Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée***


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

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

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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 8, 2019 | 2018_780699_0012 | 005653-18, 008028-18, 008105-18, 014147-18, 016999-18, 018432-18, 029005-18, 029800-18 | Critical Incident System |

**Licensee/Titulaire de permis**

City of Toronto
365 Bloor Street East 15th Floor TORONTO ON M4W 3L4

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

Kipling Acres
2233 Kipling Avenue ETOBICOKE ON M9W 4L3

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

PRAVEENA SITTAMPALAM (699), IVY LAM (646)

## 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): December 14, 17, 18, 19, 20, 21, 27, 28, 2018, January 2, 3, 4, 7, 8, 10, 11, 14, 15, 16, 2019.**

**The following Critical Incident system (CIS) reports were inspected during this inspection:**

**-Log #005653-18 (CIS #M545-000007-18), Log #01699-18 (CIS #M545-000029-18), Log #029800-18 (CIS #M545-000054-18) and Log #008028-18 (CIS #M545-000026-18) related to falls,**
**-Log #018432-18 (CIS #M545-000033018) related to resident to resident abuse,**
**-Log #008105-18 (CIS #M545-000014-18) related to injury for which resident is taken to hospital and which results in a significant change in resident's health status, and**
**-Log #014147-18 (CIS #M545-000026-18) related to potential staff to resident abuse.**

**PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 6(4)(a), identified in a concurrent inspection #2018_769646_0023 (Log # 002905-18) was issued in this report.**

**PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, r. 50. (2) (b) (iv) was identified in this inspection and has been issued in Inspection Report 2018_769646_0023, dated January 22, 2019, which was conducted concurrently with this inspection.**

**The following Follow Up intake was inspected concurrently during this inspection:**
**-Log #029005-18 related to safe transferring and positioning techniques.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Managers (NM), Manager of Resident Services (MRS), Manager of Building Services (MBS), physicians, Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Care Assistant (PCA), Physiotherapist (PT), Occupational Therapist (OT) and residents.**

**During the course of the inspection, the inspectors observed resident care, observed staff to resident interactions and provision of care, reviewed resident health records, meeting minutes, schedules, staff training records and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Skin and Wound Care**

**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)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 36. | CO #001 | 2018_525596_0003 | 699 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (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).**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

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

**Findings/Faits saillants :**

1. The licensee has 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 complement each other.

The Ministry of Health and Long-term Care (MOHLTC) received a critical incident system (CIS) report related to resident #020 who had a fall resulting in a specified injury on a specified date.

Record review of the CIS report indicated that resident #020 was transferred to hospital,

diagnosed with a specified injury, and was readmitted to the home on a specified date.

Record review of resident #020's progress notes revealed that the resident returned from hospital with a particular diagnosis and required a specific level of care for all activities of daily living. Further review of the resident's progress notes indicated resident #020 had identified behaviours and was agitated when laying in bed and sitting in chair after returning from hospital. A progress note by occupational therapist (OT) #136, revealed that they recommended a specific fall intervention equipment. There was no indication that OT #136 spoke to nursing staff regarding their recommendation. Further review of progress notes, revealed that two specified fall intervention equipments were installed on a specific date by maintenance.

Record review of the progress notes revealed that the resident fell from bed on specific dates with no injury and another referral was sent to the OT.

In an interview with registered nurse (RN) #119, they stated that the OT will verbally communicate their recommendations and registered staff are responsible for updating the care plan with the OT recommendations. RN #119 stated that the recommendation for a specific fall prevention equipment by OT #136 was not communicated to staff. RN #119 acknowledged there was no collaboration between OT and nursing to initiate the specific fall intervention equipment.

In an interview with OT #136, they stated at the time of recommending the specific fall intervention equipment for resident #020 the specific fall intervention equipment was on back order and they did not have any in the home. OT #136 stated they followed up with maintenance regarding the status of the specific fall intervention equipment weekly, however there was confusion on who was responsible for ordering them. OT #136 further stated there was there was very little communication between staff regarding the stock of the specific fall intervention equipment. OT #136 could not recall which nurse they spoke to regarding the ordering of the specific fall prevention equipment and did not document the weekly follow up with maintenance.

In an interview with Manager of Building Services (MBS) #140, they stated they did not receive a work order for the specific fall intervention equipment for resident #020 until a later specified date.

In an interview with the manager of resident services (MRS) #137, they stated if there was a shortage of the specified fall prevention equipment, the OT should be documenting

that they are following up and communicate with staff to ensure that the resident is kept on closer monitoring until stock is received.

In an interview with RN #118, they stated that communication was happening less frequently between registered staff and the OT. They further stated that the OT recommendations are documented in the progress notes but not always communicated to the nursing staff; at times the recommendation gets missed.

In an interview with nurse manager (NM) #120, they stated there should have been collaboration between the OT and staff to initiate the appropriate intervention for resident #020.

In an interview with DON #108, they stated that it was the expectation that there should be communication from the OT to the staff regarding their recommendations related to resident #020. [s. 6. (4) (a)]

2. The MOHLTC received a CIS report related to resident #021 who had a fall resulting in a specific injury on a specific date.

Record review of resident #021's progress notes showed that on specific dates, the resident had an identified number of falls with no injury. Further review of progress notes showed that on a specified date, resident #021 was seen by OT #138 who recommended a specific fall intervention equipment to be used, and they would send a referral to maintenance. No follow up was completed until another referral was sent on a later specified date requesting for the fall prevention equipment. Another progress note by OT #138, showed that they already recommended the specific fall intervention equipment, but was told by maintenance that the specific fall prevention equipment was on back order.

In an interview with OT #138, they could not recall which nurse they spoke to regarding the specific fall intervention equipment. They further stated that the home did not have the specific fall intervention equipment in stock at the time of their recommendation and they updated the nursing staff verbally. OT #138 stated that it would have been the expectation for staff to monitor the resident more closely until the specific fall intervention was put into place.

In an interview with the MBS #140, they stated that they did not receive a work requisition for the specific fall intervention equipment. They further stated that

maintenance would follow up if an item was unavailable, until it was ordered and then installed.

Review of the work order for resident #021 showed that OT #138 ordered the specific fall intervention equipment, however there was no date of when it was requested indicated on the form.

In an interview with RN #127, they stated that they were not aware that resident #021 had the specific fall intervention equipment in place. RN #127 stated that if the specific fall intervention equipment was out of stock, the nursing staff would indicate in the communication book to have next shift follow up. They further stated the OT did not communicate to the nursing staff regarding the specific fall intervention equipment and there was some collaboration between staff missing.

In an interview with RN #121, they indicated that if an OT recommendation was made, the intervention should have been initiated at the time that it was recommended. RN #121 acknowledged that there was no collaboration between staff to initiate the fall intervention.

In an interview with DON #108, they acknowledged that there was no collaboration between staff to initiate the recommended fall intervention equipment for resident #021. [s. 6. (4) (a)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other 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.

This inspection was initiated to inspect on a complaint intake, where the home received a written complaint on a specified date regarding alleged improper care of resident #001, during their stay in the home. The resident had an area of altered skin integrity and the family was not made aware. The complaint also included concerns with specified care related to another specified area of altered skin integrity. Resident #001 no longer resided in the home at the time of this inspection.

Review of resident #001's progress notes showed that the resident was admitted to the home on a specified date. The doctor noted the resident had an identified condition and was also bleeding from the identified site. The physician ordered a specific treatment for

the bleeding. Review of the nursing notes, showed that an identified body area of the resident had dried blood and a specific treatment was applied. The progress notes did not indicate that the specific treatment was applied to the resident for the duration of the stay.

Review of the home's 24-hour record for resident #001 did not indicate that the specific treatment was applied to the resident's indicated area of skin breakdown for a specific period.

Review of the resident's Medication Administration Record (MAR) showed an order was written for the specific treatment to an identified area every (q) shift. The resident's MAR did not include documentation to indicate that the specific treatment was provided to the resident on any shift. Review of the MAR for a specific month did not include the order of the specific treatment. No order for discontinuation of the treatment was seen on the progress notes, physician's order, or the MAR.

Review of resident #001's Nursing and Personal Care Record (NPCR) included provision of toileting care, but did not include instructions or documentation of resident #001's specific peri-care needs related to the application of the specific treatment.

Interview with Personal Care Assistant PCA #104 and PCA #135 who worked on two different identified shifts, and who had both worked with resident #001 during their stay in the home, indicated that the PCAs would apply the specific treatment for residents based on the registered staff members' instructions. Both PCAs also stated that they did not document if they apply the specific treatment, but the PCAs would tell the registered staff if they had applied it to resident #001's identified body area. PCA #104 stated they would not put any treatment on the resident's identified body area, especially if the resident had an identified medical device in place, unless instructed by a registered staff. PCAs #104 and #135 stated registered staff had not informed them to apply the treatment on the resident's identified body area, and the PCAs had not done so. PCA #135 further stated that they had applied the treatment to identified area of altered skin integrity but not on the other area of altered skin integrity.

Interview with RN #102 stated they had had reviewed the physician's assessment of resident #001 on a specific date, which indicated the resident had bleeding from the medical device in place and wrote to try the above mentioned specific treatment. The RN stated they noted that resident #001's identified area had dried blood and they had applied the specific treatment to the resident that day. The RN stated that they had put

this instruction in the care plan. Review of the resident's care plan during their stay did not indicate information related to the identified condition, bleeding from the medical device, or instructions to provide a specific treatment for the abovementioned condition. The RN stated it is the usual process for the registered staff to provide the treatment to the PCAs to apply to the resident, and the PCAs would communicate to the registered staff if more treatment was needed. RN #102 further stated that instructions for providing the specified treatment would be communicated at shift report to the subsequent shifts. No documentation for provision of the specific treatment for bleeding from the medical device was seen on the 24-hour shift reports or the progress notes for resident #001 during their stay. The RN further stated there was no documentation that this care was provided to the resident from the MAR/Treatment Administration Record (TAR) or the resident's progress notes, and the NPCR would not include documentation of this care.

Interview with NM #114, who is one of the skin and wound leads, indicated that it is the home's expectation for the registered staff to put information for provision of a specific treatment for the abovementioned condition for resident #001 on the TAR. NM #114 further indicated that if the provision of the specific treatment was delegated to the PCAs, the registered staff should communicate with the PCAs to ensure the PCAs are applying the treatment as directed, and to monitor the condition until it was healed.

Interview with NM #114 and the DON indicated that there was a lack of collaboration between the staff in the implementation of the planned care for resident #001's for the above mentioned condition. [s. 6. (4) (b)]

4. 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.

The MOHLTC received a CIS report, related to resident #023 who was taken to hospital on a specific date, for a specified injury. Resident #023 was diagnosed with an identified condition and returned to the home on later specified date.

Record review of the CIS report revealed resident #023 initially had discomfort on a specific date. Further review of the report indicated that resident #023 was given a particular diagnosis with no recounted injury and was recommended a specific treatment for a specified timeframe.

Record review of resident #023's care plan showed that resident required a specific level of care with bed mobility due to identified diagnoses. Further review of the care plan

indicated that resident used a specific mobility device in the morning and a different one in the evening.

Record review of resident #023's NPCR for a specific month, showed that for thirteen days, resident #023 received a different level of assistance for bed mobility.

In an interview with PCA #142, they stated that for transfers, resident #023 required a specific level of assistance, however for bed mobility and dressing, it was a different level of assistance.

In an interview with PCA #141, they stated that as per their documentation they provided a specific level of assistance for bed mobility.

In an interview with RN #147, they stated that resident #023 requires a specific level of assistance with all care. RN #147 acknowledged that resident #023's plan of care was not followed related to bed mobility.

In an interview with NM #144, they acknowledged that based on resident #023's NPCR, the care plan was not followed related to bed mobility on the above mentioned dates. [s. 6. (7)]

5. The MOHLTC received a CIS report on a specific date, related to alleged resident to resident abuse. Staff heard resident #008 yell, heard a loud noise, found resident #009 laying on the floor in a common area and they sustained a specific injury. A family member of a co-resident stated they had observed resident #008 push resident #009.

Review of the home's incident report for resident #009 on the above mentioned date indicated the resident fell around a specific time. Review of resident #009's progress notes the following days indicated that the resident was transferred to the hospital. Review of the nursing progress notes indicated that the Modified Dementia Observation System (DOS) monitoring was initiated.

Review of resident #009's DOS from a specific time period, showed that there was no documentation on the DOS during an identified shift between seven specified dates. There was also no documentation on the DOS between different specific hours on a specific date.

Interview with PSW #132 indicated that the PCA was not provided with the DOS to

complete after the above mentioned incident for resident #009.

Interviews with RPN #130 and RN #133 indicated that the DOS for resident #009 was ordered after an incident or if there are concerns with the resident's behaviors. It should be done for all shifts for seven days after it was initiated when the resident returned to the home and that it was not done.

Interview with BSO RPN #106 indicated that the DOS is usually completed by staff for a period of seven to 14 days, and is requested for a 24 hour time frame unless otherwise specified. The BSO staff further indicated that the DOS should have been completed on all shifts either by the PCAs or the registered staff and reviewed by the registered staff for completion. The DOS for resident #009 was not completed for the specific dates mentioned above.

Interview with the DON further indicated that nursing interventions written in the progress notes are a part of the resident's plan of care, and the DOS should have been completed on for all shifts for the seven days as per the planned care for the resident. [s. 6. (7)]

6. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

The MOHLTC received a CIS report on a specific date related to resident #022 had a fall that resulted in an identified injury to a specific body area.

Record review of the CIS report indicated that resident #022 was discovered on the floor. No injuries were noted at the time of assessment, however resident #022 complained of pain to a specific body area and an x-ray was ordered. The x-ray showed that the resident had an identified injury.

Record review of the care plan last updated approximately two months prior to the fall, indicated that resident #022 required a specific level of assistance. Fall interventions were identified in the resident's care plan.

Record review of progress notes by physiotherapist (PT) # 115 indicated that resident #022 required a specific level of assistance for transferring, and had a specific mobility status. Further review of PT's note indicates that they provided education to both the resident and PSW regarding the use of a small cushion/pillow to support the resident's

identified body area during repositioning.

In an interview with PT #115, they stated they completed an assessment after resident #022 fell on the above mentioned specified date, and the resident required a specific level of assistance for transferring. They communicated completion of their assessment to nursing staff and nursing staff were expected to update the care plan to reflect resident #022's transfer status, including the recommendation of using pillow to support the resident's specific body area.

In an interview with PCA #110, they recalled using a pillow when transferring resident #022's, and that resident #022 required a specific level of assistance.

In an interview with RPN #112, they stated resident #022 required a specific level of assistance with transfer. RPN #115 stated if there was a discrepancy in the care plan noted by staff, the care plan would need to be updated immediately with communication to staff.

In an interview with NM #113, they stated the registered staff were responsible to update the care plan with PT recommendations and with changes to resident care. NM #113 stated the care plan was not updated for resident #022 to reflect the resident's correct transfer status and PT recommendation.

In an interview with DON #108, they acknowledged that resident #022'S care plan was not updated with resident's correct transfer status and PT recommendation. [s. 6. (10) (b)]

7. The MOHLTC received a CIS report, related to resident #021 who had a fall resulting in a specified injury on a specific date.

Record review of the CIS report revealed that resident #021 was discovered on the floor inside the resident's room. Further review of the CIS report showed that resident #021 was sent to hospital on a specific date, for severe pain. Resident #021 returned from hospital with a particular diagnosis related to the specific injury. The CIS report indicated that resident #021's status deteriorated due to pain and required a specific level of care for all activities of daily living after returning from hospital.

Record review of progress notes containing assessment completed by OT #138 stated that resident #021 required a specific level of care for all activities of daily living and

transfers. Progress notes showed that a specific fall intervention equipment was installed on a specific date.

Record review of resident #021's care plan, indicated that the resident required a specific level assistance for transfers. The risk for falls care plan, did not indicate the use of a specific fall intervention.

In an observation by Inspector #699 on a specific date, resident #021 was observed to be transferred by a specific level of assistance into an identified mobility device. In an interview with PCA #139, they stated resident #021 required a specific level of assistance for transfers due to having many falls in the past.

In an interview with RN #127, they stated since resident #021 fell on the above mentioned specific date, the resident has required an increased level of care. They were not aware resident #021 had a specific fall intervention. RN #127 acknowledged resident #021's care plan should have been updated.

In an interview with DOC #108, they acknowledged that resident #021's care plan should have been updated to reflect the resident's transfer status and use of a specific fall intervention equipment. [s. 6. (10) (b)]

8. The MOHLTC received a CIS report, related to resident #023 who was taken to hospital on a specific date, for a specified injury. Resident #023 was diagnosed with an identified condition and returned to the home on later specified date.

Record review of the CIS report revealed resident #023 initially had discomfort on a specific date. Further review of the report indicated that resident #023 was given a particular diagnosis with no recounted injury and was recommended a specific treatment for a specified timeframe.

Record review of resident #023's care plan showed that resident required a specific level of care with bed mobility due to identified diagnoses. Further review of the care plan indicated that resident used a specific mobility device in the morning and a different one in the evening.

Record review of resident #023's MDS assessment, indicated that for bed mobility and transfers, the resident required a specific level of assistance.

In an interview with PCA #141, they stated that resident #023 was transferred via an identified mobility device and had not used a different mobility aid since admission. They further stated that after resident #023's specified injury, resident continued to use the first identified mobility device for all transfers.

In an interview with RN #147, they stated that resident #023 always required a specific level of care and could not recall if the resident used a specific mobility device. They further stated that the care plan should reflect the MDS assessment. RN #147 acknowledged that the plan of care was not updated for resident #023.

In an interview with NM #144, they stated that resident #023 was using a specific mobility device prior to their specific injury. They stated that after the resident returned from hospital, they required a different specific mobility device for transfers. NM #144 acknowledged that resident #023's care plan was not updated. [s. 6. (10) (b)]

9. The licensee has failed to ensure that when the resident was reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, different approaches were considered in the revision of the plan of care.

The MOHLTC received a CIS report related to resident #021 who had a fall resulting in an identified injury.

Record review of the CIS report revealed that resident #021 was discovered on the floor inside the resident's room. Further review of the CIS report showed that resident #021 was sent to hospital on a specific date, for severe pain. Resident #021 returned from hospital with a particular diagnosis related to the specific injury. The CIS report indicated that resident #021's status deteriorated due to pain and required a specific level of care for all activities of daily living after returning from hospital.

Record review of resident #021's progress notes showed that on specific dates, the resident had an identified number of falls with no injury.

In an interview with RN #127, they stated at the time of resident #021's falls, the fall interventions were not effective as the resident continued to fall. RN #127 further stated that there could have been a care conference with family, other team members and physician to identify other interventions to try.

In an interview with RN #121, they stated they would know if fall interventions were not

effective if the resident continued to have falls. RN #121 acknowledged that the fall interventions in place for resident #021 were not effective for the falls that occurred on specific dates.

In an interview with NM #114, they stated they acknowledged that for resident #021, the fall interventions in place at the time of the fall were ineffective. [s. 6. (11) (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 care set out in the plan of care is provided to the resident as specified in the plan of care; that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other; that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, and that that different approaches are considered in the revision of the plan of care when the plan of care is being revised because the care set out in the plan has not been effective, to be implemented voluntarily.***

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**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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The MOHLTC received a CIS report on specific date, related to resident #022 had a fall resulting in an identified injury.

Record review of the CIS report indicated that resident #022 was discovered on the floor. No injuries were noted at the time of assessment, however resident #022 complained of pain to a specific body area and an x-ray was ordered. The x-ray showed that the resident had an identified injury.

Record review of resident #022's fall prevention checklist on a specific date, indicated that head injury routine (HIR) was completed post fall every hour for 24 hours.

Record review of resident #022's HIR document on a specific date, revealed that the HIR was not completed at 11 specific times.

Interview with RN #111 indicated the HIR was to be completed every hour for twenty four hours. RN #111 acknowledged that for resident #022, the HIR was not completed at the above mentioned times.

Review of the home's policy titled Falls Prevention and Management, RC -0518-21, published October 01, 2016, indicated as part of post fall management, HIR will be initiated every hour for 24 hours or as ordered by physician.

In an interview with NM #114, they indicated that HIR was to be completed every hour for 24 hours for resident #022, and was not done at the times mentioned above. [s. 8. (1) (a),s. 8. (1) (b)]

2. The MOHLTC received a CIS report related to resident #020 who had a fall resulting in a specified injury.

Record review of the CIS report indicated that resident #020 was transferred to hospital, diagnosed with a specified injury, and was readmitted to the home on a specified date.

Record review of the HIR, revealed that HIR was not completed at seven specific times.

In an interview with RN #118, they stated the HIR was done every hour for 24 hours. RN #118 confirmed that it was not completed during the above mentioned times.

Review of the home's policy titled Falls Prevention and Management, RC -0518-21, published October 01, 2016, indicated as part of post fall management, HIR will be initiated every hour for 24 hours or as ordered by physician.

In an interview with NM #120, they stated HIR should be done every hour for 24 hours. They acknowledged that HIR was not completed for the above mentioned times for resident #20. [s. 8. (1) (a),s. 8. (1) (b)]

3. The MOHLTC received a CIS report related to resident #021 who had a fall resulting in an identified injury on specific date.

Record review of the CIS report revealed that resident #021 was discovered on the floor inside the resident's room. Further review of the CIS report showed that resident #021 was sent to hospital on a specific date, for severe pain. Resident #021 returned from hospital with a particular diagnosis related to the specific injury. The CIS report indicated that resident #021's status deteriorated due to pain and required a specific level of care for all activities of daily living after returning from hospital.

Record review of progress notes containing assessment completed by OT #138 stated that resident #021 required a specific level of care for all activities of daily living and transfers.

Record review of HIR document, on three specific dates, showed that the HIR was not completed for twelve specific times.

In an interview with RN #121, they stated the HIR is documented every hour for 24 hours. They stated that the HIR document was not completed for resident #021 on the above mentioned dates.

Review of the home's policy titled Falls Prevention and Management, RC -0518-21, published October 01, 2016, indicated as part of post fall management, HIR will be initiated every hour for 24 hours or as ordered by physician.

In an interview with NM #114, they acknowledged that the HIR was not completed as per

policy for resident #021. [s. 8. (1) (a),s. 8. (1) (b)]

4. The MOHLTC received a CIS report on a specific date, related to alleged resident to resident abuse. Staff heard resident #008 yell, heard a loud noise, found resident #009 laying on the floor in a common area and they sustained a specific injury. A family member of a co-resident stated they had observed resident #008 push resident #009.

Review of the home's policy, titled Suspected Head Injury (RC-0518-20, published on 01 -08-2013), indicated that: When residents sustain any head trauma, the HIR was to be initiated and done every hour for 24 hours or as per physician's order.

Review of the home's incident report for resident #009 on a specific date, indicated the resident fell around a specific hour. Review of resident #009's progress notes indicated that the resident was transferred to the hospital. The nursing progress notes further indicated that the Head Injury Routine (HIR) was to be initiated for the resident upon their return to the home. Review of resident #009's progress notes indicated that resident #009 had returned to the home on a specific date.

Review of the HIR form showed that the HIR was completed on a specific date at specific times, with no documentation of the HIR for certain identified times. No other documentation for the resident's HIR was done in the progress notes.

Interviews with RPN #130 and RN #133 indicated that the HIR should be done hourly for the first 24 hours and if the resident was in the hospital during that time, it should be done when the resident returns to the home for the remaining time left from the initial 24 hours.

Interviews with NM #120 and the DON indicated that the HIR should have been completed every hour for the first 24 hours, as per the home's policy, and that it was not completed hourly between specific hours on a specific date. The DON further indicated that resident #009 may be resistive with being assessed, but if the resident had refused to be assessed at the time, the staff should document that the resident had refused. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act, and complied with, to be implemented voluntarily.***

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**Issued on this 22nd day of February, 2019**

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

**Original report signed by the inspector.**