Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 13, 2019	2019_605213_0027 (A1)	017168-19	Critical Incident System

Licensee/Titulaire de permis

Sharon Farms & Enterprises Limited
108 Jensen Road LONDON ON N5V 5A4

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

Earls Court Village
1390 Highbury Avenue North LONDON ON N5Y 0B6

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

Amended by RHONDA KUKOLY (213) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Request for an extension for Compliance Order #001 related to bed rails and #002 related to falls prevention and management, from December 31, 2019 to January 31, 2020, approved.

Issued on this 13th day of December, 2019 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Amended by RHONDA KUKOLY (213) - (A1)

Amended 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): September 5, 6, 9, 10, 11, 12, 2019

The following were completed during this inspection:

Log #017168-19, Infoline #IL-69892-LO, Critical Incident #3047-000016-19 related to the unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with the Nurse Consultant, Senior Nurse Consultant , Vice President of Operations and Vice President of Finance from Responsive Health Management, the Administrator, the Acting Director of Care, the Office Manager, the Director of Facilities Services, the Director of Therapeutic Recreation, the Resident Assessment Instrument Coordinator, the Behaviour Supports Ontario Registered Practical Nurse, Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents and family members.

The Inspectors also made observations and reviewed health records, training records, policies and procedures, meeting minutes, reports, video surveillance, and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services

During the course of the original inspection, Non-Compliances were issued.

3 WN(s)
0 VPC(s)
2 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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

The home submitted a Critical Incident to the Ministry of Long-Term Care (MLTC) related to the unexpected death of a resident. The report indicated that bed rails were in use when the resident was found unresponsive.

A record review of the health record on paper and in Point Click Care (PCC) for the resident was completed. The last assessment related to the use of bed rails was the
Bed rail Use Risk Assessment and was completed 15 months previously. This assessment stated that quarter rails were used day and night, prevented the resident from freely exiting the bed and were used to assist with turning in bed. The care plan in PCC for the resident stated the resident used both quarter side rails for bed positioning. It also stated the resident had a bolstered mattress to help prevent from climbing out of bed.

In an interview with the Acting Director of Care (ADOC) and the Nurse Consultant (NC) from Responsive Health Management (RHM), the NC said that the Bed rail Use Risk Assessment had not been used in the home for approximately one year. The NC said that the expectation of the home was that the Lift/Transfer and Bed Safety Assessment was to be completed quarterly for residents using bed rails. The NC agreed that there were no Lift/Transfer and Bed Safety Assessments

completed for the resident.

Another resident was observed in bed on four separate dates with quarter bed rails in use on both sides of the bed. A record review was completed for this resident and the care plan in PCC stated the resident used two quarter bed rails. The last assessment completed in PCC related to the use of bed rails was the Bed rail Use Risk Assessment and was completed 15 months prior. There were no Lift/Transfer and Bed Safety Assessments completed for that resident.

Another resident was observed in bed on three separate dates with quarter bed rails in use on both sides of the bed. A record review was completed for this resident and the care plan in PCC stated the resident used two quarter bed rails. The last assessment completed for this resident in PCC related to the use of bed rails was the Lift/Transfer and Bed Safety Assessment and was completed eight months prior.

Another resident was observed in bed on three separate dates with quarter bed rails in use on both sides of the bed. A record review was completed for this resident and the care plan in PCC stated the resident used two quarter bed rails. The last assessment completed in PCC related to the use of bed rails was the Bed rail Use Risk Assessment and was completed 16 months prior. There were no Lift/Transfer and Bed Safety Assessments completed for this resident.

The home's "Bed Rails" policy with a revised date of May 3, 2019 stated:
• The need for bed rail(s) will be reassessed with any change in the bed system and/or resident's status to reduce the risk of entrapment.
• The use of bed rails is being reassessed and coded in RAI MDS 2.0 on a quarterly basis.
The policy did not indicate the assessment tool to be used or how other safety issues related to the use of bed rails were to be addressed.

The licensee has failed to ensure that where bed rails were used, the resident was assessed, to minimize risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the falls prevention and management program, at a minimum, provided for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The home submitted a Critical Incident to the Ministry of Long-Term Care (MLTC) related to the unexpected death of a resident. The report indicated that the resident had a history of climbing out of bed resulting in multiple falls and that multiple interventions related to falls prevention were in use.

Resident #1:
A record review of the health record on paper and in Point Click Care (PCC) for resident #1 was completed and the care plan showed several interventions related to falls prevention were to be in place.
Observations of the video surveillance and the call bell report for time of the

resident's death, showed that one of the interventions were either not in place or not functioning. In an interview with a staff member who found the resident unresponsive, they said they did not recall seeing two of the interventions in place at the time the resident was found.
A record review of the tasks and documentation of tasks in PCC for this resident showed tasks related to ensuring that falls interventions were in place and in good working order for a one month period of time. The review showed there was no documentation for 14 shifts, for three shifts the documentation showed no, the interventions were not in place and in good working order and for five shifts the documentation showed not applicable (although the intervention would have been applicable during those shifts), during that one month time period.

In an interview with a Registered Nursing staff member, the staff member said that they were unsure when fall risk assessments were to be done and after checking the home's fall prevention program policy online and were still unsure. They said they used to have assessment in the computer and would give them a fall risk score, but they were unable to find that assessment. The staff member said that they recalled an incident when the intervention was not functioning and that when this happened, they were not replaced as they were no longer using that intervention. When the Inspector demonstrated that the resident's care plan that indicated an identified intervention, the staff member said that the wording was confusing and that staff may use a different intervention so that something was in place.

Resident #2:
Resident #2 was observed in bed on four separate dates with multiple falls prevention interventions in place. A record review was completed for this resident in PCC and the care plan showed the resident was at risk for falls and was to have several falls prevention interventions in place.
The care plan did not include any information related to the use of one of the interventions observed to be in place.
There were no Lift/Transfer and Bed Safety Assessments completed for this resident.
On an identified date, Inspectors observed one of the interventions to not be functional and alerted a personal support staff member, the staff member tested the intervention and agreed it was not functional and they would report it to registered staff.
The following date, the Inspectors observed the same intervention to still be in place and still not functional. Inspectors reported this to registered nursing staff

who agreed it was not functional and they would use a different intervention instead.

In an interview with the Nurse Consultant (NC) from Responsive Health Management (RHM), the NC said that they went up and checked the intervention and spoke to the staff that day. They said that the a minor fix was implemented and the intervention was then functional.

Record review of the tasks and documentation of tasks in PCC for this resident showed tasks and documentation related to an identified falls prevention task was documented inconsistently, not at all or unclear. There were no tasks or documentation found in PCC related to one of the falls prevention interventions identified in the care plan.

Resident #3:
Resident #3 was observed in bed on three separate dates with with multiple falls prevention interventions in place. A record review was completed for this resident and the care plan showed the resident was at risk for falls and was to have several falls prevention interventions in place.
The last Lift/Transfer and Bed Safety Assessment completed in PCC for resident #036 was eight months prior.
Record review of the tasks and documentation of tasks in PCC for this resident showed tasks and documentation related to an identified falls prevention task was documented inconsistently, not at all or unclear.

Resident #4:
Resident #4 was observed in bed on three separate dates with with multiple falls prevention interventions in place. A record review was completed for this resident and the care plan showed the resident was at risk for falls and was to have several falls prevention interventions in place.
The care plan did not include any information related to one of the interventions that was observed in place.
The last "Bed rail Use Risk Assessment" completed in PCC for this resident was 15 months prior.
There were no tasks or documentation related to falls prevention POC, in PCC.

A registered nursing staff member said that they were unsure when fall risk assessments were to be done, after checking the home's fall prevention program policy online and were still unsure. They said they used to have assessment in

the computer and would give them a fall risk score, but they were unable to find that assessment.

In an interview with the Acting Director of Care (ADOC) and the Nurse Consultant (NC) from Responsive Health Management (RHM), the NC stated:
• Fall risk assessments were to be completed upon admission in PCC and then quarterly in the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)
• Lift/Transfer and Bed Safety Assessments were to be completed quarterly for every resident in PCC.
• Bolstered mattresses would be considered a restraint if they prevented a resident from getting out of bed and should have therefore had an assessment completed prior to putting the mattress in use to determine if the mattress was a restraint for that resident and any safety risks that the restraint posed.
• If a bolstered mattress was in use as a falls prevention intervention, there should have been direction in the plan of care related to that use. All falls prevention interventions should have been included in the plan of care to direct staff related to their use.
• The home was still using bed pad alarms on beds as a falls prevention intervention, there had been no direction to staff that they were no longer available.
• The use of bed alarms and chair alarms as falls prevention interventions were to be included in the plan of care when used and were to be documented every shift as being in use and functional.
• If a bed or chair alarm was found not functional upon checking, the PSWs were to immediately report this to registered staff.
• The bed pad alarms in the home were connected to the call bell system and if a bed pad alarm was triggered, it would then trigger the call bell.

The home's "Fall Prevention Program" stated, role of the unit supervisor:
• Determines level of risk.
• Implements interventions specific to risk.
• Makes environmental modifications if required an where possible.
• Documents interventions on care plan and electronic interdisciplinary notes.
• Assesses and coordinates nursing restorative programs aimed at preventing or minimizing falls such as equipment support such as positioning cushions, transferring devices, supportive devices, environmental factors, hip protectors, etc.
• Evaluates the plan of care in collaboration with the interdisciplinary care team, resident and family to ensure measures in place are effective at reducing and/or

minimizing the risk of falling.
The role of the Personal Support Worker:
• Follows preventative measures as per the plan of care.
• Follows the nursing restorative program and reports to the Unit Supervisor

The home's "Annual Evaluation Summary Report: Falls Prevention Program" was reviewed for 2019. The target dates included dates of April and May 2019.There was no documentation in the "Outcomes" column or the "Date of Achieved Outcomes" column.

The licensee has failed to ensure that the falls prevention and management program, at a minimum, provided clear direction for staff that included strategies to reduce or mitigate falls, including the monitoring of residents, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. [s. 49. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, every alleged, suspected or witnessed incident that the license knew of, or that was reported to the licensee, was immediately investigated and appropriate action was taken in response to every such incident, for anything else provided for in the regulation.

The following is additional evidence to support Compliance Order #008 identified in complaint inspection #2019_736689_0024 with a compliance date of November 1, 2019.

Ontario Regulation 79/10 s. 107 (1) 2 states that every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, an unexpected or sudden death, including a death resulting from an accident or suicide, followed by the report.

Specifically, the licensee has failed to ensure that the incident that the licensee knew of, related to the sudden and unexpected death of a resident, was investigated and appropriate actions taken related to such incident.

The home submitted Critical Incident to the Ministry of Long-Term Care (MLTC), related to the unexpected death of a resident.

Record review of the paper chart and the health record in Point Click Care (PCC)

was completed for the resident and showed that the resident was to have specific interventions in place. The call bell reports and video footage were also reviewed during the inspection.

In an interview with a staff member who found the resident unresponsive, the staff member shared that all of the required interventions were not in place at the time when the resident was found.

The tasks and documentation of tasks in Point of Care (POC) in PCC were reviewed and showed tasks of checking the specific interventions that were to be in place for this resident. The documentation during a one-month period was not completed on 14 shifts. Documentation also showed that interventions were not in place on three shifts and documented as not applicable on four of the shifts (although it should have been applicable on those shifts).

In an interview with the Executive Director (ED), they said that they did not know if the interventions were in place when the resident was found unresponsive. The ED said no investigation was completed related to the resident's care, what should have been in place or what was in place at the time of their death. They said that should have been part of the investigation and they didn't do enough to see that part. The ED said reviewing the progress notes would have been helpful, it didn't get done and it should have been.

The licensee has failed to ensure that the unexpected death of a resident was immediately investigated and appropriate actions taken in response to the incident. [s. 23. (1)]

Issued on this 13th day of December, 2019 (A1)

[redacted]

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

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by RHONDA KUKOLY (213) - (A1)
Inspection No. / No de l'inspection :	2019_605213_0027 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	017168-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 13, 2019(A1)
Licensee / Titulaire de permis :	Sharon Farms & Enterprises Limited 108 Jensen Road, LONDON, ON, N5V-5A4
LTC Home / Foyer de SLD :	Earls Court Village 1390 Highbury Avenue North, LONDON, ON, N5Y-0B6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rob Bissonnette

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

To Sharon Farms & Enterprises Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 15 (1).
Specifically, the licensee must:
a) Review and revise if necessary, the home's "Bed Rails" policy to ensure that it meets the requirements of O. Reg. 79/10 s. 15 (1) and provides clear direction to staff regarding the assessments required to be completed for residents, where, when and how often.
b) Ensure that all registered staff and personal support worker (PSW) staff receive training related to the use of bed rails and associated risks, assessments required, required monitoring and documentation, relevant to their responsibilities.
c) Ensure that the training related to bed rails is included in the new staff orientation content for registered and PSW staff.
d) Keep a written record of all training related to bed rails, including staff names, dates and training content, to ensure that all staff receive the training.
e) Ensure that resident #034, #036 and #037, and all other residents using bed rails are assessed and their bed system is evaluated in accordance with evidence-based practices and, if there are none, in a accordance with prevailing practices, with any safety issues related to the use of bed rails addressed, to minimize the risk to the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

The home submitted a Critical Incident to the Ministry of Long-Term Care (MLTC) related to the unexpected death of a resident. The report indicated that bed rails were in use when the resident was found unresponsive.

A record review of the health record on paper and in Point Click Care (PCC) for the resident was completed. The last assessment related to the use of bed rails was the Bed rail Use Risk Assessment and was completed 15 months previously. This assessment stated that quarter rails were used day and night, prevented the resident from freely exiting the bed and were used to assist with turning in bed. The care plan in PCC for the resident stated the resident used both quarter side rails for bed positioning. It also stated the resident had a bolstered mattress to help prevent from

climbing out of bed.

In an interview with the Acting Director of Care (ADOC) and the Nurse Consultant (NC) from Responsive Health Management (RHM), the NC said that the Bed rail Use Risk Assessment had not been used in the home for approximately one year. The NC said that the expectation of the home was that the Lift/Transfer and Bed Safety Assessment was to be completed quarterly for residents using bed rails. The NC agreed that there were no Lift/Transfer and Bed Safety Assessments completed for the resident.

Another resident was observed in bed on four separate dates with quarter bed rails in use on both sides of the bed. A record review was completed for this resident and the care plan in PCC stated the resident used two quarter bed rails. The last assessment completed in PCC related to the use of bed rails was the Bed rail Use Risk Assessment and was completed 15 months prior. There were no Lift/Transfer and Bed Safety Assessments completed for that resident.

Another resident was observed in bed on three separate dates with quarter bed rails in use on both sides of the bed. A record review was completed for this resident and the care plan in PCC stated the resident used two quarter bed rails. The last assessment completed for this resident in PCC related to the use of bed rails was the Lift/Transfer and Bed Safety Assessment and was completed eight months prior.

Another resident was observed in bed on three separate dates with quarter bed rails in use on both sides of the bed. A record review was completed for this resident and the care plan in PCC stated the resident used two quarter bed rails. The last assessment completed in PCC related to the use of bed rails was the Bed rail Use Risk Assessment and was completed 16 months prior. There were no Lift/Transfer and Bed Safety Assessments completed for this resident.

The home's "Bed Rails" policy with a revised date of May 3, 2019 stated:
• The need for bed rail(s) will be reassessed with any change in the bed system and/or resident's status to reduce the risk of entrapment.
• The use of bed rails is being reassessed and coded in RAI MDS 2.0 on a quarterly basis.
The policy did not indicate the assessment tool to be used or how other safety issues related to the use of bed rails were to be addressed.

The licensee has failed to ensure that where bed rails were used, the resident was assessed, to minimize risk to the resident.

The severity of this issue was a level 3 as there was actual risk of harm to the residents. The scope was level 3, widespread as three out of four residents reviewed had not been assessed. Compliance history was a level 2 as the home did not have a history of non-compliance in this subsection of the legislation. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2020(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Order / Ordre :

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

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

The licensee must be compliant with O. Reg. 79/10 s. 49 (1).
Specifically, the licensee must:
a) Review the Falls Prevention Annual Evaluation Summary Report completed in 2019 and update planned improvement initiatives/change idea and how the home will measure goal achieved, target dates, responsible person/team, outcomes and date of achieved outcomes. Document the review and changes made to the evaluation.
b) Review and revise if necessary, the home's "Falls Prevention Program" and policy to ensure that it meets the requirements of O. Reg. 79/10 s. 48(1) 1, 48(2) and 49(1) and provides clear direction to staff regarding the assessments required to be completed for residents, where, when and how often.
c) Ensure that all registered staff and personal support worker (PSW) staff receive training related to falls prevention, assessments required, interventions available in the home, required monitoring and documentation required, specific to their responsibilities.
d) Keep a written record of all training related to falls prevention, including staff names, dates and training content, to ensure that all staff receive the training.
e) Ensure that resident #034, #036 and #037, and all other residents are assessed for the risk for falls, their care plans reviewed and revised based on that assessment and appropriate interventions identified in the plan of care related to falls prevention. Ensure that care provision and outcomes of the care set out in the plan of care and the effectiveness of the plan of care documented.

Grounds / Motifs :

1. The licensee has failed to ensure that the falls prevention and management program, at a minimum, provided for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The home submitted a Critical Incident to the Ministry of Long-Term Care (MLTC) related to the unexpected death of a resident. The report indicated that the resident had a history of climbing out of bed resulting in multiple falls and that multiple interventions related to falls prevention were in use.

Resident #1:
A record review of the health record on paper and in Point Click Care (PCC) for resident #1 was completed and the care plan showed several interventions related to falls prevention were to be in place.
Observations of the video surveillance and the call bell report for time of the resident's death, showed that one of the interventions were either not in place or not functioning. In an interview with a staff member who found the resident unresponsive, they said they did not recall seeing two of the interventions in place at the time the resident was found.
A record review of the tasks and documentation of tasks in PCC for this resident showed tasks related to ensuring that falls interventions were in place and in good working order for a one month period of time. The review showed there was no documentation for 14 shifts, for three shifts the documentation showed no, the interventions were not in place and in good working order and for five shifts the documentation showed not applicable (although the intervention would have been applicable during those shifts), during that one month time period.

In an interview with a Registered Nursing staff member, the staff member said that they were unsure when fall risk assessments were to be done and after checking the home's fall prevention program policy online and were still unsure. They said they used to have assessment in the computer and would give them a fall risk score, but they were unable to find that assessment. The staff member said that they recalled an incident when the intervention was not functioning and that when this happened, they were not replaced as they were no longer using that intervention. When the Inspector demonstrated that the resident's care plan that indicated an identified intervention, the staff member said that the wording was confusing and that staff may use a different intervention so that something was in place.

Resident #2:
Resident #2 was observed in bed on four separate dates with multiple falls prevention interventions in place. A record review was completed for this resident in PCC and the care plan showed the resident was at risk for falls and was to have several falls prevention interventions in place.
The care plan did not include any information related to the use of one of the interventions observed to be in place.
There were no Lift/Transfer and Bed Safety Assessments completed for this resident.

On an identified date, Inspectors observed one of the interventions to not be functional and alerted a personal support staff member, the staff member tested the intervention and agreed it was not functional and they would report it to registered staff.
The following date, the Inspectors observed the same intervention to still be in place and still not functional. Inspectors reported this to registered nursing staff who agreed it was not functional and they would use a different intervention instead.

In an interview with the Nurse Consultant (NC) from Responsive Health Management (RHM), the NC said that they went up and checked the intervention and spoke to the staff that day. They said that the a minor fix was implemented and the intervention was then functional.

Record review of the tasks and documentation of tasks in PCC for this resident showed tasks and documentation related to an identified falls prevention task was documented inconsistently, not at all or unclear. There were no tasks or documentation found in PCC related to one of the falls prevention interventions identified in the care plan.

Resident #3:
Resident #3 was observed in bed on three separate dates with with multiple falls prevention interventions in place. A record review was completed for this resident and the care plan showed the resident was at risk for falls and was to have several falls prevention interventions in place.
The last Lift/Transfer and Bed Safety Assessment completed in PCC for resident #036 was eight months prior.
Record review of the tasks and documentation of tasks in PCC for this resident showed tasks and documentation related to an identified falls prevention task was documented inconsistently, not at all or unclear.

Resident #4:
Resident #4 was observed in bed on three separate dates with with multiple falls prevention interventions in place. A record review was completed for this resident and the care plan showed the resident was at risk for falls and was to have several falls prevention interventions in place.
The care plan did not include any information related to one of the interventions that

was observed in place.
The last "Bed rail Use Risk Assessment" completed in PCC for this resident was 15 months prior.
There were no tasks or documentation related to falls prevention POC, in PCC.

A registered nursing staff member said that they were unsure when fall risk assessments were to be done, after checking the home's fall prevention program policy online and were still unsure. They said they used to have assessment in the computer and would give them a fall risk score, but they were unable to find that assessment.

In an interview with the Acting Director of Care (ADOC) and the Nurse Consultant (NC) from Responsive Health Management (RHM), the NC stated:
• Fall risk assessments were to be completed upon admission in PCC and then quarterly in the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)
• Lift/Transfer and Bed Safety Assessments were to be completed quarterly for every resident in PCC.
• Bolstered mattresses would be considered a restraint if they prevented a resident from getting out of bed and should have therefore had an assessment completed prior to putting the mattress in use to determine if the mattress was a restraint for that resident and any safety risks that the restraint posed.
• If a bolstered mattress was in use as a falls prevention intervention, there should have been direction in the plan of care related to that use. All falls prevention interventions should have been included in the plan of care to direct staff related to their use.
• The home was still using bed pad alarms on beds as a falls prevention intervention, there had been no direction to staff that they were no longer available.
• The use of bed alarms and chair alarms as falls prevention interventions were to be included in the plan of care when used and were to be documented every shift as being in use and functional.
• If a bed or chair alarm was found not functional upon checking, the PSWs were to immediately report this to registered staff.
• The bed pad alarms in the home were connected to the call bell system and if a bed pad alarm was triggered, it would then trigger the call bell.

The home's "Fall Prevention Program" stated, role of the unit supervisor:
• Determines level of risk.

• Implements interventions specific to risk.
• Makes environmental modifications if required an where possible.
• Documents interventions on care plan and electronic interdisciplinary notes.
• Assesses and coordinates nursing restorative programs aimed at preventing or minimizing falls such as equipment support such as positioning cushions, transferring devices, supportive devices, environmental factors, hip protectors, etc.
• Evaluates the plan of care in collaboration with the interdisciplinary care team, resident and family to ensure measures in place are effective at reducing and/or minimizing the risk of falling.
The role of the Personal Support Worker:
• Follows preventative measures as per the plan of care.
• Follows the nursing restorative program and reports to the Unit Supervisor

The home's "Annual Evaluation Summary Report: Falls Prevention Program" was reviewed for 2019. The target dates included dates of April and May 2019.There was no documentation in the "Outcomes" column or the "Date of Achieved Outcomes" column.

The licensee has failed to ensure that the falls prevention and management program, at a minimum, provided clear direction for staff that included strategies to reduce or mitigate falls, including the monitoring of residents, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The severity of this issue was a level 3 as there was actual risk of harm to the residents. The scope was level 3, widespread as it affected all residents in the home. Compliance history was a level 2 as the home did not have a history of non-compliance in this subsection of the legislation. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2020(A1)

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

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

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 Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 13th day of December, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by RHONDA KUKOLY (213) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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