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
Jun 1, 2017	2017_395613_0010	008979-17	Critical Incident System

Licensee/Titulaire de permis

AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
130 ELM STREET SUDBURY ON P3C 1T6

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

CEDARWOOD LODGE
860 GREAT NORTHERN ROAD SAULT STE. MARIE ON P6A 5K7

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

LISA MOORE (613)

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 15-19, 2017.

One Critical Incident the home submitted to the Director related to a resident fall resulting in injury.

During the course of the inspection, the inspector(s) spoke with the Operations Manager of Autumnwood, Interim Administrator, Director of Support Services, Physiotherapist, Maintenance staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector also conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed the Falls Prevention and Management Program.

A concurrent Follow up Inspection #2017_395617_0009 was also conducted during this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Safe and Secure Home

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	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director in May 2017. The CI report described that resident #001 had tripped on a dip in the

hallway floor, in a specific area, which resulted with the resident falling and sustaining an injury.

A review of the incident report and progress notes, identified that resident #001's fall was witnessed by PSW #106, who had reported to RN #101, that the resident had tripped over the floor joiner in the hallway, during supervised ambulation to a specified area. The cause of resident #001's fall was identified as a dip in the concrete floor.

During an interview on May 15, 2017, with the Interim Administrator, they informed the Inspector, that they and the Operations Manager determined that the cause of resident #001's fall might have been from the dip in the floor tile in the hallway. The Interim Administrator brought the Inspector to the location of the fall. The Inspector observed that the area had been repaired. The Interim Administrator revealed that the floor joiner, sometimes caused the residents' wheelchairs to bounce when they went over the floor joiner.

On May 16, 2017, the Inspector interviewed RPN #103, who had worked in May 2017, when resident #001 had fallen in a specific area. The RPN stated the floor was uneven and caused the fall and further revealed that the floor had been uneven since the LTC home had opened in May 2015.

On May 17, 2017, at 1645 hours, RPN #103 approached the Inspector and stated that they had provided the incorrect information to the Inspector as to the location where resident #001 had fallen. The RPN brought Inspector #613 to the hallway and showed them, the location where resident #001 had fallen in May 2017, which was approximately 20 feet down the hallway from the original location that had been shown to the Inspector. At the location of the fall, Inspector #613 observed a soft black rubber joiner that was approximately two inches wide, where the two concrete floors met, and spanned the hallway from wall to wall. The Inspector observed a slight upright unlevel difference where the floors met at the soft black rubber joiner. The Inspector showed RPN #103 where the floor had been repaired, at a different location. The RPN confirmed that was not the location where resident #001 had fallen. RPN #103 identified that the area where the resident had fallen, had been uneven since the LTC home had opened and that the unlevel floor joiner also caused the items on the medication cart to bounce when pushing the cart over it.

During interviews on May 18, 2017, with PSW #106 and PSW #107, they revealed that the soft black rubber floor joiner had always been unlevel. Both PSWs reported to the

Inspector that they were aware of the unlevel soft black rubber floor joiner and they had to be careful when they pushed residents in their wheelchairs over it, as the resident's wheelchairs would bounce when they transported residents in their wheelchairs over the floor joiner. PSW #106 confirmed they had witnessed resident #001 fall in May 2017, and that resident #001 had tripped over the unlevel soft black rubber floor joiner.

A review of the "Falls Prevention and Management Program" last revised February 2017, identified that the program objective was to identify and reduce or eliminate environmental risk factors for residents.

On May 18, 2017, the Inspector met with the Operations Manager. The Inspector informed them that the area of flooring that had originally been repaired was not been the location where resident #001 had fallen and identified the correct location where the resident had fallen. The Operations Manager verified that the unlevel soft black floor joiner had not been previously reported by any staff or the Joint Occupation Health and Safety Committee of the home, as a safety or tripping hazard. The Operations Manager confirmed that the soft black rubber floor joiner was unlevel and presented a potential environmental risk factor for the residents. When asked if the licensee had ensured a safe environment for residents, the Operations Manager stated, "We could have done a better job".

During an interview with the Interim Administrator, they informed the Inspector that the area where the floor joiner connected the two concrete floors had always been unlevel. [s. 5.]

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 home is a safe and secure environment for the residents, to be implemented voluntarily.

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Issued on this 2nd day of June, 2017

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

Original report signed by the inspector.