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
May 5, 2017	2017_505103_0019	008452-17	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): May 1-3, 2017

Log #008452-17 (unexpected death).

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

During the course of the inspection, the inspector reviewed resident health care records including 24-hour admission care plans, resident plans of care, progress notes and post fall documentation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #001 was reassessed and the plan of care reviewed and revised when the resident's care set out in the plan was not effective.

Resident #001 was admitted to the home on an identified date and had identified diagnoses. The resident was identified as a risk for falls in the admission documentation provided to the home from the Community Care Access Centre (CCAC). The resident sustained seven falls over a period of six days following admission, with three of the falls occurring in a twenty hour period of time.

Resident #001 was assessed on an identified date by the physician as the resident's condition had deteriorated. The family declined to have the resident sent to hospital for further assessment and the resident deceased fourteen days after admission.

The resident 24-hour admission care plan was reviewed and was not developed and available to the direct care staff until six days after the resident was admitted . This care plan identified the resident as having falls and wandering as safety risks, but failed to identify any fall prevention measures to mitigate these risks for resident #001.

The RAI coordinator was interviewed and indicated resident #001's plan of care was initiated on an identified date. Under "Risk for falls", the plan indicated:
-analyze previous resident falls to determine whether pattern/trend can be addressed,
-ensure environment is free of clutter,
-have commonly used articles within easy reach,
-place fall mat beside bed at night on side resident exits from,
-place resident in fall prevention program,
-resident to wear hip protectors when not in bed; if falls occuring during the night, may wear during night as well.

Under "Restorative Nursing Program: to improve urinary continence", the plan indicated:
-check every two hours and assist with toileting as needed.

Under "Mobility", the plan indicated:
-independent with walker.

The physiotherapist (PT) was interviewed and indicated he assessed the resident for the first time on an identified date, six days after the resident was admitted to the home. He

indicated resident #001 had multiple falls since admission and required one person to assist with ambulation to prevent falls.

The ADOC was interviewed and stated she was the lead for the fall prevention committee. The ADOC was asked when and how fall prevention measures are assessed/reassessed. She stated post fall huddles are held by the staff immediately following each resident fall, and that strategies are to be discussed at that time to try and mitigate any factors that may have contributed to the fall such that a re-occurrence can be prevented. The inspector reviewed the documentation related to each of the falls and noted there were no contributing factors or interventions documented as a result of the post fall huddles.

The ADOC also indicated residents that have frequent or repeated falls are discussed and reassessed during the fall prevention meetings, but since this resident was a new admission, there had been no meetings held during that time frame. The ADOC indicated she recalled having discussion during morning meetings related to this resident and the repeated falls, but was unable to provide any evidence to support a documented reassessment had been completed. She believed hip protectors had been a part of the discussion. The ADOC agreed that given the fact resident #001 had sustained five falls over a period of three days, she would expect that a documented reassessment would have been completed that was specific to the reasons the resident had fallen.

The home failed to reassess resident #001 in regards to fall prevention measures, when the care set out in the plan had not been effective. [s. 6. (10) (c)]

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 residents are reassessed and the plan of care is reviewed and revised when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a 24-hour admission care plan was developed for resident #001 and communicated to direct care staff within 24 hours of the resident's admission to the home.

Resident #001's electronic health care record was reviewed and indicated the 24-hour admission care plan was developed for the first time six days following the resident admission. Direct care staff were interviewed in regards to the fall prevention measures in place for resident #001. PSWs #102, #104 and #108 were unable to identify a source for this information and none of the staff were aware of any fall prevention measures in place for this resident. All staff indicated they recalled the resident was unsteady on their feet and had sustained a number of falls in the short time they resided in the home.

RPN #109 was interviewed and stated resident #001 did not have a 24-hour care plan developed within the required 24 hour time frame and was unable to show this inspector any documentation that outlined fall prevention measures in place for resident #001 during the first six days post admission. The RPN indicated there had a been a recent turnover in staff in the secure unit and stated this may have contributed to the delay in the development of the 24-hour admission care plan. [s. 24. (1)]

2. The licensee has failed to ensure the 24-hour admission care plan included interventions to mitigate resident #001’s identified risk of falls.

As outlined in WN #1, resident #001 was admitted on an identified date. The information provided by the CCAC indicated the resident was at risk of falls. The 24-hour admission care plan was reviewed and identified, under the heading of “Behaviours/risks/interventions, by means of a check mark, falls and wandering as safety risks for resident #001. There were no interventions documented in the 24-hour admission care plan to mitigate the risk of falls.

RPN #105 was interviewed and indicated she has never seen fall prevention interventions documented in the 24-hour admission care plan when falls have been identified as a safety risk. Residents #002 and #003's health care records were reviewed. Both residents had recently been admitted to the home and both had falls identified on the 24-hour admission care plan as a safety risk. Neither of the residents had documented interventions listed on the 24-hour admission care plan to mitigate the risk of falls. [s. 24. (2) 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 to ensure the 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home, and to ensure the care plan identifies any risks the resident may pose to themself or others, including any risk of falling and interventions to mitigate those risks, to be implemented voluntarily.

Issued on this 5th day of May, 2017

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

Original report signed by the inspector.