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
Aug 20, 2019	2019_746692_0018	009318-19, 012558-19, 012634-19, 012949-19, 013900-19	Complaint

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street THUNDER BAY ON P7B 5G7

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

Hogarth Riverview Manor
300 Lillie Street THUNDER BAY ON P7C 4Y7

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

SHANNON RUSSELL (692), AMANDA BELANGER (736)

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): July 15-19 and 22-26, 2019.

The Following intakes were inspected upon during this Complaint Inspection:
-One log for a complaint submitted to the Director related to improper care of the resident in responding to a change in condition;
-One log for a complaint submitted to the Director related to falls prevention, care plans and continence care;
-One log for a complaint submitted to the Director regarding falls management; and
-One log for a complaint submitted to the Director related to resident to resident physical aggression and resident safety.

A Critical Incident System (CIS) intake related to the same concerns (falls management) was completed during this Complaint inspection.

A CIS inspection #2019_746692_0019 was conducted concurrently with this inspection.

PLEASE NOTE: Non-compliance of a Voluntary Plan of Correction (VPC) related to s. 6 (1) (a), s. 6 (4) (a), and s. 6 (7) of the LTCHA 2007, were identified in a concurrent inspection, #2019_746692_0019, and were issued in this inspection.

Inspector Stephanie Doni #681 was present throughout this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care(s) (DOCs), Clinical Manager(s) (CMs), Resident Social Worker (RSW), Medical Director (MD), Corporate Educator, Resident Assessment Instrument-Coordinator (RAI-C), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members, and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health care records, internal investigation notes, complaint logs, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A complaint was submitted to the Director on a specified date, regarding the care provided to resident #023, specifically regarding the fall's prevention management, care planning, and continence care needs.

In an interview with the Complainant, they identified to Inspector #692 that resident #023 had fallen on a specified date, and the home was to implement the use of specific fall prevention interventions when the resident was in bed. The Complainant identified that the home told them that these interventions would be added to the resident's care plan to ensure that care staff were aware of what care to provide to resident #023.

Inspector #692 reviewed resident #023's health care records, identifying a specific document, indicating that resident #023 had sustained a fall, and that the identified interventions were to be added to the resident's care plan. A review of the progress notes

identified an entry, dated the day following the fall, that the Power of Attorney (POA) agreed with adding the identified interventions for safety. A review of resident#023's care plan, dated effective the day following the fall, indicated under the "Falls/Balance" focus, one of the interventions had been added, yet there was no indication for the application of an identified device while the resident was in bed.

Inspector #692 reviewed an identified assessment document, that was completed three days after the fall, which identified that resident #023 had been assessed as a high risk for falls, and a plan was to be put in place to reduce the risk of the resident falling.

During multiple observations, Inspector #692 identified that an identified device was applied to resident #023's bed.

Inspector #692 reviewed the home's policy titled, "Extendicare Daily Personal Care and Grooming, #RC-06-01-01", effective May 10, 2018, which indicated that the nurse/care staff were to "provide individualized care as documented on care plan".

During an interview with Personal Support Worker (PSW) #106, they identified to Inspector #692, that care staff were to review the resident's care plan, providing care as outlined in the care plan. PSW #106 indicated that resident #023 had been identified as a high risk for falls and required the assistance of staff for their care needs. PSW #106 identified that after resident #023 had sustained a fall, that identified interventions were to be implemented whenever the resident was in bed.

In an interview with Inspector #692, Registered Practical Nurse (RPN) #127 indicated that resident #023 had been identified as a high fall risk and required staff assistance for all activities of daily living (ADL). RPN #127 identified that they had recently added that they were to have the identified interventions in place while the resident was in bed.

During an interview with Inspector #692, Clinical Manager (CM) #115 indicated that resident #023 had been identified as a high fall risk, and that staff were to ensure that the identified interventions were in place to assist with fall management, as indicated in their care plan. Together, Inspector#692 and CM #115 reviewed resident #023's care plan, identifying that the application of an identified device was not indicated in the care plan. CM #115 confirmed that resident #023 did have the identified device in place, and that it should have been added to the care plan at the time it was implemented.

Inspector #692 interviewed Director of Care (DOC) #138, who identified that care staff

were to follow the resident's care plan when providing care. DOC #138 indicated that resident #023's care plan did not include that fall prevention measure that was to be in place, and that it should have. [s. 6. (1) (a)]

2. A complaint and a Critical Incident System (CIS) report were submitted to the Director related to a resident who fell and sustained an injury, with a significant change in health status. The CIS report indicated that resident #026 had fallen on a specified date, and had been transferred to hospital; it was determined that the resident had sustained an injury.

Inspector #736 reviewed resident #026's health records, and noted a physician order on a specified date, which indicated that the resident was to have an identified device applied at all times, and only removed during care.

Inspector #736 reviewed the resident's care plan in effect at the time of Inspection, and could not locate that the resident required an identified device at all times, except while staff were providing care.

In an interview with PSW #158, they indicated to the Inspector that each resident's individual care would have been set out in the care plan and Kardex, and that the staff would look there for direction on how to provide care to the resident. The PSW indicated that the use of the identified device for a resident should have been indicated in resident #026's care plan.

In an interview with Inspector #736, Registered Nurse (RN) #143 indicated that staff were aware of each resident's individual care needs by reviewing the care plan and Kardex. The RN further indicated that the use of the identified device was something that would be found on the resident's care plan and Kardex. The RN confirmed that resident #026 had an order for the application of the identified device. Together, the RN and the Inspector reviewed resident #026's care plan in effect after they returned from the hospital, and could not locate the intervention that staff were to apply the identified device at all times, except for during care. The RN indicated to the Inspector that the direction should have been included in the care plan for the resident.

A review of the policy titled "Daily Personal Care and Grooming", RC-06-01-01, last updated April 2017, indicated that the care plan was to include the frequency and manner in which daily personal care and grooming was to be provided, in addition to the resident's needs and preferences related to care.

In an interview with CM #152, they indicated to Inspector #736, that staff would be made aware of individual resident care needs by the care plan. The CM indicated that an intervention, such as the identified device, should have been included in the resident's care plan in order for staff to be aware of the requirement. Together, the Inspector and the CM reviewed the resident's plan of care in effect after they returned from the hospital. The CM was unable to locate where in the care plan it had identified that staff were to apply the identified device to resident #026. The CM indicated that the care plan did not include the planned care required for resident #026, pertaining to the application of the identified device, and that it should have.

In an interview with DOC #138, they indicated to the Inspector that staff were aware of what care each resident required by reviewing the care plan. Together, the DOC and Inspector #736 reviewed the care plan for resident #026, in which the DOC indicated the residents care plan should have included the use of the identified device to the affected body part. The DOC was unable to locate where in the care plan it provided direction for the application of the identified device. [s. 6. (1) (a)]

3. A CIS report was submitted to the Director on a specified date, related to resident #020 , who had eloped from the home for more than three hours.

During separate interviews with PSW #125 and RPN #162, they stated that an identified document was to be completed for resident #020, and that the completion of this document was to ensure that resident #020 was still on the unit.

On a specified date, Inspector #681 observed that there was the identified document located at a specific area of the specified unit, and that this document was being completed for resident #020.

The Inspector reviewed resident #020's current care plan, identifying that the completion of the identified document was not included in the resident's care plan.

During an interview Inspector #681, CM #152 stated that the completion of the identified document was implemented for resident #020, so that staff could monitor resident #020, ensuring that the resident was still on the unit. CM #152 stated that the completion of the identified document was not included as an intervention in resident #020's care plan.

During an interview with DOC #138, they stated that the completion of the identified

document should have been included as an intervention in the resident's care plan. [s. 6. (1) (a)]

4. A CIS report was submitted to the Director on a specified date, for resident #009, who fell five days prior, sustaining an injury, with a significant change in health status.

Inspector #736 reviewed resident #009's electronic health care records, and identified progress notes documented on two separate dates, that indicated that the resident was to have an identified device applied to their mobility device for fall prevention. The Inspector was unable to locate the application of the identified device as an intervention on the resident's care plan.

In an interview with PSW #133, they indicated to Inspector #736 that in order to know what care each resident required, they would refer to the care plan of each resident. The PSW indicated to the Inspector that resident #009 had an identified device in place, as part of their fall prevention strategies.

In an interview with RPN #137, they indicated to the Inspector, that the staff utilized the care plan of each resident to know the specific interventions that each resident required for care. The RPN indicated that it was the registered staff's responsibility to update the care plan if it was not reflective of the resident's needs or interventions. The RPN indicated that resident #009 had an identified device as a fall prevention measure. Together, the Inspector and RPN #137, reviewed resident #009's current care plan, in effect at the time of the inspection; the RPN was unable to locate the use of an identified device in the resident's care plan. RPN #137 indicated to the Inspector that the identified device should have been on resident #009's care plan to ensure that staff were aware to apply the identified device.

A review of the home's policy titled, "Care Planning and Assessments" LTC 2-21, adopted from Extendicare on December 11, 2017, indicated the the care plan was to be updated at any time the resident's status changed, so that the care plan continued to be reflective of the current needs and preferences of the resident.

In an interview with CM #152, they indicated to the Inspector that staff would be aware of individual fall interventions for residents based on the resident's care plan. The CM reviewed the progress notes from two separate dates, for resident #009, identifying documentation that the resident was to have the identified device in place for falls prevention. Together, CM #152 and the Inspector, reviewed the care plan for resident

#009; the CM noted that the intervention of the identified device was not added to resident #009's care plan until the time of this inspection. The CM indicated to the Inspector that up until the time that the intervention was added to the care plan, they were unsure of how staff would have been aware to apply the identified device to resident #009.

During an interview with Inspector #736, DOC #138 indicated to the Inspector, that the staff would review the resident's care plan in order to know what the specific interventions and care needs were. The DOC reviewed the two separate progress notes, for resident #009, and indicated that those progress notes identified that resident #009 required the use of the identified device for falls prevention. The DOC noted that the identified device was just recently added to resident #009's care plan; however, the DOC indicated that up until that point, the care plan did include that the identified device was to be applied, and it should have. [s. 6. (1) (a)]

5. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complemented each other.

A complaint and a CIS report were submitted to the Director, related to resident #026 sustaining a fall with injury. The complainant indicated that the resident had fallen at a specific location, sustaining an injury. The CIS report indicated that the resident had fallen, sustaining an injury.

Please see WN #1, finding #2, for further details.

Inspector #736 reviewed resident #026's health care records and noted a physician order, on a specified date, that stated that the resident was to have an identified device applied to a specific part of their body at all times, and it was only to be removed when staff were providing care. A further review of the resident's health care record indicated that on a specified date, Physiotherapist (PT) #157 assessed the resident, and determined that the identified device could be removed. The progress note further indicated that the resident's Substitute Decision Maker (SDM) was notified of the recommendation; however, there was no indication that the physician was made aware of the assessment, or the change in the resident's plan of care. An additional progress note, dated the following day, indicated that Physician #155 was in to assess resident #026, and was not "happy" that the identified device was removed for a longer duration, without their approval. The physician ordered that the identified device was to remain on

at all times, and only removed after approval from the physician.

In an interview with Inspector #736, PT #157 indicated that they had felt that the identified device was applied to resident #026 to prevent concerns with another area of the body, more so than preventing further injury to the specific part of the body that had been injured. The PT indicated that they had collaborated with the resident's SDM, but had not collaborated with the physician prior to changing the directions for the application of the identified device. The PT indicated that they should have collaborated with Physician #155 related to the assessment of resident #026, and the use of the identified device.

In an interview with CM #152, they indicated to the Inspector that they were aware that PT #157 had removed resident #026 identified device, although it had been ordered by Physician #155. Together, CM and the Inspector, reviewed the residents progress notes, and could not locate an indication that the PT had collaborated with the physician, so that their assessments of the resident complimented each other. The CM indicated that the PT should have collaborated with Physician #155 prior to changing the plan of care for resident #026.

In an interview with Physician #155, they indicated to Inspector #736, that they had ordered an identified device to be applied at all times for resident #026 after the resident had received treatment for their injury. The physician further indicated that the order was to have the identified device applied at all times, except for during care for effective treatment of the injury. Physician #155 indicated that they were not made aware when PT #157 removed the identified device for a period of time. The physician stated to the Inspector that the PT should have collaborated with them prior to removing the identified device, and that the physician's expectation was that if there was a physician order related to care, that they would be contacted prior to that being changed.

In an interview with DOC #138, they indicated to the Inspector that based on the progress notes for resident #026, PT #157 had assessed the resident, and determined that they no longer required the use of the identified device. The DOC further indicated that based on the progress note, the physician was not collaborated with prior to the removal of the identified device, and they should have been. [s. 6. (4) (a)]

6. A CIS report was submitted to the Director on a specified date, regarding the care provided to resident #024, after they had fallen. In a review of the CIS report by Inspector #692, it indicated that resident #024 had sustained a fall three days prior, acquiring an

injury to an identified area on their body. The CIS report indicated that when RPN #132 contacted Physician #155, they inquired if the resident had been prescribed a specified medication, in which RPN #132 advised the physician that resident #024 was not prescribed the specified medication . The CIS report further indicated that CM #152 had identified two days following the fall, that resident #024 had been prescribed the specified medication, and that the specified medication had been administered for three days after the resident had sustained the fall, including the day of the fall. Physician #155 confirmed to CM #152 that when RPN #132 notified them of the fall with injury, they were given incorrect information, and were not informed that resident #024 was prescribed the specified medication, after specifically asking RPN #132 if they were.

Inspector #692 reviewed the health care records for resident #024. A review of the Physician Orders Review report, dated on an identified date, indicated an order for a specified medication to be administered daily. The report further identified an order for, "if falls and [sustains an identified injury], [the specified medication] should be held and MD made aware of [the specified medication]". The care plan, in effect at the time of the fall, identified under the focus of an identified focus, that if the resident, "falls and [sustains an identified injury], [the specified medication] should be held and MD made aware of [the specified medication]".

A progress note dated with an identified date and time, indicated that resident #024 had a fall at a specific area of the unit, and was found with an identified area of their body against an identified object. A progress note by RPN #132, dated the same day at a later time, indicated that an identified document was initiated, the physician was notified, and treatment ordered. A review of an identified document, as in Mede Care, was completed on an identified date, and did not identify that the resident was currently on the specified medication.

Inspector #692 reviewed the home's investigation notes, which identified an interview conducted by CM #152 with Physician #155, in which they confirmed that Physician #155 had asked RPN #132 if resident #024 was on the specified medication, and was told no. Physician #155 identified that if they had of known that resident #024 was on the specified medication, they would have held the specified medication until further assessment was completed. The investigation further identified follow up completed with RPN #132, for not providing the physician with the correct information, in order to provide the appropriate treatment for resident #024.

During an interview with Inspector #692, RPN #132 identified that resident #024 had

sustained an unwitnessed fall on an identified date, and had sustained an injury to an identified area of their body. The RPN indicated that they assessed the resident, initiated an identified document, and contacted the physician. RPN #132 identified that Physician #155 asked if resident #024 was on the specified medication, and after looking through the resident's medication list, told the physician that they were not on the specified medication. RPN #132 further identified that they had not realized that identified medication was a specified medication. RPN #132 indicated that the specified medication was to be held if the resident had sustained an injury.

Inspector #692 interviewed CM #152, who indicated that they were aware of the fall resident #024 had sustained on the identified date, and when they were following up two days following the fall, they noted resident #024 had been prescribed the specified medication. CM #152 indicated that when they reviewed resident #024's electronic Medication Administration Record (eMAR), they identified that resident #024 had continued to receive the specified medication for three days after the fall, including the day of the fall. The CM indicated that during the investigation it was confirmed, that Physician #155 had asked the RPN if resident #024 was on the specified medication, and that the RPN had told them they were not on the specified medication. Physician #155 confirmed to CM #152 that if they had been given the correct information they would have ordered the specified medication to be held.

During an interview with DOC #138, they identified that registered staff were to notify the physician when a resident had fallen, had sustained an injury, and to advise them if they were prescribed the specified medication, taking the physician's guidance for treatment. DOC #138 indicated that it was best practice to hold the specified medication when a resident had fallen, due to potential medical consequences. DOC #138 identified that RPN #132 had not collaborated with Physician #155, as they did not tell them resident #024 was on the specified medication, and they should have. [s. 6. (4) (a)]

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

A complaint was submitted to the Director on an identified date, regarding the care provided to resident #023, specifically regarding fall's management, care planning and continence care needs.

Please see WN #1, finding #1, for further details.

In an interview with the Complainant, they identified to Inspector #692 that resident #023 had fallen in an identified area of the unit on an identified date, and that the home was to implement the use of identified interventions when the resident was in bed. The Complainant identified that on an identified date, they had viewed the video footage, identifying that resident #023 had been in an identified area of the unit, and the identified interventions were not in place. They further indicated that they contacted the RN on duty, describing what they had viewed, and watched the RN place the identified interventions in place.

Inspector #692 conducted a review of resident #023's progress notes, which included documentation, dated with an identified date and time, that RN #170 had received a phone call from the resident's POA advising them that resident #023 was in bed without the application of the identified interventions. The progress note further identified that RN #170 viewed that the care staff had not put the identified interventions in place when resident #023 had been assisted to bed. The RN placed the identified interventions in place, following up with RPN #127 and PSWs.

During an interview with PSW #106, they identified to Inspector #692, that care staff were to implement the interventions in the resident care plans when providing resident care. PSW #106 indicated that resident #023 had been identified as a high risk for falls, and required the assistance of staff for their care needs. PSW #106 identified that after resident #023 had sustained a fall on an identified date that the identified interventions were to implemented whenever the resident was in bed.

In an interview with Inspector #692, RPN #127 indicated that they recalled the identified date, when RN #170 told them that resident #023's POA had contacted the home indicating that the identified interventions were not in place, and that the RN had put them in place, after receiving the phone call. RPN #127 confirmed that the identified interventions were to be put in place at the time the resident was assisted to bed by staff.

During an interview with Inspector #692, CM #152 indicated that resident #023 had been identified as a high fall risk, and that staff were to ensure that the identified interventions were in place, to assist with fall management, as indicated in their care plan. Together, Inspector #692 and CM #152, reviewed resident #023's care plan, identifying that the care staff were to ensure that the identified interventions were in place while the resident was in bed. CM #152 confirmed that the identified interventions were not put in place while resident #023 was in bed, and that they should have been.

Inspector #692 interviewed DOC #138, in which they identified that care staff were to follow the resident's care plan when providing care. DOC #138 indicated that staff were to place the identified interventions in place when the resident was in bed, and that they had not. [s. 6. (7)]

8. A CIS report was submitted to the Director on an identified date , related to resident #009 sustaining a fall which resulted in an injury, with a significant change in health status.

Inspector #736 reviewed the electronic health records for resident #009, which indicated that the resident had fallen on an identified date, and was diagnosed with an identified injury to a specific area of their body, on an identified date.

Please see WN #1, finding #4, for further details.

A review of the plan of care in effect at the time of the inspection, indicated that resident #009 was to have an identified intervention in place at all times, when the resident was in bed.

On an identified date, Inspector #736 completed an observation of resident #009, and noted that the resident was in bed. The Inspector noted that the identified interventions were not in place.

In an interview with Inspector #736, PSW #119 confirmed that resident #009's plan of care indicated that they were to have the identified intervention in place when they were in bed. Together, the Inspector and the PSW, viewed the resident in bed, and PSW#119 indicated that the identified interventions were not in place, and they should have been.

In an interview with DOC #138, they indicated to Inspector #736 that the care set out in the plan of care was to be provided to each resident. The Inspector informed the DOC that on an identified date, they noted resident #009 in bed without the identified interventions in place. DOC #138 reviewed the plan of care for resident #009, and indicated that the resident was to have the identified interventions in place when the resident was in bed. The DOC further indicated that if the resident was observed in bed without the identified interventions in place, then care was not provided, as per the plan of care. [s. 6. (7)]

9. A CIS report was submitted to the Director on an identified date, for the improper

treatment of a resident, that resulted in risk of harm to the resident. Inspector #692 reviewed the CIS report, which indicated that on an identified date, PSW #168 reported to RPN #129 that while providing care to resident #021, they discovered that an identified intervention was not in place.

Inspector #692 reviewed resident #021's health care records, and identified the completion of a specific assessment tool, dated with an identified date, which identified that resident #021 had been assessed as a high risk for falls. A review of resident #021's care plan in effect at the time of the incident, indicated under an identified focus, that staff were "to ensure that the residents [identified interventions] in place, and in proper working condition".

A review of resident #021's progress notes, indicated documentation, dated on an identified date, completed by RPN #129, that resident #021's identified intervention was not in place. The RPN documented that the unit manager was notified and a specified assessment was completed on the resident, which did not identify any concerns.

Inspector #692 reviewed the home's internal investigation notes, which identified that PSW #168 and RPN #129 had confirmed that resident #021's identified intervention was not in place on the identified date. The investigation further identified that PSW #169 had confirmed that they had not checked that the identified intervention was in place for resident #021's on the identified date, as they did not know how to check them, and that PSW #128 had not checked resident #021 to ensure that the identified intervention was in place on the identified date.

Inspector #692 reviewed the home's policy titled, "Extendicare Least Restraints, #RC-22-01-10", effective February 22, 2018, which indicated that care staff were to "observe all residents who [required] a [identified intervention] to ensure [the identified intervention] [was] in place, and functional. Promptly report all non-functioning [interventions] to the nurse".

In separate interviews with PSW #128 and RPN #129, they identified that care staff were to check all resident's identified interventions, ensuring that they were in place, and functioning. RPN #129 indicated that on the identified date, resident #021's identified intervention was not in place, and that they had been unsure at that time how long it had not been in place. PSW #128 identified that they worked on the identified shift, and confirmed that they did not check to ensure resident #021's identified intervention was in place.

During an interview with Inspector #692, CM #149 indicated that resident #021 had been identified as a high fall risk, and that staff were to ensure that the identified intervention was in place, and functioning to assist with fall management, as indicated in their care plan. CM #149 identified that the home had investigated the incident, and the CM confirmed that PSW #128 and #169 had not checked that the identified intervention was in place on the identified date; they confirmed that they should have.

Inspector #692 interviewed DOC #138, in which they identified that care staff were to check residents' identified interventions to ensure that they were applied and functional, to mitigate the risk of the resident falling. DOC #138 indicated that the care staff did not check that the identified intervention was in place for resident #021, and that they should have. [s. 6. (7)]

10. A CIS report was submitted to the Director on an identified date, related to resident #020, who had been missing from the home for more than three hours.

Please see WN #1, finding #3, for further details.

a) Inspector #681 reviewed the progress notes in resident #020's electronic medical record and identified a progress note entered by RN #141, which was dated with an identified date. The progress note indicated that, at a specified time, RPN #162 was notified by RPN #132 that they would need to initiate a identified intervention as resident #020 was observed by security leaving the home four hours prior.

The Inspector reviewed resident #020's care plan, that was in place at the time of the incident, which indicated that "if [resident #020] [did] not [complete a specified action], initiate the [identified intervention] [within a specified time frame]".

During an interview with RPN #162, they verified that they were working on the identified date. RPN #162 stated that RPN #132, who had been working the shift prior to theirs, had advised them that resident #020 had been missing from the home for four hours, and that RPN #162 would have to initiate the identified intervention. RPN #162 stated that resident #020's care plan indicated that if the resident was missing from the home for a specified time frame, then an identified intervention was to be initiated. RPN #162 stated that the resident had not completed the specified action, and that the identified intervention should have been initiated three hours prior.

During an interview with RN #141, they stated that they were notified by RPN #162 that resident #020 was missing from the home, and that the resident was last seen at an identified time. RN #141 stated that the identified intervention should have been initiated three hours prior.

During an interview with Inspector #681, CM #152 stated that when resident #020 left the home on the identified date, it was in the resident's care plan that the identified interventions were to be completed within a specific time frame, if resident #020 did not complete the specified action. CM #152 stated that the identified intervention may not have been initiated until three hours later because staff had not recognized that the resident was not on the unit until later that shift. However, the CM acknowledged that staff "should have" noticed that resident was not on the unit prior to this.

b) Inspector #681 reviewed the progress notes in resident #020's electronic health care record, and identified a progress note entered by RN #171, which was dated with an identified date. The progress note indicated that resident #020 had been off the unit since an identified time, and that the resident had only completed part of the identified intervention. The progress note further indicated that, as per resident #020's care plan, an identified intervention was to be initiated, if the resident had not completed all parts of the identified intervention.

The Inspector identified a second progress note that was entered by RN #142, dated with an identified date. This progress note indicated that resident #020 had not completed the identified intervention, and that the identified interventions were initiated three and a half hours after they should have been implemented.

The Inspector reviewed resident #020's care plan that was in place at the time of the incident, which indicated that "[resident #020] [was] known to visit [a specified location] and if [they] note that [they were] going to [the specified location], staff to initiate the identified intervention only if [they] do not [complete a specified action]".

During an interview with RN #171, they stated that they worked on the identified date, and that they were advised that resident #020 had not completed the specified action. RN #171 stated that the identified intervention was only to be called for this resident if they had not completed a specified action by a specific time frame

During an interview with RPN #161, they stated that they worked on the identified date and that resident #020 was not on the unit when they started their shift. RPN #161

stated that resident #020 was able to complete a specified action until a specific time frame, and when the resident had not completed the specified action by the specified time frame, they immediately contacted the RN. RPN #161 stated that there was a delay in initiating the identified intervention, because the RN had a difficult time collecting the appropriate information.

During an interview with Inspector #681, CM #152 stated that when resident #020 had not completed the specified action by a specific time frame, staff should have initiated the identified intervention within the specified time frame. CM #152 stated that, based on documentation, it appeared that the process was started at an identified time, and it should have been initiated three and a half hours prior. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others that are involved in the different aspects of care collaborate with each other, so that their assessments are integrated, consistent and complement each other, that the care set out in the plan of care is provided to the resident, and that the written plan of care sets out the planned care for the resident, to be implemented voluntarily.

Issued on this 22nd day of August, 2019

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

Original report signed by the inspector.