Ontario

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

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

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

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


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 22, 2015 | 2015_226192_0047 | 015633-15 | Critical Incident System |

### Licensee/Titulaire de permis

SAINT LUKE'S PLACE
1624 Franklin Blvd. CAMBRIDGE ON N3C 3P4

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

SAINT LUKE'S PLACE
1624 FRANKLIN BOULEVARD CAMBRIDGE ON N3C 3P4

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

DEBORA SAVILLE (192)

### Inspection Summary/Résumé de l'inspection

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): July 20, 21 and 22, 2015.**

**This Critical Incident Inspection related to Falls Prevention was completed concurrently with;**
**Complaint Inspection 009442-15 and**
**Critical Incident Inspection 008275-15**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Practical Nurses and Personal Support Workers.**

**The inspector reviewed medical records, incident reports, policy and procedure, Quality Improvement records and training records.**

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

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<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 | Legendé<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. (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. (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 the plan of care set out clear direction to staff and others who provide direct care to the resident.

The plan of care for continence for resident #001 indicated; on admission do three day continence assessment to establish bladder routine.
The plan of care for toileting for resident #001, in effect at the time of a fall with injury in 2015, indicated that the resident was frequently incontinent and required one person to provide constant supervision and physical assist for safety.

Interview with Registered Practical Nurses (RPN) confirmed that there was no bladder routine established for resident #001, that would provide clear direction to staff as to when resident #001 would require assistance to the bathroom. The RPNs confirmed that

resident #001 would be able to ask staff for assistance with toileting or staff would be able to identify the need for toileting by an increase in activity and restlessness, however this was not included in the plan of care for the resident.

Interview with a Registered Practical Nurse confirmed that attempts to self transfer by resident #001, at times resulted in falls and were related to the resident's need to use the bathroom.

Record review and interview with Registered Practical Nurses confirmed that resident #001 sustained several falls over a four month period in 2015. Documentation in progress notes identified that for three specified falls, the resident was going to or in the bathroom.

It is noted that the plan of care was revised to include that the resident asks for assistance with toileting and for staff to toilet the resident when they become agitated.

The licensee failed to ensure that the plan of care for resident #001 set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure 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.

A Quarterly Summary was completed for resident #001. The summary identified the resident's current status in regard to Activities of Daily Living, restorative care and mobility. Had a bed alarm in place. Had a fall in the quarter and continued to demonstrate responsive behaviours.

Interview with the Director of Care confirmed that the Quarterly Summary would be expected to accurately identify any changes in the resident over the quarter being reviewed, including the number of falls, and changes in interventions.

Record review confirmed by the Director of Care identified that resident #001 sustained a specified number of falls during the period, when the Quarterly Summary was completed.

Interview with Registered Practical Nurses confirmed that resident #001 had never had a bed alarm in place.

The licensee failed to ensure 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. [s. 6. (4) (a)]

3. The licensee has failed to ensure that if the plan of care was being revised because care set out in the plan had not been effective, the licensee ensured that different approaches were considered in the revision of the plan of care.

A fall risk assessment and the Minimum Data Set (MDS) quarterly assessment were completed for resident #001 on specified dates in 2015.

Record review and interview confirmed that resident #001 was at high risk for falls and had sustained a specified number of falls during the period in 2015 when assessments were completed.

Review of the plan of care identified that interventions that were in place at the time of the fall, on a specified date in 2015, had been initiated on the date of admission for resident #001. One change in the plan of care was identified for the resident related to an increase in supervision when using medical devices. The plan of care related to falls was not revised to include different approaches to care.

Review of canceled/resolved interventions failed to identify the introduction of new interventions for resident #001 related to falls prevention, in spite of frequent falls.

Interview with the Director of Care (DOC) identified that interdisciplinary team meetings related to resident falls were conducted by the Best Practice Nurse but the DOC was unable to provide documentation that interdisciplinary team meetings had been held with regard to the frequent falls sustained by resident #001 or that the introduction of new interventions had been discussed.

On a specified date in 2015, resident #001 sustained a fall which resulted in injury.

The licensee failed to ensure that if the plan of care was being revised because care set out in the plan had not been effective, the licensee ensured that different approaches were considered in the revision. [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 ensuring that the plan of care sets out clear direction to staff and others who provide direct care to the resident and ensuring that if the plan of care is being revised because care set out in the plan has not been effective, the licensee ensures that different approaches are considered in the revision of the plan of care, 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 where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

The home's policy titled Falls Prevention and Management, policy number N-I-V-22 dated as revised June 2015 indicated that;

A) Registered Nursing Staff will monitor, evaluate the care plan at least quarterly in collaboration with the interdisciplinary team and if interventions had not been effective in reducing falls, initiate alternative approaches and update the plan of care as necessary.

Record review and interview with the Director of Care and Registered Practical Nurses confirmed that in spite of the plan of care for falls, resident #001 sustained a specified number of falls over a specified four month period in 2015. Review of the plan of care including canceled/resolved concerns failed to identify new interventions since the resident was admitted in 2014.

Interview identified that informal discussions had been held but that no interdisciplinary team meeting had been conducted to initiate alternative approaches to fall prevention for resident #001.

B) Registered Nursing Staff complete an incident investigation and an incident report including all contributing factors and would document the fall under Progress Notes - Falls including the location of the fall, if the fall was witnessed, time of discovery of the fall, appearance of the resident at the time of discovery, environmental factors at the time of the fall, resident response, evidence of injury, notification of the physician, whether the resident was sent to hospital and would chart under Progress Notes -Fall Follow-up the status of the resident for 72 hours following a fall.

Interview with the Director of Care identified that the post fall incident report was under Risk Management on Point Click Care.

Risk Management reports were reviewed for resident #001's documented falls. Interview with the Director of Care confirmed that for two falls sustained on specified dates in 2015, by resident #001, progress notes were completed, however Risk Management reports were not completed.

Progress Notes were reviewed and identified:
i) Resident #001 sustained a fall on a specified date in 2015. No Progress Note with a Fall focus was documented for the resident. During the day shift a progress note was completed that identified that the resident had fallen through the previous night.
ii) Resident #001 sustained a fall on a specified date in 2015. A Progress Note completed indicated "see risk management". No additional information was provided in relation to the fall sustained.
iii) Resident #001 sustained a specified number of falls during a specified three month period in 2015. Record review identified that 41 percent of the time, Fall-Follow-up progress notes were not completed in relation to these falls. The Director of Care confirmed that Fall-Follow-up notes were to be documented for 72 hours following a fall.

C) Registered Nursing Staff are to arrange a unit meeting for a resident who falls frequently as indicated by - 2 falls in 72 hours, more than 3 falls in 3 months and more than 5 falls in 6 months.

Resident #001 was documented to have fallen three times in a specified 72 hour period. The resident sustained four in a specified month in 2015 and six falls over a specified three month period in 2015.

Record review and interview confirmed that no unit meeting was held in relation to resident #001 who fell frequently.

D) The interdisciplinary team is to conduct an interdisciplinary team conference to determine the possible cause of falls and develop changes to prevent re-occurrence.

Record review and interview with the Director of Care and a Registered Practical Nurse confirmed that no interdisciplinary team conference was held in relation to falls sustained by resident #001 and there is no evidence to support that falls sustained by resident #001 were analyzed to determine a possible cause of the falls. Review of the plan of care including canceled/resolved interventions failed to identify changes to the plan of care related to falls.

The licensee failed to ensure that the policy titled Falls Preventions and Management as complied with. [s. 8. (1) (a),s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that 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 ensures that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.***

**Issued on this 23rd day of July, 2015**

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

**Original report signed by the inspector.**