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 le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Dec 22, 2015;	2015_384161_0020 (A1)	O-002925-15	Complaint

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner
2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

GARDEN TERRACE
100 Aird Place KANATA ON K2L 4H8

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

KATHLEEN SMID (161) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Changed Compliance plan due date from December 5, 2015 to December 24, 2015

Issued on this 22 day of December 2015 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

KATHLEEN SMID (161) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): on-site October 23, 2015, November 2 - 5, 2015 and November 9, 10, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, RAI Coordinator, Physiotherapist, Registered Nursing staff, Registered Dietitian, Personal Support Workers and Maintenance staff.

The inspector(s) also observed the Resident and reviewed the following documentation: Infoline Complaint Inspection Report on a specified date in October 2015, Critical Incident Report on a specified date in September 2015, Bowel and Bladder Management Program #HLHS-ECC-1.3 dated January 2012, Bowel Protocol #HLHS-ECC-1.6 dated August 2011, Least Restraint, Last Resort Program #CS-5.1 dated April 2013, Chemical Restraints #CS-5.4 dated January 2011, Fall Prevention Program dated 2009, Security Check Flow Sheet Policy #CS-31.12 dated July 2011 and the Resident's Health Care records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Critical Incident Response

Falls Prevention

Hospitalization and Change in Condition

Minimizing of Restraining

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

2 WN(s)
0 VPC(s)
1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee failed to ensure that different approaches were considered when care set out for Resident #001 was not effective in mitigating falls when in his/ her wheelchair.

On a specified date in September 2015 a Critical Incident Report was submitted to the Director for an incident that occurred on an earlier date in September 2015 in which Resident #001 fell from his/her wheelchair, sustained injuries and was sent to the hospital. On a specified date in October 2015 an INFOLINE Complaint Information Report was filed with the Ministry of Health and Long Term Care and referenced the Resident's fall that occurred on the specified date in September 2015. Resident #001 had two people who were his/her Substitute Decisions Makers (SDM) and they are referred to throughout this report as SDM #1 and SDM #2.

On a specified date in April 2015 Resident #001 was admitted to the home with multiple diagnoses. Resident #001's health care record was reviewed from the date of admission to a specified date in November 2015. There were numerous references in Resident #001's progress notes of multiple attempts to get out of his/her wheelchair, standing up from the wheelchair, self-transfers and that he/she had fallen in May 2015 and in August 2015 from his/her wheelchair. On a specified date in September 2015 Resident #001 fell from his/her wheelchair, sustained two fractures and was sent to the hospital. The Resident was transferred back to the long-term care home on a specified date towards the end of September 2015.

Summary of Facts:

In May 2015 the Resident #001 made multiple attempts to stand up from his/her wheelchair, self- transfer and was observed to be weak, unsteady on his/her feet and at high risk for falls from his/her wheelchair (Progress notes on 4 identified dates in

May 2015). On a specified date in late May 2015 the Resident slid from his/her wheelchair to the floor. The Resident did not sustain injury.

On a specified date in May 2015 Resident #001 was prescribed a medication to be administered daily. According to an interview on November 10, 2015 with the RAI Coordinator, she indicated that this prescribed medication was used as a Chemical Restraint to decrease the Resident's agitation.

On a specified date in early May 2015 SDM #2 approached RPN #004 and expressed concern that when the Resident is sitting in his/her wheelchair, the Resident forgets that he/she cannot get up on his/her own and will fall. SDM #2 requested a table top as a restraint to prevent this from occurring. RPN #004 explained to SDM #2 the pros and cons of a table top restraint and suggested alternatives including scheduled toileting and the use of hip protectors. SDM #2 agreed to a trial of these alternatives.

On a specified date in late May 2015 SDM #2 expressed concern to RPN #119 regarding the Resident's risk of falls and requested a seat belt restraint be used. SDM #2 was also concerned that the Resident might remove the seat belt and thus asked for a table top to be used when the Resident was seated in his/her wheelchair. RPN #119 told the SDM that a physiotherapist seating assessment would be done.

A review of Resident #001's May 1 – 31, 2015 plan of care to mitigate falls when in his/her wheelchair included (a) gather information on past falls and attempt to determine the cause of falls, anticipate and intervene to prevent recurrence (b) administer prescribed chemical restraint daily and observe, document and notify MD of any drug related complications, ongoing usage etc (c) personal items and call bell within reach, encourage Resident to use it for assistance and respond promptly (d) physiotherapy (e) wear hip protectors (f) scheduled toileting program (g) security checks every 15 minutes for safety, comfort and well-being.

- In June 2015 Resident #001 made multiple attempts to stand up from his/her wheelchair, stood up from his/her wheelchair and was observed to be weak, unsteady on his/her feet and remained at high risk for falls from his/her wheelchair (Progress notes on 4 specified dates in June 2015).

On the morning of a specified date at the beginning of June 2015 the attending physician was telephoned by RPN #120 who asked for and received an order for a seat belt restraint to be worn when Resident #001 was seated in his/her wheelchair. Later on that day, Physiotherapist #105 telephoned SDM #2 to discuss the Resident's

seating assessment. SDM #2 was upset regarding the Resident's fall from his/her wheelchair on a specified date in late May 2015 and asked the Physiotherapist for a seat belt restraint and table top to prevent Resident #001 from falling again. The Physiotherapist #105 suggested to SDM #2 that a chair alarm be used when the Resident sits in his/her wheelchair as well as have the Resident sit in a common area where there would be increased monitoring. Physiotherapist #105 informed SDM #2 of the risks of using restraints. SDM #2 indicated that now that she knew the risks she wanted the seat belt restraint discontinued immediately. Physiotherapist #105 informed the Assistant Director of Care (ADOC) of SDM #2's decision to discontinue the seat belt restraint immediately and to have a chair alarm installed on the Resident's wheelchair.

On a specified date in early June 2015 a meeting was held with SDM #2, the ADOC and Physiotherapist #105 to discuss Resident #001's care and fall prevention strategies that at that time included (a) gather information on past falls and attempt to determine the cause of falls, anticipate and intervene to prevent recurrence (b) administer prescribed chemical restraint daily and observe, document and notify MD of any drug related complications, ongoing usage etc (c) personal items and call bell within reach, encourage Resident to use it for assistance and respond promptly (d) physiotherapy (e) wear hip protectors (f) scheduled toileting program (g) security checks every 15 minutes for safety, comfort and well-being.

On a specified date in June 2015 a progress noted indicated that Registered Nurse #121 reviewed with the DOC and the Clinical Care Coordinator, the frequency of security checks of the Resident with the aim of eventually discontinuing the security checks as the Resident's health had settled over the past few weeks. On a specified date in June 2015 the frequency of security checks was decreased from every 15 minutes to every 30 minutes.

On a specified date in June 2015 the DOC and a technician met with SDM #1 and showed him a magnetic seat belt alarm. SDM #1 consented to the use of the alarm which was subsequently attached to the Resident's wheelchair. A discussion was held on November 9, 2015 between Inspector #161 and staff members RPN #105 and Physiotherapist #105. They indicated that the magnetic seat belt alarm was not designed to restrain or hold Resident #001 in his/her wheelchair but was used as a reminder not to get up from his/her wheelchair.

A review of Resident #001's June 1 – 30, 2015 plan of care to mitigate falls when in his/her wheelchair included (a) gather information on past falls and attempt to

determine the cause of falls, anticipate and intervene to prevent recurrence (b) administer prescribed chemical restraint daily and observe, document and notify MD of any drug related complications, ongoing usage etc (c) personal items and call bell within reach, encourage Resident to use it for assistance and respond promptly (d) physiotherapy (e) wear hip protectors (f) scheduled toileting program (g) chair alarm (h) magnetic seat belt alarm as of a specific date in June 2015 (i) seat Resident in common area. (j) security checks every 15 minutes and then this was decreased on a specified date in June 2015 to every 30 minutes for safety, comfort and well-being.

- In July 2015 the Resident #001 undid his/her magnetic seat belt alarm several times; he/she made multiple attempts to stand up from his/her wheelchair, he/she kept getting up from his/her wheelchair and was observed walking in the hallway. The Resident was weak, unsteady on his/her feet and remained at high risk for falls from his/her wheelchair (Progress notes on 7 identified dates in July 2015).

On a specified date in July 2015 Resident #001 undid his/her magnetic seat belt alarm several times. SDM #2 met with RPN #114 to discuss her concerns regarding the Resident's ongoing behaviour of undoing his/her magnetic seat belt alarm and requested to talk with RPN #115 to see if there is a solution to resolve this issue.

Two days later in July 2015, during discussion with the SDM #2, RPN #115 indicated that Resident #001 was always able to undo the magnetic seat belt and that it was not intended to restrain the Resident. RPN #115 also indicated that when the Resident is sitting in his/her wheelchair, he/she wears a magnetic seat belt alarm, sits on a chair alarm and staff conducts 30 minute security checks. RPN #115 further indicated to SDM #2 that she would prefer not to initiate a seat belt restraint due to the potential risk of increased Resident behaviours as well as possible injury. According to a progress note dated two days after this meeting in July 2015, RPN #115 told SDM #2 of an incident that had occurred previously with another Resident who had a seat belt restraint, fallen and was injured. SDM #2 subsequently agreed not to use a seat belt restraint and asked that the evening nurse continue to monitor the Resident's behaviour in the evening when it was more likely that the Resident would get out of his/her wheelchair.

A review of Resident #001's July 1 – 31, 2015 plan of care to mitigate falls when in his/her wheelchair included (a) gather information on past falls and attempt to determine the cause of falls, anticipate and intervene to prevent recurrence (b) administer prescribed chemical restraint daily and observe, document and notify MD of any drug related complications, ongoing usage etc (c) personal items and call bell

within reach, encourage Resident to use it for assistance and respond promptly (d) physiotherapy (e) wear hip protectors (f) scheduled toileting program (g) chair alarm (h) magnetic seat belt alarm (i) seat Resident in common area. (j) security checks every 30 minutes for safety, comfort and well-being.

- In August 2015 the Resident #001 undid his/her magnetic seat belt alarm several times, made multiple attempts to stand up from his/her wheelchair, was observed walking in the hallway, unsteady on his/her feet, wandering into other Resident's rooms and remained at high risk for falls from his/her wheelchair (Progress notes on 6 identified dates in August 2015).

On a specified date in August 2015 at the beginning of the evening shift, Resident #001 was found on the floor near his/her bathroom door with the chair alarm activated. The Resident had not sustained any injury. A review of the PSW Observational Flow Sheet indicated that the Resident had been toileted during the day shift. Discussion with RPN #118 who indicated to Inspector #161 that the Resident had been sitting in his/her wheelchair prior to finding the Resident on the floor. A Post Fall assessment was conducted and no injuries were noted.

A review of Resident #001's August 1 – 31, 2015 plan of care to mitigate falls when in his/her wheelchair included (a) gather information on past falls and attempt to determine the cause of falls, anticipate and intervene to prevent recurrence (b) administer prescribed chemical restraint daily and observe, document and notify MD of any drug related complications, ongoing usage etc (c) personal items and call bell within reach, encourage Resident to use it for assistance and respond promptly (d) physiotherapy (e) wear hip protectors (f) scheduled toileting program (g) chair alarm (h) magnetic seat belt alarm (i) seat Resident in common area. (j) security checks every 30 minutes for safety, comfort and well-being. There were no changes from the July 2015 plan of care despite the Resident's ongoing fall risk behaviours and subsequent fall on a specified date in August 2015.

- In September 2015 the Resident #001 undid his/her magnetic seat belt alarm several times, made multiple attempts to stand up from his/her wheelchair, was observed standing at his/her wheel chair, unsteady on his/her feet, self-transferred from his/her wheelchair, and remained at high risk for falls from his/her wheelchair (Progress notes on 4 specified dates in September 2015).

On a specified date in September 2015 PSW #108 notified RPN #106 that Resident #001 had transferred himself/herself from his/her wheelchair to a couch in the lounge

and that the Resident knew how to undo his/her magnetic seat belt alarm. RPN #106 was concerned that this intervention was not effective and brought his/her concerns to nursing management. The Residents plan of care was not revised when the magnetic seat belt alarm was known to be ineffective.

Four days later, Resident #001 was in the hallway, sitting in his/her wheelchair with a magnetic seat belt alarm in place. The Resident undid the magnetic seat belt alarm, stood up, held onto the hallway hand rail and fell to the floor. The magnetic seat belt alarm was activated, and an audible alarm was heard by a PSW who ran to assist the Resident. Resident #001 was lying on the floor by the time the PSW arrived. RPN #106 was immediately notified by PSW #108 and came to assess the Resident. Resident #001 was complaining of severe pain in his/her left hip and was observed to have a skin tear on his/her left elbow. An ambulance was called and the Resident was transferred to hospital where he/she was diagnosed with two fractures. The Resident #001 underwent surgical repair of his/her fractures and was transferred back to the home on a specified date in September 2015.

A review of Resident #001's September 1, 2015 – to the date of the fall in September 2015 that resulted in 2 fractures, the Resident's plan of care to mitigate falls when in his/her wheelchair included (a) gather information on past falls and attempt to determine the cause of falls, anticipate and intervene to prevent recurrence (b) administer prescribed chemical restraint daily and observe, document and notify MD of any drug related complications, ongoing usage etc (c) personal items and call bell within reach, encourage Resident to use it for assistance and respond promptly (d) physiotherapy (e) wear hip protectors (f) scheduled toileting program (g) chair alarm (h) magnetic seat belt alarm (i) seat Resident in common area. (j) security checks every 30 minutes for safety, comfort and well-being. There were no changes from the August 2015 plan of care despite the Resident's ongoing fall risk behaviours, his/her fall from his/her wheelchair on a specified date in August 2015 and that on a specified date in September 2015, four days before the Resident fell and sustained two fractures, staff had reported that the Resident knew how to undo his/her magnetic seat belt alarm.

On November 9, 2015 discussion held with PSW #108 who provided care to Resident #001 on a specified date in September 2015. She indicated that she had provided routine morning care to the Resident, had transferred the Resident to his/her wheelchair, attached the magnetic seat belt alarm and brought the Resident to the dining room for breakfast. At 09:30 a.m. the PSW was returning to the resident care area and heard Resident #001's magnetic seat belt audible alert alarm and ran to

his/her aid. The Resident was lying on the floor when she arrived.

In summary, Resident #001 fell from his/her wheelchair on a specified date in May 2015 and on a specified date in August 2015. Despite the interventions in the Resident's plan of care, there were multiple episodes of the Resident attempting to get out of his/her wheelchair, getting out of his/her wheelchair and walking unassisted while unsteady on his/her feet. As such, the licensee failed to ensure that different approaches were considered when care set out for Resident #001 was not effective in mitigating falls when in his/her wheelchair.

A Compliance Order was issued based on the severity of actual harm to the Resident.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: 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 :

The licensee has failed to ensure that 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 to be complied with, in that the home failed to ensure compliance with the following policy

As per O.Reg79/10, s. 51 (1)3 the licensee failed to ensure that the protocol for bowel management was followed for Resident #001 in September 2015 and October 2015.

On November 3, 2015 Inspector #161 asked for and received from the DOC the home's Bowel and Bladder Management Program #HLHS-ECC-1.3 dated January 2012. This program contained the home's Bowel Protocol #HLHS-ECC-1.6 dated August 2011. The protocol was reviewed with the DOC who highlighted the bowel algorithm to be followed unless contraindicated by a physical or medical condition, as well as the bowel protocol interventions. According to the protocol, there are specific interventions to be followed depending on the number of days that a Resident has not had a bowel movement. The bowel movements of a Resident are recorded on the Resident's monthly PSW Observational Flow Sheet. When a specific bowel intervention as prescribed by the protocol is administered, the intervention is recorded on the Resident's Medication Administration Record (MAR).

Resident #001's plan of care was reviewed. According to the Medication Administration Records (MAR) from the Resident's date of admission on a specified date in April 2015 to a specified dated in October 2015, when the Resident was admitted to hospital, Resident #001 received a daily laxative, was on a restorative eating program in which staff encouraged the Resident to consume the prescribed food and fluids. The Resident's nutritional intake was monitored on a daily basis and assessed quarterly by the home's dietician. The Resident's activities of daily living including toilet use, bowel and bladder function were documented daily on the Resident's PSW Observational Flow Sheets.

On November 3, 2015 Inspector #161 asked for and received from the DOC the home's Bowel and Bladder Management Program #HLHS-ECC-1.3 dated January 2012. This program contained the home's Bowel Protocol #HLHS-ECC-1.6 dated August 2011. The protocol was reviewed with the DOC who highlighted the bowel algorithm to be followed unless contraindicated by a physical or medical condition, as well as the bowel protocol interventions. According to the protocol, there are specific interventions to be followed depending on the number of days that a Resident has not

had a bowel movement. The bowel movements of a Resident are recorded daily on the Resident's monthly PSW Observational Flow Sheet. When a specific bowel intervention as prescribed by the protocol is administered, the intervention is recorded on the Resident's MAR.

Resident #001's physician's orders from the beginning of September 2015 – end of October 2015 indicated that the attending physician had prescribed that the home's bowel protocol was to be followed. According to the protocol, if Resident #001 had not had a bowel movement after 1 day, on the following day, day 2, the Resident was to receive either ½ to 1 whole high fibre cookie. Inspector #161 and the DOC reviewed Resident #001's PSW Observational Flow Sheets for September 2015 and October 2015. The September 2015 flow sheet indicated that the Resident did not have a bowel movement on two consecutive dates in September 2015. A review of the Resident's MAR for September 2015 indicated that on the second consecutive date in September 2015, Resident #001 had not received a ½ to 1 whole high fibre cookie as per the home's bowel protocol for Day 2. A similar pattern was observed in October 2015. A review of the Resident's October 2015 flow sheet indicated that the Resident did not have a bowel movement on two consecutive dates in October 2015. A review of the Resident's MAR for October 2015 indicated that on the second consecutive date in October 2015, the Resident had not received a ½ to 1 whole high fibre cookie as per the home's bowel protocol for Day 2. On November 3, 2015 the DOC indicated that Resident #001 should have received the Day 2 intervention as prescribed by the bowel protocol. On December 17, 2015 during discussion with RPN #116, she indicated to Inspector #161 that she could not recall if she had listened to the Resident's abdomen for bowel sounds on October 24, 2015. She did recall that she had palpated the Resident's abdomen and that the Resident didn't indicate any discomfort; a review of the Resident's previous 48 hour fluid did not indicate any issues; she had reviewed the frequency of Resident #001's bowel movements recorded in the October 2015 PSW Observational Flow Sheets and believed that the Resident was not constipated but may have been developing a urinary tract infection. Based on her assessment of the Resident, RPN #116 did not follow the bowel protocol for Day 2.

As such, the licensee failed to ensure that the protocol for bowel management was followed for Resident #001 in September 2015 and October 2015.

Issued on this 22 day of December 2015 (A1)

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

Original report signed by the inspector.

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : KATHLEEN SMID (161) - (A1)

Inspection No. / No de l'inspection : 2015_384161_0020 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-002925-15 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Dec 22, 2015;(A1)

Licensee / Titulaire de permis :
Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner
2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6

LTC Home / Foyer de SLD :
GARDEN TERRACE
100 Aird Place, KANATA, ON, K2L-4H8

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : CAROLYN DELLA FORESTA

To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to achieve compliance to ensure that when care set out in the plan has not been effective, different approaches are considered in the revision of the plan including:

1. Reassessment of all Residents identified at risk for falls particularly from wheelchairs, to ensure the effectiveness of planned interventions to mitigate falls.

2. Staff responsible for providing direct care should communicate details of the ineffectiveness of the fall prevention intervention(s) to registered nursing staff immediately.

3. Different approaches are considered in the revision of the plan of care until approaches are effective.

4. When faced with Residents with ongoing, unresolved risk for falls, a plan for the interdisciplinary team to communicate in a consistent manner with the Substitute Decision Maker(s) to review all possible options in a timely manner as they work towards common goals.

5. Ensure that the interdisciplinary team uses ethically sound strategies with respect to decision making regarding the use of restraints.

6. Timelines are included (start and completion dates) for the above as well as the people responsible.

This plan must be submitted in writing to Kathleen Smid, LTCH Inspector Nursing at 347 Preston St., 4th floor, Ottawa ON K1S 3J4 OR by fax at 1.613.569.9670 on or before December 24, 2015

Grounds / Motifs :

1. The licensee failed to ensure that different approaches were considered when care set out for Resident #001 was not effective in mitigating falls when in his/ her wheelchair.

On a specified date in September 2015 a Critical Incident Report was submitted to

the Director for an incident that occurred on an earlier date in September 2015 in which Resident #001 fell from his/her wheelchair, sustained injuries and was sent to the hospital. On a specified date in October 2015 an INFOLINE Complaint Information Report was filed with the Ministry of Health and Long Term Care and referenced the Resident’s fall that occurred on the specified date in September 2015. Resident #001 had two people who were his/her Substitute Decisions Makers (SDM) and they are referred to throughout this report as SDM #1 and SDM #2.

On a specified date in April 2015 Resident #001 was admitted to the home with multiple diagnoses. Resident #001’s health care record was reviewed from the date of admission to a specified date in November 2015. There were numerous references in Resident #001’s progress notes of multiple attempts to get out of his/her wheelchair, standing up from the wheelchair, self-transfers and that he/she had fallen in May 2015 and in August 2015 from his/her wheelchair. On a specified date in September 2015 Resident #001 fell from his/her wheelchair, sustained two fractures and was sent to the hospital. The Resident was transferred back to the long-term care home on a specified date towards the end of September 2015.

Summary of Facts:

In May 2015 the Resident #001 made multiple attempts to stand up from his/her wheelchair, self- transfer and was observed to be weak, unsteady on his/her feet and at high risk for falls from his/her wheelchair (Progress notes on 4 identified dates in May 2015). On a specified date in late May 2015 the Resident slid from his/her wheelchair to the floor. The Resident did not sustain injury.

On a specified date in May 2015 Resident #001 was prescribed a medication to be administered daily. According to an interview on November 10, 2015 with the RAI Coordinator, she indicated that this prescribed medication was used as a Chemical Restraint to decrease the Resident’s agitation.

On a specified date in early May 2015 SDM #2 approached RPN #004 and expressed concern that when the Resident is sitting in his/her wheelchair, the Resident forgets that he/she cannot get up on his/her own and will fall. SDM #2 requested a table top as a restraint to prevent this from occurring. RPN #004 explained to SDM #2 the pros and cons of a table top restraint and suggested alternatives including scheduled toileting and the use of hip protectors. SDM #2 agreed to a trial of these alternatives.

On a specified date in late May 2015 SDM #2 expressed concern to RPN #119 regarding the Resident's risk of falls and requested a seat belt restraint be used. SDM #2 was also concerned that the Resident might remove the seat belt and thus asked for a table top to be used when the Resident was seated in his/her wheelchair. RPN #119 told the SDM that a physiotherapist seating assessment would be done.

A review of Resident #001's May 1 – 31, 2015 plan of care to mitigate falls when in his/her wheelchair included (a) gather information on past falls and attempt to determine the cause of falls, anticipate and intervene to prevent recurrence (b) administer prescribed chemical restraint daily and observe, document and notify MD of any drug related complications, ongoing usage etc (c) personal items and call bell within reach, encourage Resident to use it for assistance and respond promptly (d) physiotherapy (e) wear hip protectors (f) scheduled toileting program (g) security checks every 15 minutes for safety, comfort and well-being.

- In June 2015 Resident #001 made multiple attempts to stand up from his/her wheelchair, stood up from his/her wheelchair and was observed to be weak, unsteady on his/her feet and remained at high risk for falls from his/her wheelchair (Progress notes on 4 specified dates in June 2015).

On the morning of a specified date at the beginning of June 2015 the attending physician was telephoned by RPN #120 who asked for and received an order for a seat belt restraint to be worn when Resident #001 was seated in his/her wheelchair. Later on that day, Physiotherapist #105 telephoned SDM #2 to discuss the Resident's seating assessment. SDM #2 was upset regarding the Resident's fall from his/her wheelchair on a specified date in late May 2015 and asked the Physiotherapist for a seat belt restraint and table top to prevent Resident #001 from falling again. The Physiotherapist #105 suggested to SDM #2 that a chair alarm be used when the Resident sits in his/her wheelchair as well as have the Resident sit in a common area where there would be increased monitoring. Physiotherapist #105 informed SDM #2 of the risks of using restraints. SDM #2 indicated that now that she knew the risks she wanted the seat belt restraint discontinued immediately. Physiotherapist #105 informed the Assistant Director of Care (ADOC) of SDM #2's decision to discontinue the seat belt restraint immediately and to have a chair alarm installed on the Resident's wheelchair.

On a specified date in early June 2015 a meeting was held with SDM #2, the ADOC

and Physiotherapist #105 to discuss Resident #001's care and fall prevention strategies that at that time included (a) gather information on past falls and attempt to determine the cause of falls, anticipate and intervene to prevent recurrence (b) administer prescribed chemical restraint daily and observe, document and notify MD of any drug related complications, ongoing usage etc (c) personal items and call bell within reach, encourage Resident to use it for assistance and respond promptly (d) physiotherapy (e) wear hip protectors (f) scheduled toileting program (g) security checks every 15 minutes for safety, comfort and well-being.

On a specified date in June 2015 a progress noted indicated that Registered Nurse #121 reviewed with the DOC and the Clinical Care Coordinator, the frequency of security checks of the Resident with the aim of eventually discontinuing the security checks as the Resident's health had settled over the past few weeks. On a specified date in June 2015 the frequency of security checks was decreased from every 15 minutes to every 30 minutes.

On a specified date in June 2015 the DOC and a technician met with SDM #1 and showed him a magnetic seat belt alarm. SDM #1 consented to the use of the alarm which was subsequently attached to the Resident's wheelchair. A discussion was held on November 9, 2015 between Inspector #161 and staff members RPN #105 and Physiotherapist #105. They indicated that the magnetic seat belt alarm was not designed to restrain or hold Resident #001 in his/her wheelchair but was used as a reminder not to get up from his/her wheelchair.

A review of Resident #001's June 1 – 30, 2015 plan of care to mitigate falls when in his/her wheelchair included (a) gather information on past falls and attempt to determine the cause of falls, anticipate and intervene to prevent recurrence (b) administer prescribed chemical restraint daily and observe, document and notify MD of any drug related complications, ongoing usage etc (c) personal items and call bell within reach, encourage Resident to use it for assistance and respond promptly (d) physiotherapy (e) wear hip protectors (f) scheduled toileting program (g) chair alarm (h) magnetic seat belt alarm as of a specific date in June 2015 (i) seat Resident in common area. (j) security checks every 15 minutes and then this was decreased on a specified date in June 2015 to every 30 minutes for safety, comfort and well-being.

- In July 2015 the Resident #001 undid his/her magnetic seat belt alarm several times; he/she made multiple attempts to stand up from his/her wheelchair, he/she

kept getting up from his/her wheelchair and was observed walking in the hallway. The Resident was weak, unsteady on his/her feet and remained at high risk for falls from his/her wheelchair (Progress notes on 7 identified dates in July 2015).

On a specified date in July 2015 Resident #001 undid his/her magnetic seat belt alarm several times. SDM #2 met with RPN #114 to discuss her concerns regarding the Resident's ongoing behaviour of undoing his/her magnetic seat belt alarm and requested to talk with RPN #115 to see if there is a solution to resolve this issue.

Two days later in July 2015, during discussion with the SDM #2, RPN #115 indicated that Resident #001 was always able to undo the magnetic seat belt and that it was not intended to restrain the Resident. RPN #115 also indicated that when the Resident is sitting in his/her wheelchair, he/she wears a magnetic seat belt alarm, sits on a chair alarm and staff conducts 30 minute security checks. RPN #115 further indicated to SDM #2 that she would prefer not to initiate a seat belt restraint due to the potential risk of increased Resident behaviours as well as possible injury. According to a progress note dated two days after this meeting in July 2015, RPN #115 told SDM #2 of an incident that had occurred previously with another Resident who had a seat belt restraint, fallen and was injured. SDM #2 subsequently agreed not to use a seat belt restraint and asked that the evening nurse continue to monitor the Resident's behaviour in the evening when it was more likely that the Resident would get out of his/her wheelchair.

A review of Resident #001's July 1 – 31, 2015 plan of care to mitigate falls when in his/her wheelchair included (a) gather information on past falls and attempt to determine the cause of falls, anticipate and intervene to prevent recurrence (b) administer prescribed chemical restraint daily and observe, document and notify MD of any drug related complications, ongoing usage etc (c) personal items and call bell within reach, encourage Resident to use it for assistance and respond promptly (d) physiotherapy (e) wear hip protectors (f) scheduled toileting program (g) chair alarm (h) magnetic seat belt alarm (i) seat Resident in common area. (j) security checks every 30 minutes for safety, comfort and well-being.

- In August 2015 the Resident #001 undid his/her magnetic seat belt alarm several times, made multiple attempts to stand up from his/her wheelchair, was observed walking in the hallway, unsteady on his/her feet, wandering into other Resident's rooms and remained at high risk for falls from his/her wheelchair (Progress notes on 6 identified dates in August 2015).

On a specified date in August 2015 at the beginning of the evening shift, Resident #001 was found on the floor near his/her bathroom door with the chair alarm activated. The Resident had not sustained any injury. A review of the PSW Observational Flow Sheet indicated that the Resident had been toileted during the day shift. Discussion with RPN #118 who indicated to Inspector #161 that the Resident had been sitting in his/her wheelchair prior to finding the Resident on the floor. A Post Fall assessment was conducted and no injuries were noted.

A review of Resident #001's August 1 – 31, 2015 plan of care to mitigate falls when in his/her wheelchair included (a) gather information on past falls and attempt to determine the cause of falls, anticipate and intervene to prevent recurrence (b) administer prescribed chemical restraint daily and observe, document and notify MD of any drug related complications, ongoing usage etc (c) personal items and call bell within reach, encourage Resident to use it for assistance and respond promptly (d) physiotherapy (e) wear hip protectors (f) scheduled toileting program (g) chair alarm (h) magnetic seat belt alarm (i) seat Resident in common area. (j) security checks every 30 minutes for safety, comfort and well-being. There were no changes from the July 2015 plan of care despite the Resident's ongoing fall risk behaviours and subsequent fall on a specified date in August 2015.

- In September 2015 the Resident #001 undid his/her magnetic seat belt alarm several times, made multiple attempts to stand up from his/her wheelchair, was observed standing at his/her wheel chair, unsteady on his/her feet, self-transferred from his/her wheelchair, and remained at high risk for falls from his/her wheelchair (Progress notes on 4 specified dates in September 2015).

On a specified date in September 2015 PSW #108 notified RPN #106 that Resident #001 had transferred himself/herself from his/her wheelchair to a couch in the lounge and that the Resident knew how to undo his/her magnetic seat belt alarm. RPN #106 was concerned that this intervention was not effective and brought his/her concerns to nursing management. The Residents plan of care was not revised when the magnetic seat belt alarm was known to be ineffective.

Four days later, Resident #001 was in the hallway, sitting in his/her wheelchair with a magnetic seat belt alarm in place. The Resident undid the magnetic seat belt alarm, stood up, held onto the hallway hand rail and fell to the floor. The magnetic seat belt alarm was activated, and an audible alarm was heard by a PSW who ran to assist

the Resident. Resident #001 was lying on the floor by the time the PSW arrived. RPN #106 was immediately notified by PSW #108 and came to assess the Resident. Resident #001 was complaining of severe pain in his/her left hip and was observed to have a skin tear on his/her left elbow. An ambulance was called and the Resident was transferred to hospital where he/she was diagnosed with two fractures. The Resident #001 underwent surgical repair of his/her fractures and was transferred back to the home on a specified date in September 2015.

A review of Resident #001's September 1, 2015 – to the date of the fall in September 2015 that resulted in 2 fractures, the Resident's plan of care to mitigate falls when in his/her wheelchair included (a) gather information on past falls and attempt to determine the cause of falls, anticipate and intervene to prevent recurrence (b) administer prescribed chemical restraint daily and observe, document and notify MD of any drug related complications, ongoing usage etc (c) personal items and call bell within reach, encourage Resident to use it for assistance and respond promptly (d) physiotherapy (e) wear hip protectors (f) scheduled toileting program (g) chair alarm (h) magnetic seat belt alarm (i) seat Resident in common area. (j) security checks every 30 minutes for safety, comfort and well-being. There were no changes from the August 2015 plan of care despite the Resident's ongoing fall risk behaviours, his/her fall from his/her wheelchair on a specified date in August 2015 and that on a specified date in September 2015, four days before the Resident fell and sustained two fractures, staff had reported that the Resident knew how to undo his/her magnetic seat belt alarm.

On November 9, 2015 discussion held with PSW #108 who provided care to Resident #001 on a specified date in September 2015. She indicated that she had provided routine morning care to the Resident, had transferred the Resident to his/her wheelchair, attached the magnetic seat belt alarm and brought the Resident to the dining room for breakfast. At 09:30 a.m. the PSW was returning to the resident care area and heard Resident #001's magnetic seat belt audible alert alarm and ran to his/her aid. The Resident was lying on the floor when she arrived.

In summary, Resident #001 fell from his/her wheelchair on a specified date in May 2015 and on a specified date in August 2015. Despite the interventions in the Resident's plan of care, there were multiple episodes of the Resident attempting to get out of his/her wheelchair, getting out of his/her wheelchair and walking unassisted while unsteady on his/her feet. As such, the licensee failed to ensure that different approaches were considered when care set out for Resident #001 was not

effective in mitigating falls when in his/her wheelchair.

A Compliance Order was issued based on the severity of actual harm to the Resident.
(161)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jan 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22 day of December 2015 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : KATHLEEN SMID

Service Area Office / Bureau régional de services : Ottawa