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
Dec 6, 2016	2016_330573_0027	031872-16	Critical Incident System

Licensee/Titulaire de permis

Arnprior Regional Health
350 John Street North ARNPRIOR ON K7S 2P6

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

THE GROVE, ARNPRIOR AND DISTRICT NURSING HOME
275 IDA STREET NORTH ARNPRIOR ON K7S 3M7

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

ANANDRAJ NATARAJAN (573)

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): November 08, 09 and 10, 2016.

The following critical incident log #031872-16 was inspected related to an incident that causes an injury to a resident for which resident was transferred to hospital.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), RAI Coordinator, registered nurse (RN), registered practical nurses (RPN) and personal support workers (PSW).

The inspector reviewed Critical Incident (CI) reports, reviewed residents health record (including care plans, progress notes, medication administration records, PSW daily care documentation and Fall incident reports) and the home's written program for Fall Prevention and Management.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

s. 24. (10) When the care plan 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 care plan. O. Reg. 79/10, s. 24 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. Specifically in relation to (a) Resident's falls risk level and (b) Physical functioning and the type and level of assistance that is required relating to activities of daily living.

A Critical Incident Report (CIR) was submitted to the Director for an incident on specified date, that caused an injury to resident #001 for which the resident was taken to hospital and resulted in significant change in resident's health status. Further the CIR indicated that resident #001 deceased on a specified date, at the hospital.

On a specified date, Resident #001 was admitted for a specific type of care to the home with multiple diagnosis including history of recent falls and unsteady gait. At the time of admission resident #001 was on a specific drug for anticoagulant therapy. A review of resident #001's MDS assessment by the placement coordinator on a specified date prior to admission indicated that resident #001's cognitive skill for daily decision making was moderately impaired and identified a decline in resident #001's activities of daily living (ADL). The assessment indicated that resident #001 required increased need for cueing and supervision for ADLs including transfers. Further the assessment identified that the resident had two recent falls with injury and indicated that resident's transfers are getting more difficult and the resident's gait becoming more shuffled.

On November 08, 2016, Inspector #573 reviewed resident #001's nursing progress notes documentation at the time of admission, which indicated that resident #001 was unsteady on feet and was at high risk for falls. Upon review, resident #001's health care record (fall incident report / nursing progress notes) indicated that on two specified subsequent date

resident #001 was found on the floor outside the resident's bathroom and on the third day, resident was found on the floor near the nursing station with an injury. For the resident #001's second and third fall incident on a specified date, resident sustained injuries and was transferred to the hospital for further assessment.

On November 08, 2016, Inspector #573 reviewed resident #001's 24-hour admission written plan of care for transfers and mobility at the time of admission which indicated that resident #001 is independent without assistance and aids. Further the written plan of care for toileting did not identify the resident's physical functioning and the type and level of assistance required for toileting. Furthermore, the resident's fall risk level was not identified in the resident's 24-hour admission written plan of care at the time of admission was only added after the resident's second fall incident.

On November 08, 2016, during an interview with RPN #101, indicated to the Inspector #573 that resident #001 was admitted in the home with cognitive impairment. At the time of admission, resident #001 was observed with unsteady on feet with no mobility aid and was at high risk for falls.

Inspector #573 spoke with RN #102 who indicated to the inspector that the resident 24-hour admission written plan of care was developed based on the CCAC placement coordinator MDS assessment, resident's SDM information and resident's assessment for ADLs at the time of admission. She also indicated that registered nursing staff would complete a transfers assessment tool which is used to identify the resident's physical functioning and the type and level of assistance required for transfers and mobility for all residents admitted in home.

On November 09, 2016, during an interview, the home's DOC indicated to the inspector that the Registered Nursing staff will complete a fall risk assessment within 24 hours of resident admission and the resident's fall risk level will be identified in resident's written plan of care. Further she indicated that it is the home's expectation that registered nursing staff would complete a transfer assessment tool upon resident admission to the home.

On November 09, 2016, Inspector #573 reviewed resident #001's health records in the presence of the DOC. Upon review,
- the Inspector found that there was no fall risk assessment that was completed within 24 hours of the resident's admission. Further the resident's 24-hour admission written plan of care does not identify the resident's fall risk level.

- the Inspector found that at the time of admission, no transfer assessment tool was completed for resident #001.

Inspector reviewed resident #001's 24-hour admission written plan of care for transfers, mobility and toileting at the time of resident's admission in the presence of DOC. The DOC indicated to the inspector that the resident #001 written plan of care for resident transfers, mobility and toileting does not reflect the resident needs and further indicated resident #001's written plan of care was revised after resident's second fall incident on a specified date.

The care set out in the resident #001's 24-hour admission written plan of care was not based on an assessment of the resident needs in relation to falls risk level and the type and level of assistance that is required relating to resident #001's ADL. [s. 24. (4)]

2. The licensee failed to ensure that different approaches in the home's fall prevention program were considered when the care set out for resident #001 was not effective in mitigating falls when in her/his wheelchair.

A Critical Incident Report (CIR) was submitted to the Director for an incident on specified date, that caused an injury to resident #001 for which the resident was taken to hospital and resulted in significant change in resident's health status. Further the CIR indicated that resident #001 deceased on a specified date, at the hospital.

On a specified date, resident #001 was admitted for a specific type of care to the home with multiple diagnosis including history of recent falls and unsteady gait. At the time of admission, resident #001 was on a specific drug for anticoagulant therapy.

On November 08, 2016, Inspector #573 reviewed resident #001's health care records. From the day of resident #001's admission to the home, there were numerous references in resident #001's progress notes of her/his unsteady gait, self-transfers, standing up from her/his wheelchair and multiple attempts to get out of her/his wheelchair. On a specified date and time, resident #001 fell from her/his wheelchair, sustained injuries with the loss of consciousness. Resident #001 was immediately sent to the hospital for further assessment. Nursing progress notes indicated that resident #001 returned from the hospital on the following day.

Upon review of resident #001's health care records (written plan of care/ nursing progress notes/fall incident report) indicate:-

Fall incident (1) - on a specified date time, resident found on the floor outside the resident's bath room, unwitnessed fall with an injury. Immediate Actions: - vitals assessed, injury assessed and treated. Fall prevention intervention at the time of fall – (a) Ensure environment is free of clutter (b) Reinforce need to call for assistance (c) Resident to wear proper and non-slip footwear.

Fall incident (2) - The following day, resident found on the floor beside the resident's washroom, unwitnessed fall with unknown injury. Immediate Actions:-referred to Emergency department, Care plan reviewed / revised and risk of fall noted on the chart / care plan. Fall prevention interventions at the time of fall – (a) Ensure environment is free of clutter (b) Reinforce need to call for assistance (c) Resident to wear proper and non-slip footwear (d) Bed in lowest position at all times (e) Call bell in reach.

Fall incident (3) - on the third day, resident found on the floor, unwitnessed fall with injury and loss of consciousness. Resident #001 was immediately sent to the hospital for further assessment. Fall prevention interventions at the time of fall – (a) Wheel chair with brakes (b) Personal alarm on at all time when resident in bed /chair (c) Resident situated close to the nursing station (d) Bed in lowest position at all times (e) Check q1h to ensure safety.

On November 08, 2016, during an interview with RPN #101, indicated to the Inspector #573 that resident #001 was admitted in the home with cognitive impairment. At the time of admission, resident #001 was observed to be unsteady on feet and was at high risk for falls. The RPN #101 indicated to the inspector that in spite, of the use of wheel chair with the tab alarm and staff frequent monitoring, resident #001 was constantly attempting to get out of her/his wheelchair and remained at high risk for falls.

On November 09, 2016, Inspector spoke with RN #102 who indicated to the inspector that resident #001 was at high risk for falls. Further the RN #102 indicated to the inspector, that considering resident #001's frequent falls, the fall prevention interventions and strategies in place for resident #001 were not effective.

On November 09, 2016, during an interview the DOC indicated to inspector that when resident #001's fall prevention interventions in place were not effective, the staff failed to consider different intervention and strategies to reduce resident #001's risk for falls as per the home's fall prevention program.

In summary, on a specified date resident #001 fell from her/his wheelchair, sustained injuries with the loss of consciousness. Despite the interventions in resident #001's plan of care, there were multiple episodes of the resident walking unassisted while unsteady on her/his feet, standing up from her/his wheelchair and multiple attempts to get out of her/his wheelchair. 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 her/his wheelchair.

A Compliance Order was issued based on the severity of actual harm to the Resident. [s. 24. (10)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 care set out in the 24-hour admission written plan of care is based on resident's assessed condition, fall history, needs, behaviours and preferences, to be implemented voluntarily.

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 :

1. The licensee failed to ensure that the home's policy "Falls Prevention and Management" was complied with.

According to O.Reg 79/10, s. 48 (1) 2, 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.

A review of the home's Falls Prevention Policy # VI-G-10.58, revision date June 2016, under procedure, Section A: Fall prevention indicates that the registered Nursing staff are to do the following:
- On admission complete Fall Risk Assessment on Point Click Care (PCC). Determine the resident's level of risk as low or high. Any risk should be care planned and treated.
- Initiate a written plan of care within 24 hours of admission based on resident's assessed condition, fall history, needs, behaviours and preferences using the intervention/ Strategies to reduce the risk of falls (Appendix B) as a guide.

A review of Appendix B: Interventions/ strategies to reduce risk for falls indicated that staff "must do" all the strategies listed for low and high falls risk. Further it indicated that for high fall risk staff will consider doing the following Interventions/ strategies listed below:
- Hip Protectors
- Reviewing the need for bed rail use (caution; if the intent is to restrain, the bed rail will be considered a restraint)
- Strongly recommending involvement in an exercise program
- Utilizing alternatives to using restraints
- Collaborating with resident POA/ SDM – engage in fall prevention strategies as able (one on one, Stagger visits)

Under Section B: Fall and Post fall Assessment and Management indicates that the registered Nursing staff are too:
- Initiate Head Injury Routine (HIR) for all falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy.
- For unwitnessed falls, complete the Glasgow Coma Scale of shift for 72 hours
- Complete incident report in RL6 solutions and Post Fall Huddle (Appendix D)

A Critical Incident Report (CIR) was submitted to the Director for an incident on specified date, that caused an injury to resident #001 for which the resident was taken to hospital and resulted in significant change in resident's health status. Further the CIR indicated that resident #001 deceased on a specified date, at the hospital.

On a specified date, Resident #001 was admitted for a specific type of care to the home with multiple diagnosis including history of recent falls and unsteady gait. At the time of admission, resident #001 was on a specific drug for anticoagulant therapy.

On November 08, 2016, Inspector #573 reviewed resident #001's nursing progress notes documentation at the time of admission on a specified date, indicated that resident #001 was unsteady on her/his feet and was at high risk for falls. Upon review, resident #001's health care record (written plan of care /fall incident report / nursing progress notes) indicates -

Fall incident (1) - on a specified date time, resident found on the floor outside the resident's bath room, unwitnessed fall with an injury. Immediate Actions: - vitals assessed, injury assessed and treated. Fall prevention intervention at the time of fall – (a) Ensure environment is free of clutter (b) Reinforce need to call for assistance (c) Resident to wear proper and non-slip footwear.

Fall incident (2) - The following day, resident found on the floor beside the resident's washroom, unwitnessed fall with unknown injury. Immediate Actions:-referred to Emergency department, Care plan reviewed / revised and risk of fall noted on the chart / care plan. Fall prevention interventions at the time of fall – (a) Ensure environment is free of clutter (b) Reinforce need to call for assistance (c) Resident to wear proper and non-slip footwear (d) Bed in lowest position at all times (e) Call bell in reach.

Fall incident (3) - on the third day, resident found on the floor, unwitnessed fall with loss of consciousness and injuries. Resident #001 was immediately sent to the hospital for further assessment. Fall prevention interventions at the time of fall – (a) Wheel chair with brakes (b) Personal alarm on at all time when resident in bed /chair (c) Resident situated close to the nursing station (d) Bed in lowest position at all times (e) Check q1h to ensure safety.

On November 09, 2016, Inspector spoke with RN #102 who indicated to the inspector that resident #001 was high risk for falls. The RN #102 indicated that for each of the resident's fall, the home's process is that registered nursing staff would complete a post huddle assessment tool and staff would discuss and implement possible fall prevention interventions. Further the RN #102 indicated to the inspector, considering resident #001's frequent falls, the fall prevention interventions and strategies in place for resident #001 were not effective.

During this Inspection, Inspector #573 spoke with the Director of Care, who indicated that the Registered Nursing staff will complete a fall risk assessment within 24 hours of resident admission and the resident's fall risk level will be identified in resident's written plan of care. The DOC indicated that registered nursing staff are expected to complete a Post Fall Huddle tool for every resident's fall, which helps in the implementation of fall prevention interventions. Further she indicated that in the event of an unwitnessed fall, head injury are to be assessed and neuro vital signs for the resident are to be taken as per the home's policy.

Inspector #573 reviewed resident #001's health records in the presence of the DOC. Upon review, the Inspector found that there was no fall risk assessment that was completed within 24 hours of the resident's admission. The resident's fall risk level was not identified in the resident's written plan of care at the time of admission and after the first fall, but was only added after the resident's second fall incident on a specified date. Further the assessment for the Head Injury Routine/ Glasgow Coma Scale of shift for 72 hours for resident #001's unwitnessed falls was not found in resident record health records. The DOC was unable to find the completed Post Fall Huddle tool for resident #001's falls, as per the policy.

On November 09, 2016, during an interview with the DOC indicated to inspector that when resident #001's fall prevention interventions in place were not effective, the staff failed to consider different fall prevention interventions. Further she indicated that staff did not explore other possible interventions and strategies to reduce resident #001's risk for falls as per the home's fall prevention program. [s. 8. (1) (a),s. 8. (1) (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 home's policy "Falls Prevention and Management" was complied with specifically in relation to a) Fall Risk Assessment b) Head Injury Routine (HIR) /Glasgow Coma Scale c) Post Fall Huddle for every resident's fall, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

A Critical Incident Report (CIR) was submitted to the Director for an incident on specified date, that caused an injury to resident #001 for which the resident was taken to hospital and resulted in significant change in resident's health status. Further the CIR indicated that resident #001 deceased on a specified date, at the hospital.

On a specific date and time, resident #001 fell from her/his wheelchair sustained injury with the loss of consciousness. Resident #001 was immediately sent to the hospital for further assessment. Nursing progress notes documentation on the following day, indicated that resident #001 returned from the hospital.

On November 10, 2016, Inspector #573 spoke with home's DOC who indicated that resident #001's fall resulted in a significant change in the resident's health status.

The Licensee informed the Director through the Critical Incident Reporting System on a specified date and time, which is eight business days after the Licensee became aware of the significant change in the resident #001's health status. [s. 107. (3)]

Issued on this 7th day of December, 2016

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

Original report signed by the inspector.

Ontario

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

Ministére 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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ANANDRAJ NATARAJAN (573)
Inspection No. / No de l'inspection :	2016_330573_0027
Log No. / Registre no:	031872-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 6, 2016
Licensee / Titulaire de permis :	Arnprior Regional Health 350 John Street North, ARNPRIOR, ON, K7S-2P6
LTC Home / Foyer de SLD :	THE GROVE, ARNPRIOR AND DISTRICT NURSING HOME 275 IDA STREET NORTH, ARNPRIOR, ON, K7S-3M7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Eric Hanna

To Arnprior Regional Health, 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (10) When the care plan 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 care plan. O. Reg. 79/10, s. 24 (10).

Order / Ordre :

The licensee is hereby ordered to:

1) Reassess all residents identified at medium and high risk for falls to ensure that the planned interventions are effective in mitigating the risk for falls.

2) To consider different approaches in the revision of the planned interventions, as per the home's Falls Prevention and Management policy, when the care set out in the plan is not effective. This process should be supported by an interdisciplinary health care team through timely, consistent communication and careful coordination of care interventions.

3) Re- train all staff who provide direct care to the residents on the home's policy of "Falls Prevention and Management" with an emphasis on clarifying the roles and responsibilities of each discipline within the health care team when implementing interventions to mitigate risks for falls for residents who repeatedly fall.

Grounds / Motifs :

1. The licensee failed to ensure that different approaches in the home's fall prevention program were considered when the care set out for resident #001 was not effective in mitigating falls when in her/his wheelchair.

A Critical Incident Report (CIR) was submitted to the Director for an incident on specified date, that caused an injury to resident #001 for which the resident was taken to hospital and resulted in significant change in resident's health status. Further the CIR indicated that resident #001 deceased on a specified date, at

the hospital.

On a specified date, resident #001 was admitted for a specific type of care to the home with multiple diagnosis including history of recent falls and unsteady gait. At the time of admission, resident #001 was on a specific drug for anticoagulant therapy.

On November 08, 2016, Inspector #573 reviewed resident #001's health care records. From the day of resident #001's admission to the home, there were numerous references in resident #001's progress notes of her/his unsteady gait, self-transfers, standing up from her/his wheelchair and multiple attempts to get out of her/his wheelchair. On a specified date and time, resident #001 fell from her/his wheelchair, sustained injuries with the loss of consciousness. Resident #001 was immediately sent to the hospital for further assessment. Nursing progress notes indicated that resident #001 returned from the hospital on the following day.

Upon review of resident #001's health care records (written plan of care/ nursing progress notes/fall incident report) indicate:-

Fall incident (1) - on a specified date time, resident found on the floor outside the resident's bath room, unwitnessed fall with an injury. Immediate Actions: - vitals assessed, injury assessed and treated. Fall prevention intervention at the time of fall – (a) Ensure environment is free of clutter (b) Reinforce need to call for assistance (c) Resident to wear proper and non-slip footwear.

Fall incident (2) - The following day, resident found on the floor beside the resident's washroom, unwitnessed fall with unknown injury. Immediate Actions:- referred to Emergency department, Care plan reviewed / revised and risk of fall noted on the chart / care plan. Fall prevention interventions at the time of fall – (a) Ensure environment is free of clutter (b) Reinforce need to call for assistance (c) Resident to wear proper and non-slip footwear (d) Bed in lowest position at all times (e) Call bell in reach.

Fall incident (3) - on the third day, resident found on the floor, unwitnessed fall with injury and loss of consciousness. Resident #001 was immediately sent to the hospital for further assessment. Fall prevention interventions at the time of fall – (a) Wheel chair with brakes (b) Personal alarm on at all time when resident in bed /chair (c) Resident situated close to the nursing station (d) Bed in lowest

position at all times (e) Check q1h to ensure safety.

On November 08, 2016, during an interview with RPN #101, indicated to the Inspector #573 that resident #001 was admitted in the home with cognitive impairment. At the time of admission, resident #001 was observed to be unsteady on feet and was at high risk for falls. The RPN #101 indicated to the inspector that in spite, of the use of wheel chair with the tab alarm and staff frequent monitoring, resident #001 was constantly attempting to get out of her/his wheelchair and remained at high risk for falls.

On November 09, 2016, Inspector spoke with RN #102 who indicated to the inspector that resident #001 was at high risk for falls. Further the RN #102 indicated to the inspector, that considering resident #001's frequent falls, the fall prevention interventions and strategies in place for resident #001 were not effective.

On November 09, 2016, during an interview the DOC indicated to inspector that when resident #001's fall prevention interventions in place were not effective, the staff failed to consider different intervention and strategies to reduce resident #001's risk for falls as per the home's fall prevention program.

In summary, on a specified date resident #001 fell from her/his wheelchair, sustained injuries with the loss of consciousness. Despite the interventions in resident #001's plan of care, there were multiple episodes of the resident walking unassisted while unsteady on her/his feet, standing up from her/his wheelchair and multiple attempts to get out of her/his wheelchair. 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 her/his wheelchair.

A Compliance Order was issued based on the severity of actual harm to the Resident.
(573)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2017

Ontario

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

Ministére 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

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 6th day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Anandraj Natarajan

Service Area Office /
Bureau régional de services : Ottawa Service Area Office