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
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 23, 2015	2015_360111_0003	O-000978-14	Follow up

Licensee/Titulaire de permis

MARYCREST HOME FOR THE AGED
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

ST JOSEPH'S AT FLEMING
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

Ontario

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 2-6, 2015

Four critical incident reports were inspected concurrently during this follow-up inspection (log # 001205, 001528, 001032& 001449).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Staff educator, Registered Nurses(RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, and Unit managers. reviewed health records of residents, observed residents and reviewed home's policy on Falls Prevention Program.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **1 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. 8. (1)	CO #002	2014_360111_0022	111

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	Legendé 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. (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. Related to log # 001449:

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 critical incident report was received on a specified date for Resident #7 with a fall incident that resulted in transfer to hospital. The CIR indicated the resident sustained a fall after ambulating without the use of an assistive device. The resident was transferred to hospital for treatment of the injury which resulted in a significant change in condition. The CIR indicated the resident was already "on the Falling Star program".

Review of the progress notes for Resident #7 (for a 9 month period) indicated the resident sustained 10 falls during that time:
-the 1st fall resulted in injury to a specified area. Physio assessed the resident and noted a decline in the residents physical endurance and strength, and recommended staff to monitor the resident for increased lethargy and provide rest periods.
-the 2nd fall (8 days later) the resident was found in room not wearing proper footwear or

using assistive device and did not sustain any injuries.
-the 3rd fall (2 months later) was found on the floor in room and complained of pain to a specified area. The resident was attempting to transfer without use of assistive device and was wearing improperly fitted footwear.
-the 4th fall (2 months later) was found on the floor in room and sustained an injury to a specified area.
-the 5th fall (five days later) was found on floor in room and complained of pain to a specified area. The resident was transferring without use of assistive device. Physio assessed the resident and recommended "one staff assist with transfers and call bell to be clipped to resident when in chair in room for safety".
-the 6th fall (four days later) was found on floor in room. The resident was not wearing protective aid and not using assistive device while transferring. The resident sustained an injury, complained of nausea and pain to a specified area. Staff "requested extension to call bell so resident can reach the call bell and recommended a chair alarm clipped to clothing due to frequent falls, and not to be left alone in room unsupervised in wheelchair".
-the following day, Physio indicated the resident is unable to reach call bell in [mobility aid] and needed an extension to prevent further falls as soon as possible and maintenance notified.
-two days post fall, the resident was unable to sit up without assistance and complained of severe pain to specified areas. Staff "noted in chart (7 days earlier) from physician that resident may have x-ray if severe pain continued". POA contacted and resident taken for x-ray. Four days later, the physician reviewed x-ray results which indicated an injury to a specified area.
-the 7th fall (two months later) was found on floor in hallway by room and complained of pain to specified areas. The resident was transferred for assessment and treatment of an injury. The resident returned from hospital 6 days later with a significant change in condition.
-the 8th fall (three weeks later) was found on the floor in room. No injury noted. Physio assessed and indicated that resident "is high risk of falls, staff to ensure resident is wearing protective device, not to be left alone in room in [mobility aid], call bell to be clipped to clothing, and for staff to attend promptly".
-the 9th fall (15 days later) was found on the floor in room with mobility aid beside the resident. No injuries noted.
-the 10th fall (two days later) was found on the floor in room and reported hit specified area (but was wearing protective aid), and no injury sustained. "Family requesting other interventions to prevent falls". POA consented to use of a trunk restraint and physician order also obtained.

Review of the written care plan for Resident #7 indicated the resident was a high risk for falls due to high Morse fall score, unsteady gait/physical limitations, and cognitive impairment. Interventions included: not to leave in mobility aid alone in room (transfer to bed or easy chair), clip call bell to clothes when in room, falling star logo at room doorway, leave bathroom light on, protective aid to be worn when awake, ultra-low bed in lowest position when resident in the bed, check every hour, wear proper fitted, non-slip footwear, teach to transfer positions slowly, reinforce need to call for assistance, environment free of clutter, and have commonly used articles within reach.

Observation of Resident #7 on a specified date and time, the resident was found in the room unattended, in a mobility aid with trunk restraint in place. The call bell was lying on top of the bed (not clipped to the resident clothing), and the resident was not wearing the protective aid as per the written plan of care.

Therefore, the interventions in the written plan of care were not implemented as the resident was found on the floor in room left unattended eight times, without the call bell clipped to gown (to alert staff when self-transferring), two incidents where the resident was not wearing proper fitted/non-slip shoes, and observation of the resident on a specified date when the resident was again left unattended in room in a mobility aid without call bell clipped to gown (call bell was lying on top of the bed)and the resident was not wearing a protective aid, as per the written plan of care. Furthermore, the x-ray was not completed (as per physician's order 7 days earlier) despite the resident having continued complaints of pain to a specified area(and receiving narcotic analgesics for six days), until the 7th day when the family took the resident for the x-ray. [s. 6. (7)]

2. Related to log #001205:

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 critical incident report was received on a specified date for a fall that caused an injury for which the resident was taken to hospital. The CIR indicated 3 days earlier Resident #6 was observed walking into another resident's room and tripped on an assistive device and fell. The resident was transferred to hospital for assessment and sustained an injury resulting in significant change in condition. The resident was "placed on Falling Star program" upon return from the hospital.

A second CIR was received on a specified date(4 months later) for a fall that caused an injury to which the resident was taken to hospital. The CIR indicated that on a specified date and time, Resident #6 bed alarm was activated and the resident was found on the floor(after climbing out of the bed). The resident sustained an injury to a specified area. The resident was transferred to hospital two days post fall, for assessment to the specified area and resulted in a significant change in condition.

Review of the progress notes (for a nine month period) for Resident #6 indicated the resident sustained 12 falls and one near miss:
-the 1st fall (on a specified date), fell walking outside (with someone present) and sustained an injury to three specified areas.
-the 2nd fall (four days later) wandered into another resident's room, tripped over another resident’s assistive device and resulted in an injury requiring transfer to hospital for treatment. The resident returned from hospital 3 days later with a significant change in condition and upon return from hospital, Physio assessed and recommended an "ultra-low bed, fall mat on both sides of bed, call bell clipped to gown when in bed, and tilted [mobility aid] to prevent falls".
-the 3rd fall (two days later) found on the floor in room (climbed out of mobility aid) and no injuries noted.
-the 4th fall (4 days later) found on the floor in dining room (climbed out of mobility aid) and no injuries noted.
-the 5th fall (3 days later) found on the floor in hallway (fell out of mobility aid) and no injuries noted.
-the 6th fall (4 days later) found on floor in room beside bed (slid out of mobility aid) and sustained an injury to a specified area.
-the 7th fall (6 days later) found on floor in lounge (after climbing out of mobility aid) and no injuries notes. POA and physician contacted for trunk restraint while in mobility aid.
-the 8th fall (a month later) found on the floor in hallway(fell out of mobility aid) and no injury noted.
-the 9th fall (a month later) found on the floor in room (mobility aid found flipped upside down and restraint undone). No injury noted.
-the 10th fall (a month later) found on floor in lounge(resident had removed trunk restraint) and sustained an injury to a specified area.
-(five days later) the resident was found in room sliding out of bottom of mobility aid with the trunk restraint around the resident's neck(near miss). Staff recommended "Resident to be checked hourly and in common area for better visibility".
-the 11th fall (10 days later)found on floor in room and the "bed alarm had been activated" and the resident had climbed out end of bed. The resident sustained an injury

to a specified area. The POA and physician were notified. Two days later, POA agreed to transfer resident to hospital for assessment and resulted in significant change in condition.
-nine days later, the resident was assessed by OT and recommended using "manual" mobility aid instead of "tilted" mobility aid as resident demonstrating "more leg movement".
-the 12th fall (approximately 3 months later) the resident was found on the floor outside of dining room. The resident had fallen out of mobility aid. The staff indicated the resident "often plays with [trunk restraint]". POA notified that "[trunk restraint] covers are available" from OT "if interested".

Review of care plan for resident #6 (in place at time of first fall) indicated: the resident was a "moderate risk" for falls due to moderate Morse fall score, physical limitations, unsteady gait and cognitive impairment. Interventions included: staff to initiate HIR for any un-witnessed fall (head injuries may require further assessment in hospital due to blood thinner), porter in assistive device as needed, if wandering and fatigued, take to room to lie down, to wear non-slip footwear, and encourage resident to use handrails or assistive devices. Additional interventions were added after the 2nd fall: two side rails up to prevent falls, ultra-low bed with bed in lowest position when in bed, bed alarm in place, fall out mat on both sides of bed, check every hour for safety, and call bell clipped to gown when in bed. Further interventions were added after the 11th fall: falling star program with falling star logo on doorway, keep in area where resident can be seen, protective aid to be worn, up in mobility aid (in tilted position), and toilet "when able" and "when gets restless".

Observation of Resident #6 on a specified date and time, indicated the resident was up in a manual mobility aid with a trunk restraint in place. The resident was in the hallway and visible to staff. The mobility aid was not in the tilted position and no protective aid was in place. Eight days later, at a specified time, the resident was observed by Inspector #553 in bed with 2 side rails in the "up" position, bed alarm was in place, and the bed was in the lowest position. One fall mat was located on the floor beside the bed and the other fall mat was located leaning against the wall. The call bell was attached to the resident's pillow (not to the resident's clothing) as indicated in the plan.

Non-compliance was issued under LTCHA, 2007, s.6(7) on September 2, 2014 under inspection #2014_360111_0022 (related to falls), on September 13, 2013 under inspection #2013_031194_0035 (related to falls), on July 9, 2013 under inspection #2013_179103_0034 (related to falls), and on April 12, 2013 under inspection #

2013_196157_0012 (related to falls). [s. 6. (7)]

3. The licensee has failed to ensure that when the resident is reassessed,the plan of care is reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary.

Related to log # 000978:

Review of the (current) care plan for Resident #3 indicated the resident was at "moderate" risk for falls (as per Morse Fall Score), due to unsteady gait, responsive behaviours, cognitive impairment, physical limitations, and inability to follow directions. Interventions included: adjust height of bed so appropriate for resident to rise or sit according to resident height, on blood thinner and Reg Staff to initiate HIR for any un-witnessed fall (may require further assessment at hospital with POA consent ONLY), do not close door to resident room when resident in room unattended, electric lift chair height adjustable for easy in/out, falls inhibitor mattress, on Falling Star program (has star on door), see Alternative to Restraint Assessment, protective aid to be worn, bed exit alarm in place and functioning (test every shift), if wandering to the point of fatigue, take to room to lie down (if compliant), to wear proper and non slip footwear, and ensure environment is free of clutter.

Observation of Resident #3 on a specified date and time indicated the door was almost completely closed with a wander guard strip in place on door frame. The resident was laying in bed sleeping in a Hi-Low bed (which was in the lowest position). The call bell was not attached to the resident's clothing. There was no fall inhibitor mat available (or in place) and no bed alarm in place.

Interview of PSW # 106 & #107 indicated Resident #3 is at "high risk" for falls and has falling star logo but the resident has since deteriorated and is no longer independently mobile. Both PSW's indicated the resident now requires two person assist with lifts into tilted mobility aid, does not require trunk restraint (as resident no longer moves). Both PSW's indicated the resident only has hi-low bed in place (no fall mattress, bed alarm, or protective aid) any longer due to no longer required.

Therefore, the when the resident was reassessed and the plan of care reviewed, it was not revised when the resident's care needs changed, or the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

4. The licensee has failed to ensure that if the resident is being reassessed and the plan of care is being revised because the care set out in the plan has not been effective, that different approaches have been considered in the revision of the plan of care.

Related to log # 001449:

Review of the progress notes for Resident #7 (for a nine month period) indicated the resident sustained 10 falls. After the last fall, the POA "inquired about any other interventions to prevent falls". The POA was "informed of [trunk restraint]" and POA signed trunk restraint consent.

Observation of Resident #7 indicated the trunk restraint was in place while the resident was in the mobility aid but the intervention was not considered until after the resident had sustained 10 falls, and at the request of the family for further interventions to prevent falls. [s. 6. (11) (b)]

5. Related to log # 001205:

Review of the progress notes (for a nine month period) for Resident #6 indicated the resident sustained 12 falls. Upon return from hospital after second fall, the resident sustained 9falls out of the moblity aid and 1 near miss.

Review of care plan for resident #6 (in place at time of first fall) indicated: the resident was a "moderate risk" for falls. Interventions included: porter in mobility aid as needed, if wandering and fatigued, take to room to lie down, to wear non-slip footwear, encourage resident to use handrails or assistive devices. Additional interventions were added after the 2nd fall: two side rails up to prevent falls, ultra-low bed with bed in lowest position when in bed, bed alarm in place, fall out mat on both sides of bed, check every hour for safety, and call bell clipped to gown when in bed. After the 11th fall, further interventions included: falling star program with falling star logo on doorway, keep in area where resident can be seen, protective aid to be worn, up in tilt mobility aide (in tilted position), and toilet "when able" and "when gets restless".

Therefore, when the care set out in the plan had not been effective (as the resident was demonstrating ongoing falls out of the mobility aid (and a near miss of strangulation from trunk restraint), different approaches were not considered in the revision of the plan of care to reduce the risk for injury. [s.6. (11)(b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 resident is reassessed and the plan of care is reviewed and revised at least every six months and at nay other time when the resident's care needs change or care set out in the plan is no longer necessary and when the care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered int he revision of the plan of care., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting Resident #5.

Related to Log # 001032:

A critical incident report was received on a specified date for Resident #5 who was transferred to hospital two days prior, post medical event. The CIR indicated ten days earlier, the resident had sustained a fall off the toilet resulting in a head injury and was transferred to hospital for assessment and treatment. The resident returned from hospital the same day. Eight days post fall, the resident had a medical event and was transferred to hospital again for assessment. The hospital indicated the resident had an infection and sustained an injury as a result of the fall.

Unsafe transferring technique was used resulting in Resident #5 falling off the toilet and sustaining an injury. Review of the progress notes for Resident #5 indicated:
-on a specified date, physio assessed the resident and indicated the resident's walking ability had deteriorated, now required 2 staff assistance, and the resident was "having difficulty to stand up and maintain upright posture, needs verbal cueing constantly to maintain erect posture".
-approximately a month later, physio assessed the resident again and indicated the resident "requires 2 staff assist with sit to stand lift and difficult to maintain upright posture in sitting and standing position".
-approximately two weeks later, the resident was found on floor after having fallen off the toilet. The resident was left unattended on the toilet. The resident sustained a head injury and complained of pain to a specified area. The resident indicated "leaned over and could not stop self" from falling. Resident was transferred to hospital for assessment and treatment.
-the following day, a family member expressed "concern re: safety while on toilet related to recent fall off toilet".

Therefore, the resident was left unattended on the toilet, despite assessment by physiotherapy indicating the resident had poor posture control and required constant cueing. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident was taken to hospital.

Related to Log # 001032:

A critical incident report was received on a specified date for Resident #5 who was transferred to hospital two days prior (post medical event). The CIR indicated ten days earlier, the resident had sustained a fall off the toilet resulting in a head injury and was transferred to hospital for assessment and treatment. The resident returned from hospital the same day. Eight days post fall, the resident had a medical event and was transferred to hospital again for assessment. The hospital indicated the resident had an infection and sustained an injury as a result of the fall.

Resident #5 was transferred to hospital on a specified date (after sustaining a fall and resulted in a head injury). Eight days later, the resident then had a medical event, and again was transferred to hospital and diagnosed with an infection and head injury (post fall).The Director was not notified until two business days after the second transfer to hospital which resulted in a significant change in the resident's condition. [s.107.(3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the Director is informed no later than one business day after the occurrence of an incident that causes injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to hospital, to be implemented voluntarily.

Issued on this 24th day of March, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2015_360111_0003
Log No. / Registre no:	O-000978-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 23, 2015
Licensee / Titulaire de permis :	MARYCREST HOME FOR THE AGED 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
LTC Home / Foyer de SLD :	ST JOSEPH'S AT FLEMING 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Patrick Gillespie

To MARYCREST HOME FOR THE AGED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, s. 6 (7), by ensuring that:
- a process is in place to monitor that care set out in the plan of care is provided to Resident #6 & #7(and any other resident at moderate to high risk for falls), as specified in the plan, specific to falls prevention strategies, in an effort to reduce risk of falls and/or injury.

The plan shall be submitted in writing and emailed to LTCH Inspector, Lynda Brown at lynda.brown2@ontario.ca on or before March 31, 2015. The plan shall identify who will be responsible for each of the corrective action listed.

Grounds / Motifs :

1. 2. Related to log #001205:

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 critical incident report was received on a specified date for a fall that caused an injury for which the resident was taken to hospital. The CIR indicated 3 days earlier Resident #6 was observed walking into another resident's room and tripped on an assistive device and fell. The resident was transferred to hospital for assessment and sustained an injury resulting in significant change in condition. The resident was "placed on Falling Star program" upon return from the hospital.

A second CIR was received on a specified date(4 months later) for a fall that caused an injury to which the resident was taken to hospital. The CIR indicated

that on a specified date and time, Resident #6 bed alarm was activated and the resident was found on the floor(after climbing out of the bed). The resident sustained an injury to a specified area. The resident was transferred to hospital two days post fall, for assessment to the specified area and resulted in a significant change in condition.

Review of the progress notes (for a nine month period) for Resident #6 indicated the resident sustained 12 falls and one near miss:
-the 1st fall (on a specified date), fell walking outside (with someone present) and sustained an injury to three specified areas.
-the 2nd fall (four days later) wandered into another resident's room, tripped over another resident's assistive device and resulted in an injury requiring transfer to hospital for treatment. The resident returned from hospital 3 days later with a significant change in condition and upon return from hospital, Physio assessed and recommended an "ultra-low bed, fall mat on both sides of bed, call bell clipped to gown when in bed, and tilted [mobility aid] to prevent falls".
-the 3rd fall (two days later) found on the floor in room (climbed out of mobility aid) and no injuries noted.
-the 4th fall (4 days later) found on the floor in dining room (climbed out of mobility aid) and no injuries noted.
-the 5th fall (3 days later) found on the floor in hallway (fell out of mobility aid) and no injuries noted.
-the 6th fall (4 days later) found on floor in room beside bed (slid out of mobility aid) and sustained an injury to a specified area.
-the 7th fall (6 days later) found on floor in lounge (after climbing out of mobility aid) and no injuries notes. POA and physician contacted for trunk restraint while in mobility aid.
-the 8th fall (a month later) found on the floor in hallway(fell out of mobility aid) and no injury noted.
-the 9th fall (a month later) found on the floor in room (mobility aid found flipped upside down and restraint undone). No injury noted.
-the 10th fall (a month later) found on floor in lounge(resident had removed trunk restraint) and sustained an injury to a specified area.
-(five days later) the resident was found in room sliding out of bottom of mobility aid with the trunk restraint around the resident's neck(near miss). Staff recommended "Resident to be checked hourly and in common area for better visibility".
-the 11th fall (10 days later)found on floor in room and the "bed alarm had been activated" and the resident had climbed out end of bed. The resident sustained

an injury to a specified area. The POA and physician were notified. Two days later, POA agreed to transfer resident to hospital for assessment and resulted in significant change in condition.
-nine days later, the resident was assessed by OT and recommended using "manual" mobility aid instead of "tilted" mobility aid as resident demonstrating "more leg movement".
-the 12th fall (approximately 3 months later) the resident was found on the floor outside of dining room. The resident had fallen out of mobility aid. The staff indicated the resident "often plays with [trunk restraint]". POA notified that "[trunk restraint] covers are available" from OT "if interested".

Review of care plan for resident #6 (in place at time of first fall) indicated: the resident was a "moderate risk" for falls due to moderate Morse fall score, physical limitations, unsteady gait and cognitive impairment. Interventions included: staff to initiate HIR for any un-witnessed fall (head injuries may require further assessment in hospital due to blood thinner), porter in assistive device as needed, if wandering and fatigued, take to room to lie down, to wear non-slip footwear, and encourage resident to use handrails or assistive devices. Additional interventions were added after the 2nd fall: two side rails up to prevent falls, ultra-low bed with bed in lowest position when in bed, bed alarm in place, fall out mat on both sides of bed, check every hour for safety, and call bell clipped to gown when in bed. Further interventions were added after the 11th fall: falling star program with falling star logo on doorway, keep in area where resident can be seen, protective aid to be worn, up in mobility aid (in tilted position), and toilet "when able" and "when gets restless".

Observation of Resident #6 on a specified date and time, indicated the resident was up in a manual mobility aid with a trunk restraint in place. The resident was in the hallway and visible to staff. The mobility aid was not in the tilted position and no protective aid was in place. Eight days later, at a specified time, the resident was observed by Inspector #553 in bed with 2 side rails in the "up" position, bed alarm was in place, and the bed was in the lowest position. One fall mat was located on the floor beside the bed and the other fall mat was located leaning against the wall. The call bell was attached to the resident's pillow (not to the resident's clothing) as indicated in the plan.

Non-compliance was issued under LTCHA, 2007, s.6(7) on September 2, 2014 under inspection #2014_360111_0022 (related to falls), on September 13, 2013 under inspection #2013_031194_0035 (related to falls), on July 9, 2013 under

inspection #2013_179103_0034 (related to falls), and on April 12, 2013 under inspection # 2013_196157_0012 (related to falls). [s. 6. (7)] (111)

2. 1. Related to log # 001449:

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 critical incident report was received on a specified date for Resident #7 with a fall incident that resulted in transfer to hospital. The CIR indicated the resident sustained a fall after ambulating without the use of an assistive device. The resident was transferred to hospital for treatment of the injury which resulted in a significant change in condition. The CIR indicated the resident was already "on the Falling Star program".

Review of the progress notes for Resident #7 (for a 9 month period) indicated the resident sustained 10 falls during that time:
-the 1st fall resulted in injury to a specified area. Physio assessed the resident and noted a decline in the residents physical endurance and strength, and recommended staff to monitor the resident for increased lethargy and provide rest periods.
-the 2nd fall (8 days later) the resident was found in room not wearing proper footwear or using assistive device and did not sustain any injuries.
-the 3rd fall (2 months later) was found on the floor in room and complained of pain to a specified area. The resident was attempting to transfer without use of assistive device and was wearing improperly fitted footwear.
-the 4th fall (2 months later) was found on the floor in room and sustained an injury to a specified area.
-the 5th fall (five days later) was found on floor in room and complained of pain to a specified area. The resident was transferring without use of assistive device. Physio assessed the resident and recommended "one staff assist with transfers and call bell to be clipped to resident when in chair in room for safety".
-the 6th fall (four days later) was found on floor in room. The resident was not wearing protective aid and not using assistive device while transferring. The resident sustained an injury, complained of nausea and pain to a specified area. Staff "requested extension to call bell so resident can reach the call bell and recommended a chair alarm clipped to clothing due to frequent falls, and not to be left alone in room unsupervised in wheelchair".
-the following day, Physio indicated the resident is unable to reach call bell in

[mobility aid] and needed an extension to prevent further falls as soon as possible and maintenance notified.
-two days post fall, the resident was unable to sit up without assistance and complained of severe pain to specified areas. Staff "noted in chart (7 days earlier) from physician that resident may have x-ray if severe pain continued". POA contacted and resident taken for x-ray. Four days later, the physician reviewed x-ray results which indicated an injury to a specified area.
-the 7th fall (two months later) was found on floor in hallway by room and complained of pain to specified areas. The resident was transferred for assessment and treatment of an injury. The resident returned from hospital 6 days later with a significant change in condition.
-the 8th fall (three weeks later) was found on the floor in room. No injury noted. Physio assessed and indicated that resident "is high risk of falls, staff to ensure resident is wearing protective device, not to be left alone in room in [mobility aid], call bell to be clipped to clothing, and for staff to attend promptly".
-the 9th fall (15 days later) was found on the floor in room with mobility aid beside the resident. No injuries noted.
-the 10th fall (two days later) was found on the floor in room and reported hit specified area (but was wearing protective aid), and no injury sustained. "Family requesting other interventions to prevent falls". POA consented to use of a trunk restraint and physician order also obtained.

Review of the written care plan for Resident #7 indicated the resident was a high risk for falls due to high Morse fall score, unsteady gait/physical limitations, and cognitive impairment. Interventions included: not to leave in mobility aid alone in room (transfer to bed or easy chair), clip call bell to clothes when in room, falling star logo at room doorway, leave bathroom light on, protective aid to be worn when awake, ultra-low bed in lowest position when resident in the bed, check every hour, wear proper fitted, non-slip footwear, teach to transfer positions slowly, reinforce need to call for assistance, environment free of clutter, and have commonly used articles within reach.

Observation of Resident #7 on a specified date and time, the resident was found in the room unattended, in a mobility aid with trunk restraint in place. The call bell was lying on top of the bed (not clipped to the resident clothing), and the resident was not wearing the protective aid as per the written plan of care.

Therefore, the interventions in the written plan of care were not implemented as the resident was found on the floor in room left unattended eight times, without

the call bell clipped to gown (to alert staff when self-transferring), two incidents where the resident was not wearing proper fitted/non-slip shoes, and observation of the resident on a specified date when the resident was again left unattended in room in a mobility aid without call bell clipped to gown (call bell was lying on top of the bed)and the resident was not wearing a protective aid, as per the written plan of care. Furthermore, the x-ray was not completed (as per physician's order 7 days earlier) despite the resident having continued complaints of pain to a specified area(and receiving narcotic analgesics for six days), until the 7th day when the family took the resident for the x-ray. [s. 6. (7)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 23rd day of March, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Ottawa Service Area Office