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

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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
Apr 2, 2019	2019_730593_0009	033415-18, 000735-19, 003273-19	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

GILLIAN CHAMBERLIN (593)

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): March 26 - 29, 2019.

Critical Incident (CIS) log's #033415-18, #000735-19 and #003273-19 were inspected, related to hopitalization and change in condition.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nursing Staff, Personal Support Workers (PSW) and residents.

The Inspector observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment and reviewed resident health care records and licensee policies..

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

During the course of this inspection, Non-Compliances were issued.
- **1 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	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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #002 was provided to the resident as specified in the plan.

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), reporting a fall sustained by resident #002 that resulted in an injury for which the resident was taken to hospital and which resulted in a significant change in condition.

A review of resident #002's progress notes found the following entry related to the fall:

Resident #002 fell this morning when they transferred them self to the bathroom. Resident #002 complained of pain to a specific area. Three staff assisted resident to the bathroom, with resident weight bearing. Resident was toileted and placed in bed. Medication administered for pain. Gave report to Day RN. No injury to the head or arms or any other limb noted. Resident will be on HIR (head injury routine) for the next three days.

A review of resident #002's progress notes by Inspector #593, found an additional fall resulting in an injury for which the resident was taken to hospital and which resulted in a significant change in condition:

Resident #002 sustained a small skin tear on hand. Resident #002 complaining of pain to a specific area. Resident ambulating to the bathroom independently. Will also review documentation to see the last time resident #002 was toileted. If resident #002 is remaining in bed throughout the morning, they need to be toileted as they cannot ring the call bell for assistance.

It was documented further in the progress notes that as a result of this fall, resident #002 sustained a a fracture to a specific area.

Inspector #593 reviewed a post falls assessment completed by RN #100 the same day of the second fall. The following was documented in the assessment:

Time of fall: 1050 hours

• Root cause of fall: Resident ambulating to the bathroom independently. Will also review documentation to see the last time resident was toileted.
• Describe how the fall may have been prevented: Resident should have been toileted through the morning. Resident had remained in bed.
• Follow up plan: If resident is remaining in bed throughout the morning, they need to be

toileted as they cannot ring the call bell for assistance.

A review of resident #002's written plan of care, found that the resident was a high risk for falls and a high fracture risk. The following intervention was documented related to toilet use:

• Toilet use- Resident #002 continues to recognize the urge to void and to defecate. Toilet at their request in addition to days- upon waking, around 1000 hours and after lunch, around 0100 - 0130 hours.

A review of the Point of Care (POC) records for resident #002, the day of the second fall, found that the resident was toileted on the night shift and then at the beginning of the afternoon shift. There was no documentation to indicate that resident #002 was toileted on the day shift.

During an interview with Inspector #593, March 27, 2019, RN #100 indicated that before the second fall, toileting was a repetitive behavior for resident #002. The resident was requesting to be toileted repeatedly. Resident #002 was trying to get to the bathroom when they fell, they managed a few steps on their own before falling near their closet. After they fell, they still insisted that they needed to go to the bathroom and so the staff toileted the resident before they were sent to hospital.

During a second interview with Inspector #593, March 28, 2019, RN #100 indicated that the day of the second fall, they were still able to toilet resident #002 however after the fall, the RN checked the POC documentation and found that there was a lack of documentation around the time of the fall to show whether the resident was toileted.

During an interview with Inspector #593, March 29, 2019, ADOC #101 indicated that resident #002 was to be toileted every two hours for wetness or need to use the toilet as per the POC tasks. ADOC #101 added that the POC documentation for the day of the second fall, indicated that resident #002 was not toileted on the day shift.

During an interview with Inspector #593, March 29, 2019, DOC #102 indicated that if the staff do not document in POC, then the care was not done. DOC #102 added that they were not sure if resident #002 was not toileted prior to the fall or whether the toileting was not documented.

Resident #002 was a high risk for falls. Having already sustained a significant injury from

a previous fall, resident #002 attempted to self-ambulate to the bathroom, when they fell and sustained a second fracture to a different location. This occurred at 1050 hours, the POC documentation indicated that the resident had not been toileted since the night shift and the post falls assessment completed indicated that resident #002 should have been toileted through the morning as resident #002 could not use the call bell for assistance. Resident #002's plan of care indicated that the resident was to be toileted upon waking and around 1000 hours. As such, the licensee has failed to ensure that the care set out in the plan of care for resident #002 was provided to the resident as specified in the plan. [s. 6. (7)]

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 ensuring that the plan of care for resident #002 is provided to the resident as specified in the plan of care, to be implemented voluntarily.

Issued on this 9th day of April, 2019

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

Original report signed by the inspector.