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
Jan 31, 2019	2019_644507_0002	009629-18, 026905-18	Critical Incident System

Licensee/Titulaire de permis

Cedarvale Terrace LTC Inc. as general partner of Cedarvale Terrace LTC Limited Partnership
c/o All Seniors Care Living Centres 175 Bloor Street East, Suite 601 TORONTO ON M4W 3R8

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

Cedarvale Terrace
429 Walmer Road TORONTO ON M5P 2X9

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

STELLA NG (507)

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): January 15 - 18, and 21, 2019.

The following critical incident system intakes were inspected: #009629-18 (CIS #2591-000022-18) and #026905-18 (CIS #2591-000039-18) related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), Environmental Manager (EM) and residents.

The inspectors conducted observations of staff and resident interactions, provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

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

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 O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home.

Review of the home's "Assessment of a Fall" policy, revised December 2017, stated "assessment of a fall must be done immediately following the fall by the registered staff".

Review of the home's "Post Fall Assessment" policy, revised December 2017, stated "assist resident up if it has been determined that resident can be moved. Observe for facial expression, guarding, or complaints of pain. If resident unable to weight bear, do not move resident, call ambulance and prepare transfer to hospital for assessment." The policy also stated "if there was evidence of a head injury, initiate the head injury routine (HIR) immediately and follow the HIR protocol."

Review of the home's "Head Injury Routine" policy, Index I.D. E-35, revised May 2, 2018, indicated residents are closely observed and assessed and vital signs are monitored according to established guidelines subsequent to a head injury or suspected head injury. Procedures included checking and recording vital signs for forty-eight (48) hours in the electronic progress notes as follows:
- First four (4) hours, to be checked hourly
- Next four (4) hours, to be checked every two hours
- Next sixteen (16) hours, to be checked every four hours, and
- Next twenty-four (24) hours, to be checked every eight hours.

The policy also indicated vital assessments, such as blood pressure, pulse, respiration, pupil reaction (Pupil Equal Round Reactive Light Accommodation – PERRLA) and level of consciousness were to be included for this procedure.

A) An identified Critical Incident System (CIS) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date in regard to resident #002's fall which occurred five days prior.

Review of the CIS report and the progress notes of resident #002 indicated that on an identified date at an approximate time, staff #116 went to resident #002's room and told the resident it was meal time, and staff would return to assist them up for meals. When staff #116 returned to resident #002's room, staff #116 found the resident was lying on the floor by the door. Resident #002 was assessed by staff #123 and was transferred to bed. Resident #002 was transferred to hospital approximately four hours later for further assessment related to identified health conditions. This was confirmed by interviews with staff #116 and #123.

Review of the progress notes of resident #002 indicated staff #123 documented the following related to the resident's vital assessments after the fall occurred on the above mentioned identified date:
- At an identified time, staff #123 took vital signs, included blood pressure, heart rate, oxygen saturation and temperature
- At another identified time, resident's blood pressure, temperature, heart rate and oxygen saturation were taken.

In interviews, staff #107 and #123 stated that head injury routine (HIR) should be initiated after a resident had an unwitnessed fall or the resident hit their head during the fall. Staff #107 and #123 further stated resident #002's fall occurred on the above mentioned identified date at the identified time was considered an unwitnessed fall, and the HIR should be followed. Both staff stated that the HIR for resident #002 was not completed for a period of approximately four hours after the fall.

B) Another identified CIS report was submitted to the MOHLTC on an identified date in regard to resident #003's fall which occurred the previous day.

Review of the CIS report and the progress notes of resident #003 indicated that on an identified date at an approximate time, staff #113 heard a resident ask for help while completing the documentation at the nursing station. Upon investigation, staff #113 found

resident #003 sitting on the floor near the door of the room. Staff #113 asked the resident what happened and were they hurt. Resident #003 asked staff #113 to get them up, and staff #113 assisted the resident back to bed with the assistance of another staff. Then staff #121 arrived to the scene and assessed resident #003. This was confirmed during an interview with staff #113.

Further review of the CIS report and progress notes for resident #003 indicated that the resident was transferred to the hospital approximately three hours later for further assessment related to identified health conditions.

Review of the progress notes of resident #003 indicated the following documentation related to the resident's vital assessments after the fall occurred on the above mentioned identified date:
- At an identified time, staff #124 documented resident complained of an identified health condition due to the fall. Vital assessments included blood pressure, heart rate, oxygen saturation, temperature and respiration rate. Resident agreed to be transferred to hospital
- At another identified time, staff #121 documented the post fall assessment.

In an interview, resident #003 stated they were going to the washroom and fell in the past. Resident #003 stated they did not ring the bell for assistance prior to getting up from bed.

In an interview staff #113 stated that they were not supposed to move the resident without the assessment and direction from the registered staff. On the above mentioned date, when resident #003 was found on the floor, the resident kept asking staff to assist them to get up; and staff #113 assisted the resident to get up with the assistance of another staff.

Staff #121 was not available for interview, and staff #124 was no longer working in the home.

In an interview, staff #107 stated that resident should not be moved prior to the assessment by a registered staff and determined to be safe to transfer after a fall. In addition, the post fall assessment should be completed immediately after a fall, and head injury routine should be initiated for any unwitnessed fall. Staff #107 stated that staff did not follow the home's fall prevention policy after resident #003 experienced a fall on the above mentioned date, which included transferring the resident to bed prior to the

assessment and direction from registered staff, post fall assessment was not completed immediately after the fall, and HIR was not initiated for the above mentioned unwitnessed fall. [s. 48. (1) 1.]

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 falls prevention and management program to reduce the incidence of falls and the risk of injury is implemented in the home, to be implemented voluntarily.

Issued on this 7th day of February, 2019

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

Original report signed by the inspector.