create a sound.

On an identified date, the resident had two consecutive falls (7th and 8th fall). The progress notes indicated the resident was found both times on the floor beside the wheelchair.

On another identified date, the progress notes indicated the resident had a 10th fall with

no injury. The resident likes to get up and walk. The resident has cognitive impairment and is not aware of his/her limitations.
Interview with RN #106 indicated that the resident was sitting in the wheelchair before the fall.

On an identified date the resident had a eleventh fall. The progress notes and the Risk Management Incident report indicated the resident was found sitting in the hallway beside the wheelchair.
Interview with the ADOC revealed the Post Fall Assessment report for the eleventh fall, indicated the chair alarm system did emit a sound but the resident was already on the floor when the staff responded.

Interview with ADOC revealed that both the bed alarm and the tab alarm is a way to prevent resident's fall but the system is not preventing all resident #001's falls.

Interview with the ADOC and DOC confirmed that the fall's training did include the monitoring of the bed and chair alarms monitoring, but the staff did not take into consideration all aspect of care related to the assessment, development and the implementation when the resident #001's care set out in the plan related to the falls were not effective. [s. 6. (10) (c)]

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 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 hat their assessments are integrated and are consistent with and complement each other; and
(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, to be implemented voluntarily.

Issued on this 20th day of July, 2016

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

Original report signed by the inspector.