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 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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
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Bureau régional de services de Centre Ouest
1e étage 609 rue Kumpf
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Public Copy/Copie 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
Mar 27, 2019	2019_787640_0008	003476-19, 005010-19	Critical Incident System

Licensee/Titulaire de permis

488491 Ontario Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Avalon Retirement Centre
355 Broadway Avenue ORANGEVILLE ON L9W 3Y3

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

HEATHER PRESTON (640)

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): March 13, 14 and 15, 2019

The following Critical Incident reports were inspected:
Log #005010-19 related to fall with injury and significant change in condition.

The following Follow Up inspections were conducted during this inspection:
Intake #003476-19 related to CO #001 from inspection #2018_739694_0010 related to O.Reg 79/10, s. 50 (2), weekly skin assessments.

During the course of the inspection the Long Term Care Homes (LTCH) Inspector toured the home, observed the provision of care, reviewed clinical records, policy and procedure and conducted interviews.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Restorative Care Coordinator/Falls Prevention Program Lead, Director of Care (DOC) and the Administrator.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #001	2018_739694_0020	640

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 this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy or procedure, the policy or procedure was complied with.

In accordance with O. Reg. 79/10, s. 30, the licensee was required to ensure that the falls prevention program included policies related to the assessment and re-assessment of residents following any fall.

Specifically, staff did not comply with the licensee's policy "Resident Rights, Care and Services - Required Programs - Falls Prevention and Management - Program", Version 5 with a revised date of 2018-10-22, that directed staff to initiate head injury routine (HIR) if head injury was evident and for all unwitnessed falls, and; the licensee's policy "Resident Rights, Care and Services - Emergency Care - Head Injury", Version 3 with a revised date of 2016-7-18, that directed staff to initiate HIR for all head injuries sustained as a result of injury, fall or unknown origin.

a) On an identified date in February 2019, resident #006 sustained a fall where the resident was observed to have an injury. The resident was transferred to a higher level of care for further assessment.

The Long Term Care Homes (LTCH) Inspector reviewed the clinical record and found no specific assessments following this fall.

The Acting Director of Care (ADOC), told the LTCH Inspector there had not been any specific assessments completed following this fall.

b) Resident #008 sustained an unwitnessed fall on an identified date in February 2019 and the resident informed staff they had an injury.

The LTCH Inspector reviewed the clinical record and identified a specific assessment had been initiated immediately following the fall. All of the required assessments were not documented.

The ADOC told the LTCH Inspector that all required assessments were to be completed.

The ADOC acknowledged the specific assessments were not completed as per the policy for residents #006 and #008.

The licensee failed to ensure their policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring techniques when assisting residents.

On an identified date in February 2019, resident #006 was being assisted by staff from bed using a device. During the process resident #006 fell and sustained an injury. The resident was transferred to a higher level of care for further assessment.

The LTCH Inspector reviewed the clinical record and found that on an identified date in June 2018, a fall occurred under the same circumstances.

The licensee failed to ensure that residents were transferred using safe techniques. [s. 36.]

Additional Required Actions:

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

Issued on this 27th day of March, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HEATHER PRESTON (640)
Inspection No. / No de l'inspection :	2019_787640_0008
Log No. / No de registre :	003476-19, 005010-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 27, 2019
Licensee / Titulaire de permis :	488491 Ontario Inc. c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	Avalon Retirement Centre 355 Broadway Avenue, ORANGEVILLE, ON, L9W-3Y3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Klara Hamvas

To 488491 Ontario Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) (b) of O. Reg. 79/10.

Specifically, the licensee must ensure that:

a) The licensee's policy "Resident Rights, Care and Services - Required Programs - Falls Prevention and Management - Program" that directed staff to initiate head injury routine (HIR) if head injury was evident and for all unwitnessed falls is complied with; and

b) The licensee's policy "Resident Rights, Care and Services - Emergency Care - Head Injury" that directed staff to initiate HIR for all head injuries sustained as a result of injury, fall or unknown origin is complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy or procedure, the policy or procedure was complied with.

In accordance with O. Reg. 79/10, s. 30, the licensee was required to ensure that the falls prevention program included policies related to the assessment and re-assessment of residents following any fall.

Specifically, staff did not comply with the licensee's policy "Resident Rights,

Care and Services - Required Programs - Falls Prevention and Management - Program", Version 5 with a revised date of 2018-10-22, that directed staff to initiate head injury routine (HIR) if head injury was evident and for all unwitnessed falls, and; the licensee's policy "Resident Rights, Care and Services - Emergency Care - Head Injury", Version 3 with a revised date of 2016 -7-18, that directed staff to initiate HIR for all head injuries sustained as a result of injury, fall or unknown origin.

a) On an identified date in February 2019, resident #006 sustained a fall where the resident was observed to have an injury. The resident was transferred to a higher level of care for further assessment.

The Long Term Care Homes (LTCH) Inspector reviewed the clinical record and found no specific assessments following this fall.

The Acting Director of Care (ADOC), told the LTCH Inspector there had not been any specific assessments completed following this fall.

b) Resident #008 sustained an unwitnessed fall on an identified date in February 2019 and the resident informed staff they had an injury.

The LTCH Inspector reviewed the clinical record and identified a specific assessment had been initiated immediately following the fall. All of the required assessments were not documented.

The ADOC told the LTCH Inspector that all required assessments were to be completed.

The ADOC acknowledged the specific assessments were not completed as per the policy for residents #006 and #008.

The licensee failed to ensure their policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

The severity of this issue was determined to be a level 2, minimal harm or potential for actual harm. The scope of the issue was determined to be a level 2, pattern, as it related to two of three residents reviewed. The home had a

compliance history of 3 as they had previous related non-compliance with this section of the LTCHA that included;

- voluntary plan of correction (VPC) issued January 15, 2018 (2017_482640_0021)
- written notification (WN) issued February 8, 2019 (2018_739694_0020) (640)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 15, 2019

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with O.Reg, 79/10, s. 36, specifically the licensee must ensure that;

a) All direct care staff receive training on safe transfer of residents and,
b) All direct care staff receive training related to the use, care and adjustment of wheelchairs.

Grounds / Motifs :

1. The licensee failed to ensure that staff used safe transferring techniques when assisting residents.

On an identified date in February 2019, resident #006 was being assisted by staff from bed using a device. During the process resident #006 fell and sustained an injury. The resident was transferred to a higher level of care for further assessment.

The LTCH Inspector reviewed the clinical record and found that on an identified date in June 2018, a fall occurred under the same circumstances.

The licensee failed to ensure that residents were transferred using safe techniques. [s. 36.]

The severity of this issue was determined to be a level 3, actual harm/risk to the resident. The scope was determined to be a level 1, isolated as it related to one of three residents reviewed. The home had a level 3 compliance history as the home had previous related non-compliance with this section of the LTCHA that included;

- VPC issued December 6, 2016 (2016_431527_0017) (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 29, 2019

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:

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 27th day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Heather Preston

Service Area Office /
Bureau régional de services : Central West Service Area Office