Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Nov 22, 2019	2019_815623_0017	012990-19, 014870-19, 015048-19, 016870-19, 017770-19, 017771-19, 017772-19, 017773-19, 017774-19, 019168-19	Complaint

Licensee/Titulaire de permis

Regional Municipality of Durham
605 Rossland Road East WHITBY ON L1N 6A3

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

Hillsdale Estates
590 Oshawa Blvd. North OSHAWA ON L1G 5T9

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

SARAH GILLIS (623), JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 15, 16, 17, 18, 21, 22, 23, 2019

During the course of the inspection the following intake were inspected:
Complaint Log #012990-19, 015048-19, 017770-19, 017771-19, 017772-19, 017773-19, 017774-19, 019168-19 related to bed refusals.
Complaint Log #014870-19 related to a fall resulting in injury.
Complaint Log #016870-19 related to improper transfers.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), Resident Care Coordinator (RCC), Social Worker (SW), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Manager of Nurse Practice, Administrative Assistant, Occupational Therapist (OT), Occupational Therapy Assistant (OTA), Physiotherapist (PT), residents and families.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Falls Prevention
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. Under the LTCHA, 2007, s. 44(7) the appropriate placement coordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43(6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless, (a) the home lacked the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances existed which were provided for in the regulations as being a ground for withholding approval.

Related to complaint Log #012990-19

A complaint was received by the Director on a specified date from the Central East Local

Health Integration Network (CELHIN) Case Manager for applicant #018 challenging the bed refusal for admission to Hillsdale Estates LTCH located in Oshawa, Ontario.

Review of the applicant's refusal letter for admission indicated that the home lacked the nursing expertise to meet the applicants care requirements. The explanation provided by the licensee in the refusal letter indicated that the resident requires the use of a specific medical device to receive treatment. The nursing staff are not equipped to provide care for this treatment. This letter was written by the Social Worker.

During an interview with Inspector #623, the Social Worker (SW) #112 indicated that they reviewed the application for admission for applicant #018. The SW indicated that they were not familiar with the medical device that the applicant had, therefore the application was referred to the Director of Care (DOC) to review. The SW indicated that they understood that the DOC made the decision that this applicant could not be supported in the home based on the existing medical device. The SW indicated that they did not do the research on the device itself, this was completed by the DOC and was a nursing decision. The SW indicated that they write the letter to the applicant and include the reason for refusal that is provided by the DOC.

During an interview with Inspector #623, the DOC indicated that they declined the application for admission for applicant #018 based on the last update that the home received from the CELHIN which indicated that a specific medical device was being used and not just maintained. The DOC felt that it could not be safely supported in the home. The DOC indicated that if the specific device was just being maintained, then it could be supported. The DOC indicated that they were unsure of why applicant #018 required the specific medical device but felt that there were not enough registered nursing staff with the skill-set and knowledge to look after it.

The documented evidence provided by the licensee did not support how the home lacked the nursing expertise or did not have the necessary resources to meet the applicant's care requirements.

Related to complaint Log #015048-19

A complaint was received by the Director on a specified date from the Central East Local Health Integration Network (CELHIN) Case Manager for applicant #019 challenging the bed refusal for admission to Hillsdale Estates LTCH located in Oshawa, Ontario. The Case Manager indicated that the rejection was based on behaviours that occurred more

than six months prior to the application being declined.

Review of the applicant's refusal letter for admission indicated that the home lacked the nursing expertise to meet the applicants care requirements. The explanation provided by the licensee in the refusal letter indicated that the behavioural assessment and history from Lakeridge Health indicated that the resident had been admitted to hospital in on a specified date in an acute medical crisis and they remained in the hospital for a specified period of time. The applicant exhibited specific identified responsive behaviours. The application was withheld because the nursing staff lack the expertise to care for complex mental health issues and the licensee is required to provide a safe environment for all residents. This letter was written by the Social Worker.

During an interview with Inspector #623, the Social Worker (SW) #112 indicated that they reviewed the application for admission for applicant #019. The SW indicated that when an applicant exhibits responsive behavoiurs that are due to a specific diagnosis, this is very different than responsive behaviours. The SW indicated that a specific diagnosis is an issue that could not be managed in the home. The SW was unable to provide details regarding when applicant #019's behavoiurs had occurred or if they were still occurring. The SW indicated that the application was declined as directed by the DOC.

During an interview with Inspector #623, the Director of Care indicated that applicant #019 was declined for the wait list based on information which indicated the applicant was receiving sedation and no longer exhibiting responsive behaviours. The applicant had specific identified diagnosis. The DOC indicated that staffing ratios at the hospital and at Ontario Shores are smaller than can be offered in the LTC Home and the home cannot provided that ratio. The DOC indicated that the specific identified diagnoses are different from responsive behavoiurs and staff area not trained to manage them. The DOC indicated that there was no mention in the application that applicant #019 would require enhanced monitoring. The DOC indicated that the application indicated that the applicant was readmitted to Lakeridge Health (LH) Oshawa after being discharge from the hospital. The DOC confirmed that there is a Behavioural Support Ontario (BSO) team in the home and that external support is available through Ontario Shores if required to assist with residents who exhibit responsive behaviours.

The documented evidence provided by the licensee did not support how the home lacked the nursing expertise or did not have the necessary resources to meet the applicant's care requirements.

Related to complaint Log #017770-19

A complaint was received by the Director on a specified date from the Central East Local Health Integration Network (CELHIN) Case Manager for applicant #022 challenging the bed refusal for admission to Hillsdale Estates LTCH located in Oshawa, Ontario.

Review of the applicant's refusal letter for admission indicated that the home lacked the nursing expertise to meet the applicants care requirements. The explanation provided by the licensee in the refusal letter indicated that the applicant has specific challenges and the nurses and Personal Support Workers in the home are not trained and do not have the specific expertise to provide care for the resident. This letter was written by the Social Worker.

During an interview with Inspector #623, the Social Worker #114 indicated that applicant #022 was declined to the waitlist because they had a history of specific identified behaviours. The applicant spent many years in Ontario Shores following the incident and were non-compliant with medications during that time. The applicant currently resides in the community and the information provided with the application indicated that there has been no behaviours exhibited in decades. The SW indicated that they wrote the letter as instructed by the DOC and they were unable to indicate the reason for the refusal.

During an interview with Inspector #623, the DOC indicated that the applicants history sets off red flags for admission to LTC even though it was many years ago. The DOC indicated that the applicant has had a specific identified diagnosis. The behavioural assessment also indicated that the applicant experiences specific responsive behaviours. The DOC indicated that the ratio of staff in the home on the night shift would make it difficult to manage specific behaviours. The DOC indicated that specific identified diagnosis are different from responsive behaviour. The DOC confirmed that there are other residents in the home with the same diagnosis who are stable and managed. The DOC also confirmed that residents who have specific identified diagnosis have been admitted to the home in the past.

The documented evidence provided by the licensee did not support how the home lacked the nursing expertise or did not have the necessary resources to meet the applicant's care requirements.

Related to complaint Log #017771-19

A complaint was received by the Director from the Central East Local Health Integration Network (CELHIN) Case Manager for applicant #021 challenging the bed refusal for admission to Hillsdale Estates LTCH located in Oshawa, Ontario.

Review of the applicant's refusal letter for admission indicated that the home lacked the nursing expertise to meet the applicants care requirements. The explanation provided by the licensee in the refusal letter indicated that documentation provided by the hospital identified specific behavioural needs that the home lacks the staffing to support. This letter was written by the Social Worker.

During an interview with Inspector #623, the Social Worker #114 indicated that applicant #021 was declined approval for the homes wait list because their responsive behaviours required more staffing than the home can support. The Social Worker indicated that the home has a BSO team and almost every day there is someone in the building from that team. The team consists of 2 PSWs and an RPN. External resources are available as well that include the Psychiatric Resource Consultant (PRC) and the Ontario Shores team also provide support to the home to assist with managing responsive behaviours. The Social Worker indicated that there are many staff in the home who also have training on PIECES, Gentle Persuasive Approach (GPA).

During an interview with Inspector #623, the Director of Care indicated that after reviewing the application, they are unable to provide the Inspector with a reason why the application was refused. The DOC indicated that there are some identified triggers that with approach could be managed and the applicant has a specific diagnosis which does have some concerns, it requires a different approach in how it is managed. The DOC confirmed that there are internal resources including Behavioual Support Ontario (BSO) to assist with a plan if necessary and many staff have received PIECES, GPA training as well as external resources are also available.

The documented evidence provided by the licensee did not support how the home lacked the nursing expertise or did not have the necessary resources to meet the applicant's care requirements.

Related to Complaint Log #017772-19

A complaint was received by the Director from the Central East Local Health Integration Network (CELHIN) Case Manager for resident #024 challenging the bed refusal for admission to Hillsdale Estates LTCH located in Oshawa, Ontario.

Review of the applicant's refusal letter for admission indicated that the home lacked the nursing expertise to meet the applicants care requirements. The explanation provided by the licensee in the refusal letter indicated that a behavioural assessment indicated the applicant exhibits specific identified responsive behavoiurs. The applicant would require a secured area and the types of behaviours they exhibit could be a trigger to other residents.

During an interview with Inspector #623, the Social Worker #114 indicated that they were instructed by the DOC to decline the application of applicant #024 for the waiting list on the basis that the home could not provide a secured area for the applicant and other residents to live harmoniously based on identified behaviours.

During an interview with Inspector #623, the DOC indicated that the application for admission for applicant #024 was declined based on the information that was provided in the behaviour assessment. The assessment indicated that applicant #024 had a specific diagnosis and they exhibited specific responsive behaviours that were unpredictable and at all hours of the day. They experienced episodes of specific behavours that could last 30 to 60 minutes several times a day. The behaviour assessment also indicated that the applicant will get upset if visitors try to leave and will attempt to follow, requiring a secured unit. The DOC indicated that the home has a secured unit and there are internal and external resources available to support responsive behaviours but did not feel that they could manage applicant #024's behaviours in the home.

The documented evidence provided by the licensee did not support how the home lacked the nursing expertise or did not have the necessary resources to meet the applicant's care requirements.

Related to Complaint Log #017773-19

A complaint was received by the Director from the Central East Local Health Integration Network (CELHIN) Case Manager for applicant #019 challenging the bed refusal for admission to Hillsdale Estates LTCH located in Oshawa, Ontario.

Review of the applicant's refusal letter for admission indicated that the home lacked the nursing expertise to meet the applicants care requirements. The explanation provided by the licensee in the refusal letter indicated that the resident was identified as experiencing specific identified challenges. Nurses and Personal Support Workers in the home do not

have the expertise to provide care for the applicant. This letter was written by the Social Worker.

During an interview with Inspector #623, the Social Worker indicated that applicant #019 had specific identified challenges. The applicant had specific identified diagnosis and responsive behaviours. The Social Worker indicated that historically there have been other residents in the home with the identified diagnosis and they could not speak to why this application would be refused. The Social Worker indicated that all applications that have identified responsive behaviours or medical concerns that are beyond the typical application, are given to the DOC for review and the DOC makes the final decision. The Social Worker indicated that the letters are written with the reason for refusal that is provided by the DOC after the application has been reviewed.

During an interview with Inspector #623, the DOC indicated that the refusal letter for applicant #019 does not provide details to support the decision. The DOC indicated that this application was refused due to specific identified responsive behaviours. The DOC indicated that specific diagnosis and the responsive behaviours are managed very differently. The DOC indicated that the ratio of staff to resident in LTC makes it difficult to manage the mix of the specific diagnosis and responsive behaviours.

The documented evidence provided by the licensee did not support how the home lacked the nursing expertise or did not have the necessary resources to meet the applicant's care requirements.

Related to Complaint Log #017774-19

A complaint was received by the Director from the Central East Local Health Integration Network (CELHIN) Case Manager for resident #023 challenging the bed refusal for admission to Hillsdale Estates LTCH located in Oshawa, Ontario.

Review of the applicant's refusal letter for admission indicated that the home lacked the nursing expertise to meet the applicants care requirements. The explanation provided by the licensee in the refusal letter indicated that identified behaviours from the initial application (original refusal) were still noted to be present in the current application. The letter indicated that the documentation provided for review indicated that the applicant required close observation, displayed specific responsive behaviours. The behavioural challenges were not within the scope of the nursing expertise in the home and they could not safely support the care requirements.

During an interview with Inspector #623, the Social Worker indicated that applicant #023 was refused because identified behaviours were still present following the initial applications. The Social Worker indicated that they were told this was unusual behaviour. The SW indicated that the applicant has specific identified diagnosis.

During an interview with Inspector #623, the DOC indicated that the application for admission of applicant #023 was declined due to concerns about the applicant exhibiting specific identified responsive behaviour. The applicant had a specific identified diagnosis and exhibit specific behaviours and it was felt that this could be a trigger for other residents in the home. The DOC indicated that there is a BSO team active in the home and that there are external resources available to assist staff with managing challenging responsive behaviours.

The documented evidence provided by the licensee did not support how the home lacked the nursing expertise or did not have the necessary resources to meet the applicant's care requirements.

Related to Complaint Log #019168-19

A complaint was received by the Director from the Central East Local Health Integration Network (CELHIN) Case Manager for resident #017 challenging the bed refusal for admission to Hillsdale Estates LTCH located in Oshawa, Ontario. The resident was initially approved to the wait-list but when a bed match was made the application was refused.

Review of the applicant's refusal letter for admission indicated that the home lacked the nursing expertise to meet the applicants care requirements. The explanation provided by the licensee in the refusal letter indicated that a new Behavioural Assessment was received that indicated the resident currently resided in another Long-term Care home and was exhibiting responsive behaviours towards other residents that were triggered by the other residents. The letter also indicated that the resident would require a secured unit due to exit seeking, and the secured unit in Hillsdale Estates was an environment that would pose many triggers to the types of behaviours noted on the assessment. This letter was signed by the social worker.

During an interview with Inspector #623, the Social Worker indicated that the current vacancy applicant #017 was matched to was not in the secured home area. The SW

indicated that the applicant's behaviour would be a challenge in the secured unit given the current population. The SW indicated that the DOC had not decided about this particular application at the time the bed offer was to be made, so the application was refused to allow the CELHIN to make another bed offer. The SW indicated that the home does have a wander guard system on the front door of the home, but it is not reliable. The applicant is currently considered a crisis because they are exiting the LTC home that they presently live in. The current vacant bed at Hillsdale Estates is on the 3rd floor which would require the applicant to take an elevator to the main floor, but the home would not consider putting a resident on this unit that has exit seeking behaviour.

During an interview with Inspector #623, the DOC indicated that #017's application was refused because the applicant exhibited behaviours that would be a trigger to other residents who are in the current population in the secured unit. The applicant was supposed to be a crisis admission because they required a secured unit due to exit seeking behaviour. The DOC indicated that there is currently a BSO team in place in the home as well as Ontario Shores that can consult for challenging behaviours. The DOC indicated that they have concerns with the boundaries in the secured unit and that there could be a confrontation as a result. It was felt that the secured unit was not appropriate at this time. The DOC indicated that they would not consider applicant #017 for any other unit until the elevators were secured with a roam alert system, this is something that is being investigated for the home but is not currently available. The DOC indicated that there is a roam alert on the main floor doors but the system is not reliable because there is not always someone at reception to answer the alarm.

The documented evidence provided by the licensee did not support how the home lacked the nursing expertise or did not have the necessary resources to meet the applicant's care requirements. [s. 44. (7)]

2. s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to theapplicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

The licensee has failed to ensure that when withholding approval for admission, the licensee shall provide to persons described in subsection (10) a written notice setting out the the ground or grounds on which the licensee is withholding approval, a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care, an explanation of how the supporting facts justify the decision to withhold approval and contact information for the Director.

Related to complaint Log#012990-19, 015048-19, 017770-19, 017771-19, 017772-19, 017773-19, 017774-19, 019168-19

Complaints were received by the Director from the Central East Local Health Integration Network (CELHIN) Case Manager for applicant #017, #018, #019, #020, #021, #022, #023 and #024 challenging the bed refusal for admission to Hillsdale Estates LTCH located in Oshawa, Ontario.

Review of the refusal letters that were provided to applicants #017, #018, #019, #020, #021, #022, #023 and #024 was completed by Inspector #623. It was identified that the written notice did not set out the the ground or grounds on which the licensee is withholding approval, a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care, an explanation of how the supporting facts justify the decision to withhold approval and contact information for the Director.

During an interview with Inspector #623, the Social Worker #112 indicated that they are responsible for reviewing the applications for admission and writing the refusal letters as directed by the DOC. The Social Worker indicated that the refusal letters contained the reason that was provided by the DOC, to withhold admission, and they were not aware the refusal letter was required to include contact information for the Director.

During an interview with Inspector #623, the DOC confirmed that the refusal letters for applicants #017, #018, #019, #020, #021, #022, #023 and #024 lacked detail to support the reason why applications were withheld and that they were unaware that the refusal letter was required to have the contact information for the Director.

The licensee failed to ensure that when withholding approval for admission, the licensee shall provide a written notice setting out the the ground or grounds on which the licensee is withholding approval, a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care, an explanation of

how the supporting facts justify the decision to withhold approval and contact information for the Director. [s. 44. (9)]

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 by ensuring that applications for admission are approved unless the home lacks the physical facilities necessary to meet the applicants care requirements, the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements, or circumstances existed which were provided for in the regulations as being a ground for withholding approval. Also by ensuring that if the licensee withholds approval for admission, the licensee shall provide to persons described in subsection (10) a written notice setting out the the ground or grounds on which the licensee is withholding approval, a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care, an explanation of how the supporting facts justify the decision to withhold approval and contact information for the Director., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment, supplies, devices and assistive aids for the falls prevention and management program were readily available in the home.

Related to Log #014870-19:

A Critical Incident Report was submitted to the Director on a specified date, related to a

fall sustained by resident #025 that morning. Immediately after the fall, resident #025 was assessed and transferred to the hospital, where they were diagnosed with specific identified injuries, and were admitted for a specified amount of time.

The Director received a complaint from resident #025's family member on an identified date. The complaint stated that resident #025 was admitted to the home on a specified date, and during the admission intake, resident #025's family members informed the staff of the LTCH that resident #025 had a history of falls and was at risk for falling. The complainant indicated that during the admission intake, they requested resident #025 receive specific interventions to assist in preventing falls from occurring and/or injuries as a result from fall, but the fall prevention interventions had not yet been implemented when resident #025 fell on an identified date.

During record review, Inspector #672 observed that a referral to the physiotherapy and occupational therapy teams had been sent after resident #025's admission to the home, which requested that resident #025 be assessed for the need of specific interventions to assist in preventing falls from occurring and/or injuries, as per the request of the resident's family members. The referrals indicated they were reviewed by the occupational therapy team on an identified date, after resident #025 had sustained the fall and was admitted to the hospital. The admission plan of care indicated resident #025 was at risk for falls and interventions were implemented in an attempt to prevent falls from occurring.

During separate interviews, OT #125 and OTA #158 indicated the referral sent by the nursing department which requested resident #025 be assessed for the need of specific interventions to assist in preventing falls from occurring and/or injuries, as per the family request, was not sent until late in the evening on an identified date, therefore the OT team had already gone home for the day. OT #125 indicated that occupational therapy was not scheduled to be present in the home on a daily basis, therefore the referral was not reviewed until after resident #025 had sustained the fall. OTA #158 indicated that specified equipment was supplied by the environmental services department in the home and the environmental team was present in the home on a daily basis, therefore the equipment could have been provided prior to resident #025's fall, if the nursing department had contacted them directly. OT #125 and OTA #158 stated the nursing department being confused about which team supplied specific fall prevention supplies to the residents continued to be an ongoing issue in the home which they had discussed with the nursing management team several times over the past year, with the goal of having the nursing team become responsible for supplying residents with all of the fall

prevention supplies. It was determined that this would be safer for the residents who were at risk for falling. OT #125 indicated that every resident home area was expected to have extra specific falls prevention equipment available to the nursing team to utilize while waiting for the resident to be assessed by the PT and OT teams, but often the specified equipment would be assigned to residents without the OT team being notified. The nursing team would have to call other resident home areas to enquire if there was equipment available for usage on a short term basis, until the resident could be assessed. OT #125 further indicated that resident #025 did receive specific identified equipment for falls prevention after they returned to the home from the hospital, but the interventions were not necessarily required, as resident #025 had a significant change in status after the fall.

During an interview, RPN #152 indicated fall prevention supplies were provided by the occupational therapy team. RPN #152 further indicated they were unaware of where the supplies were stored, and did not believe RPNs had access to the supplies. RPN #152 indicated perhaps the charge nurse in the home had access to the area, as the charge nurse had keys for every area of the home, but could not recall the charge nurse ever providing fall prevention supplies to residents outside of the occupational therapy hours.

Following resident #025's return to the home from the hospital, the written plan of care was updated to include fall prevention interventions. Additional interventions were added several days later.

During an interview, the DOC indicated the expectation in the home was for occupational and physiotherapy referrals to be responded to within 24 hours, or on the next day the PT/OT teams were available in the home. The DOC further indicated it was the responsibility of the OT department to supply residents with fall prevention interventions after assessing the resident's fall prevention needs. Due to the OT department being responsible for the fall prevention supplies, the DOC stated they were unsure if the nursing department would know where to look to find these supplies, or if the nursing team had access to the room the supplies were stored in, if a resident required the fall prevention supplies outside of the routine occupational therapy hours of work.

The licensee failed to ensure that equipment, supplies and devices for the falls prevention and management program were readily available in the home when resident #025's family requested the specific identified equipment, and the nursing department was unable to supply the devices prior to resident #025's fall which resulted in the resident being hospitalized with specific injuries. [s. 49. (3)]

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 by ensuring that equipment, supplies, devices and assistive aids for the falls prevention and management program are readily available in the home, to be implemented voluntarily.

Issued on this 3rd day of December, 2019

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

Original report signed by the inspector.