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 3, 2019	2018_722630_0031	031712-18, 031840-18, 032637-18	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

McGarrell Place
355 McGarrell Drive LONDON ON N6G 0B1

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

AMIE GIBBS-WARD (630), MEAGAN MCGREGOR (721)

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 20 and 21, 2018.

The following Critical Incident intakes were completed within this inspection:

Related to falls prevention:
Critical Incident Log #031712-18 / CI 2964-000085-18
Critical Incident Log #031840-18 / CI 2964-000086-18
Critical Incident Log #032637-18 / CI 2964-000091-18

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Quality Manager/Falls Program Lead, the Behavioural Supports Ontario (BSO) Program Lead, a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The inspectors also observed residents and the care provided to them, reviewed health care records and plans of care for identified residents and reviewed documentation related to the home's Falls Prevention and Management program and Responsive Behaviours program.

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

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

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

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

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based

on an assessment of the resident and the needs of that resident.

The home submitted a Critical Incident System (CIS) report related to a fall with an injury for an identified resident. This report showed that the resident had experienced previous falls and the home planned to implement specific interventions to help prevent falls.

During the inspection Inspector #630 observed this identified resident and found there were specific interventions that were in place.

During an interview a Personal Support Worker (PSW) said they were familiar with this resident and said there had been specific changes in their care needs. The PSW said this resident required specific types of care from staff due to their risk of falling.

During another interview a Registered Practical Nurse (RPN) said they were familiar with this resident and this resident had a history of multiple falls. The RPN said that the resident needed supervision and assistance with mobility as well as specific interventions to help prevent them from falling.

During an interview with the Behavioural Supports Ontario (BSO) RPN they said they were familiar with this resident and that this resident had a history of multiple falls since admission. The BSO RPN said this resident needed specific types of assistance from staff to help minimize their risk of falling. BSO RPN said they had completed a behavioural assessment of their behaviours after admission and that they had not assessed the resident more recently related to responsive behaviours for falls prevention.

The clinical record for this resident included the following documentation:
- An admission progress note which stated that the resident was at high risk for falls related to responsive behaviours, medications and unsteady gait/balance.
- The "assessment" section of PointClickCare (PCC) included multiple post-fall assessments that had been completed for this resident between admission and the inspection.
- Progress notes by the multidisciplinary team members which identified factors contributing to the resident's risk for falls and recommended interventions.
- The plan of care included a focus which stated "at high risk for a fall." This section of the plan of care included specific interventions and did not include other interventions that had been identified in assessments and by staff as being needed by the resident.

During an interview the Quality Manager (QM) said they were the Falls Program Lead for the home and they were familiar with this resident. The QM said that this resident had limited insight into their safety and mobility and had experienced multiple falls since admission. The QM said that they had identified concerns related to this resident's frequent falls and had discussed the falls prevention strategies with the multidisciplinary team recently. The QM said there were specific interventions in place for this resident and acknowledged that all the interventions in place were not identified in the plan of care. The QM also said there were assessments and interventions that they were in the process of completing and implementing for the resident at the time of the inspection that were not yet included in the plan of care.

During an interview the Executive Director (ED) said they were familiar with this resident. The ED said that it was the expectation in the home that the plan of care for this resident and all other residents would be up to date at all times and based on the assessments and resident care needs related to falls prevention.

Based on these observations, interviews and record reviews the licensee has failed to ensure that the care set out in the plan of care for this identified resident was based on the multidisciplinary assessments and the needs of the resident for falls prevention. [s. 6. (2)]

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 based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

Issued on this 3rd day of January, 2019

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

Original report signed by the inspector.