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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 14, 2016	2016_505103_0031	014143-16, 016497-16, 017294-16	Critical Incident System

Licensee/Titulaire de permis

AON INC.
33 HARBOUR SQUARE SUITE 825 TORONTO ON M5J 2G2

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

MOIRA PLACE LONG-TERM CARE HOME
415 RIVER STREET WEST TWEED ON K0K 3J0

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

DARLENE MURPHY (103)

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): July 28, 29 August 3-5, 2016

The following logs were included in this inspection: 014143-16 (incident resulting in significant change in resident's status), 016497-16 (alleged resident to resident abuse), and 017294-16 (alleged resident to resident abuse).

During the course of the inspection, the inspector(s) spoke with Personal Support workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Assistant Director of Care (ADOC) and the Director of Care (DOC).

During the course of the inspection, the inspector reviewed resident health care records, made resident observations and reviewed the home's fall prevention/management policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that fall prevention interventions were in place as outlined in resident #001's plan of care.

On an identified date, resident #001 was found on the floor at the bedside. RPN #106 was interviewed and indicated at the time of this fall she noted the resident's chair/bed alarm had not sounded. Upon investigation, the RPN stated she found the resident did not have a chair or bed alarm in place.

Resident #001's care plan in effect at the time of this fall was reviewed and indicated under "Risk for falls":
-ensure chair alarm is in place and attached to the resident when in wheelchair as well as when in bed. [s. 6. (7)]

2. On a second identified date, resident #001 was found on the floor at the foot of the bed. RPN #106 indicated at the time of the fall, the resident's bed alarm did not sound. The RPN was interviewed and indicated the alarm was in the bed but believed the resident may have unpinned the alarm before getting up.

The DOC was interviewed and stated the home implements a wide range of alternative strategies to ensure the resident's risk of injuries related to falls is minimized. She indicated the home has a no restraint policy and that under no circumstances would a restraint be utilized. The DOC stated it would be her expectation that all fall prevention measures included in a resident plan of care have been assessed as important for that resident and should be in place at all times.

The ADOC #105 was identified as the lead for the falls committee and was interviewed. She indicated bed and chair alarms are an important strategy to alert staff to unsafe transfers by residents. The ADOC indicated it would be her expectation that when clipping the alarms to residents, the clips would be placed out of reach such that residents could not unclip them.

The home failed to ensure fall prevention measures to minimize risk of injury were in place in accordance with the resident's plan of care. [s. 6. (7)]

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 fall prevention interventions are in place in accordance with the resident's plan of care, to be implemented voluntarily.

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 resident #001 was assessed post fall in accordance with the home's post fall policy.

Fall prevention and management is a required program as outlined under O. Reg. 79/10, s. 48 (1) 1 and is therefore required under O. Reg. 79/10, s. 30 (1) 1 to have relevant policies, procedures and protocols to reduce risk and monitor outcomes.

Resident #001 was admitted to the home on an identified date and had identified diagnoses. According to the Physiotherapist's assessment, resident #001 was at high risk for falls related to unsafe self transfers and poor judgement. On an identified date, resident #001 was found on the floor in the bedroom and was attended to by RPN #106 post fall.

RPN #106 was interviewed and was asked what details she typically includes in a post fall assessment. The RPN indicated unless there is evidence of an obvious injury she

will document "assessed" either in the resident progress notes or under risk management and would describe the factors that may have contributed to the fall. If there are no obvious injuries, the RPN indicated she would assist the resident to stand to see if the resident is able to weight bear. RPN #106 stated at the time of resident #001's fall, she observed the resident laying on his/her right side at the foot of the bed, saw no evidence of an obvious injury and assisted the resident back into bed. The resident's progress notes and risk management documentation were reviewed and there was no evidence of a post fall assessment.

Later that same day, RN #104 was asked to reassess the resident and during an interview indicated the resident had evidence of pain that was she felt was consistent with an injury. The resident was sent to hospital and diagnosed with an injury. [s. 8. (1) (a),s. 8. (1) (b)]

2. The home's policy #RS-I-24, "Responding to Resident Falls" was reviewed and stated under Procedure, "Immediate Action":
- complete an initial post fall assessment of the resident.
-if the resident has risen on their own initiative, post fall, assist resident to the nearest chair and proceed with the initial post fall head to toe assessment. Only move the resident with a two person mechanical lift.
-the initial post-fall assessment must include the following assessment for injuries: level of consciousness/evidence of seizure activity, evidence of gross injury (ie. bleeding, bone fragment protusion, lacerations, hematomas), vital signs, assessment of damage to the hip joint, limited range of motion of joints, signs and symptoms of shock or hemorrhage, and pain level identified.

The DOC was interviewed and indicated an upcoming education session has been planned for all registered nursing staff in the area of post fall assessment and documentation. [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 to ensure all registered nursing staff assess residents post fall in accordance with the home's post fall policy, to be implemented voluntarily.

Issued on this 14th day of September, 2016

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

Original report signed by the inspector.