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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Oct 18, 2019	2019_790730_0028	019485-19	Critical Incident System

Licensee/Titulaire de permis

Ritz Lutheran Villa
16 Lot Road 164 5# R.R. #5 MITCHELL ON N0K 1N0

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

Mitchell Nursing Home
184 Napier Street, S.S. #1 MITCHELL ON N0K 1N0

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

CHRISTINA LEGOUFFE (730)

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): October 15 and 16, 2019.

The following Critical Incident System (CIS) intake was completed within this inspection:

Related to prevention of abuse and neglect:

Log #019485-19/ CI 2689-000009-19

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Administrator, a Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN), Registered Nurses (RNs), and a Personal Support Worker (PSW).

The inspector also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed policies and procedures of the home.

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	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. 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 where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the licensee was required to ensure that the strategy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 1, and in reference to O. Reg. 79/10, s. 49 (1) the licensee was required to have a falls prevention and management program that provided strategies to monitor residents.

Specifically, staff did not comply with the licensee's "Fall Prevention & Management" strategy (#RC-201-38, reviewed October 2018), which was part of the licensee's Falls Prevention and Management program, which required registered staff to avoid moving a resident after they had fall, if there was suspicion or evidence of an injury.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long Term Care (MOLTC) related to an alleged incident of resident to resident physical abuse. The CIS report stated that on a specified date staff heard residents #001 and #002 yelling at each other. Resident #002 was found on the floor in a specified area of the home and resident #001 was standing nearby. Resident #002 was transferred to hospital with a suspected injury.

Review of the progress notes in PCC for resident #002 showed a note titled "Fall with Injury" written by Registered Nurse (RN) #104, which stated that at a specified time, they were in the medication room and heard a loud noise. Resident #002 was found on the floor in a specified area of the home and resident #001 was standing nearby. The note stated that resident #002 had a visible injury. An initial assessment was completed. The resident also complained of pain. The note also detailed which assessments were

completed by RN #104. It said that a head to toe assessment was not completed as the resident was being transferred to hospital immediately, and that the writer would inform another RN to perform a head to toe assessment when the resident returned from hospital.

During two interviews with Personal Support Worker (PSW) #106, they said that they arrived in the home right after resident #002 fell. They said that the nurse had assessed the resident on the floor before they moved the resident via the passive lift into their wheelchair. They said that the resident was complaining of pain and was bleeding. They said that the resident was breathing heavily and crying. That said that they moved the resident into their bed using the passive lift from their wheelchair. They said that while the resident was in bed, they were trying to pull their pants down and was very agitated and crying. PSW #106 said that they and another PSW removed the resident's pants with approval from RN #107. PSW #106 said that the resident was in pain when they removed their pants and changed them into a gown.

During an interview with Director of Care (DOC) #100, they said that the typical practice in the home was to leave a resident where they fell until the ambulance arrived if there were signs or symptoms of a fracture. They said that the passive/sling lift would not be used if there was suspicion of a fracture, as it could have made a fracture worse. They said that were unaware that resident #002 had been moved from the floor in the dining room to bed until they spoke with RN #104, as their notes were not a good reflection of the events that had occurred. DOC #100 also said that it would be their expectation that a resident would stay in their own clothes if there was suspicion of a fracture. They said that staff should have explained to resident #002 that they could not remove their clothes, but that sometimes it was difficult to know how a resident with cognitive impairment would respond to pain.

During an interview with Administrator #101, they said that after a resident fell, they should not be moved until they had a head to toe assessment with no signs of pain or fracture. They said if the resident was in pain that they would call Emergency Medical Services (EMS). They also said that if a resident had a fall and was exhibiting pain that they would never move the resident or change the resident's clothing. They said that it would be their expectation that they would make the resident comfortable and possibly cover them with a blanket until the EMS arrived and initiated a transfer.

During a telephone interview with RN #104, they said that they had been working when resident #002 fell. They said that they had not witnessed the incident. RN #104 said they

saw an injury to the resident upon their arrival. They said that the resident was very agitated and scared. They said the resident complained of pain on the floor, but they could not point out where the pain was. RN #104 said they wanted to attend to the resident's injury. They said the resident was very scared once transferred to the wheelchair and was trying to get up. They said that they took resident #002 to bed, via their wheelchair and used the passive lift to get them into bed. They said they called the physician and told them that the resident was complaining of pain to a specified body part. The physician said to transfer the resident to hospital, so they called the paramedics. They said that they would not typically move a resident after a fall. They also said that they had not been present when the PSWs changed the resident into a gown, and that they would not expect that a resident would be changed into a gown after a fall.

The licensee has failed to comply with the home's strategy for Falls Prevention and Management, when resident #002 fell. [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 that the home's strategy for falls prevention and management is complied with, to be implemented voluntarily.

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. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. A) The licensee has failed to ensure that when a resident fell, a post- fall assessment

using a clinically appropriate assessment that was specifically designed for falls, was conducted.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long Term Care (MOLTC) related to an alleged incident of resident to resident physical abuse. The CIS report stated that on a specified date staff heard residents #001 and #002 yelling at each other. Resident #002 was found on the floor in a specified area of the home and resident #001 was standing nearby. Resident #002 was transferred to hospital with a suspected injury.

Review of the home's policy #RC-201-38 with subject "Fall Prevention & Management" with a reviewed date of October 2018, stated under the "Post Falls Assessment" heading that registered staff were to have "[completed] a Falls Incident Report, under the Risk Management portal in the computerized record; an associated progress note [would] be generated;…"

Review of the progress notes in PCC for resident #002 showed a note titled "Fall with Injury" written by Registered Nurse (RN) #104, which stated that at a specified time, they were in the medication room and heard a loud noise. Resident #002 was found on the floor in a specified area of the home and resident #001 was standing nearby.The note stated that resident #002 had a visible injury.

During an interview with Director of Care #100 they said that the expectation in the home was that after a resident fell, a post-fall assessment would be completed in Point Click Care (PCC) under the assessments tab. They said that the post falls assessment was triggered and linked to the Risk Management entry for falls.

Review of the assessments tab in PCC for resident #002 by inspector #730, did not show a post-fall assessment for resident #002 for their fall on the specified date.

During an interview with RN #103, they said that there was no post- fall assessment completed for resident #002, for the specified date. They said that they thought that it had not been completed because the resident was transferred to hospital.

During a telephone interview with RN #104, they said that they had been working when resident #002 fell. They said that they had not completed a post- fall assessment, as the incident occurred at the end of their shift and they had been focused on assessing the resident. They said that they had not thought to complete a post-fall assessment, but

typically would have if a resident had a fall.

B) During an interview with RN #103, they identified resident #004 as a resident who had recently sustained a fall.

A review of the progress notes in PCC for resident #004, showed a progress note titled "Fall Without Injury." The note stated that resident #004 was found lying on the floor between a piece of furniture and equipment. The resident stated that they were moving from the equipment to the furniture and laid down on the floor. The resident was assisted by two staff, using the passive lift, a head injury routine was initiated, and the resident denied pain.

A review of the Risk Management section in PCC by inspector #730 showed that an entry had been made for a "Fall" for resident #004 on a specified date. Under the "Action" section of the Risk Management entry it showed Triggered User Defined Assessments (UDAs). The "Post Fall Assessment- V2" was listed as "Not Created" and "Due: [past date]" under the UDAs.

During an interview with Personal Support Worker #106, they said that they had been working when resident #004 fell on a specified date. They said that the resident had a fall trying to transfer themselves.

During an interview with RN #105, they said that when a resident fell, they completed a post-fall assessment in Risk Management. They said that when registered staff were documenting the post-fall assessment would pop up in the UDAs in Risk Management. They said that they were aware that resident #004 fell recently and that a post-fall assessment was not completed related to resident #004's fall. They said that they expected that a post-fall assessment would have been completed related to this fall.

The licensee has failed to ensure that when residents #002 and #004 fell, post-fall assessments were conducted using a clinically appropriate assessment that was specifically designed for falls. [s. 49. (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 when a resident falls a post- fall assessment using a clinically appropriate assessment that was specifically designed for falls, is conducted, to be implemented voluntarily.

Issued on this 18th day of October, 2019

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

Original report signed by the inspector.