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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 13, 2013	2013_049143_0058	O-000830-13	Complaint

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

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

BENDALE ACRES
2920 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1P-2T8

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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 10th and 11th, 2013.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Administrator, the Director of Care, three Nurse Managers, a Registered Practical Nurse, residents and a family member.

During the course of the inspection, the inspector(s) reviewed a resident health care record inclusive of plans of care, fall assessments, medication administration records, physician orders, lab results, hospital discharge records, fall prevention as well as head injury policies and procedures and the homes internal investigation of the incident.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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 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 :

Ontario Regulation 79/10 section 48.(1) states that every licensee of a long-term care

home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and risk of injury.

A review of the homes Falls Prevention and Management policy (RC-0518-20, review date 01-04-13) was completed.

Procedure A. Falls risk assessment (page 2 of 6) procedure 3 RN/RPN states:
After each fall, convene the care team to identify root causes for the fall by completing the Post Fall Assessment Huddle.

Procedure C. Post Fall Management (page 5 of 6) states:
1. Initiate Head Injury Routine qhr x 24 hrs or as ordered by physician (including through the night) and assess the resident's level of consciousness and any potential injury associated with the fall.
2. Document resident's health status q 8 hrs x 24 hrs post fall.
3. Notify the attending Physician and ensure immediate treatment after the fall. Inform the physician if resident is receiving heparin, coumadin or aspirin.
4. Complete incident report and detailed progress note.
6. Conduct Post Fall Assessment Huddle meeting with the interdisciplinary Care Team present on the unit at the time of the fall. Identify root causes for the fall and preventative strategies for future fall and injury prevention. Document the meeting on the Post Fall Assessment Huddle Form.
9. Communicate to all shifts in the 24 Hour Report that resident has fallen and is at risk to fall.
10. Monitor the resident for 48 hours after a fall and if resident is receiving anticoagulants document results and report immediately to physician any signs of bleeding.
11. Monitor implementation of preventative measures identified during the Post Fall Assessment Huddle.

Resident #1's plan of care indicates that the resident is at high risk for falls and receives coumadin.

On a specified date Resident #1 fell. Registered Nurse(RN) (S107) and a Registered Practical Nurse(RPN) (S108) were called to assess the resident. S108(RPN)

documented an assessment in the progress notes that Resident #1 fell.

A review of the health care record indicated that there was no evidence to indicate that the RN S107 completed a documented assessment of the resident. S107 failed to notify the attending physician of resident #1's fall and inform the physician that the resident was receiving coumadin. S107 failed to complete a Post Fall Assessment Huddle, failed to identify that the resident was on an anticoagulant and at risk for a bleed, did not initiate and direct the RPN S108 to implement the head injury routine and monitor the resident hourly. There is no evidence to support that S107 implemented preventative measures to decrease the risk of Resident #1 having another fall, which occurred approximately 6 and 1/2 hours later.
In addition to this there is no documented evidence that Registered Practical Nurse S108 implemented the head injury routine and completed hourly assessments as required within policy RC-0518-20.

On a specified date (approximately 6.5 hours following the first fall) Resident #1 sustained another fall and was assessed by a Registered Practical Nurse S109. S109 documented that resident #1 was found on her/his back and sustained an injury and was assessed, no complaint of pain and head injury routine started. S109 initiated the head injury routine form at a specified time. S109 completed additional documentation on the Head Injury Routine form at approximately two hour intervals.

A review of the health care record indicated that S109 failed to monitor, assess and document Resident #1's condition hourly as per policy RC-0518-20.

On a specified date RN (S110) documented that resident had dry blood noted on his/her injury and bruising. S110 documented that the ambulance was called and that the resident was transferred to hospital. Resident #1 was admitted to hospital for further assessment.

The home completed an internal investigation of the incident. This internal investigation indicated that S108 (RPN) and S107 (RN) had observed a large hole and an indentation in a wall and had discussed the cause of the damaged wall. The Inspector was provided by the complainant a picture of this hole and it was determined that the size of the hole was approximately 10 to 15 centimetres (cm) in diameter with a lateral crack of approximately 6-10 cms in the drywall. The homes internal investigation determined that Resident #1 had sustained an injury as a result

of striking themselves on the wall and not from the second fall that occurred approximately 6.5 hours later.

Management staff at the home completed an internal investigation and staff received progressive discipline.
It is noted that at the time of this inspection Bendale Acres had revised and updated the Falls Prevention and Management Policy with a published and approval history date of August 1st, 2013.

The licensee has failed to comply with Ontario Regulation 79/10 section 8.(1)(b) by not complying with the homes falls prevention and management policy. [s. 8. (1)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act
Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. On a specified date Resident #1 fell and sustained an injury. Resident #1 had an additional fall approximately 6.5 hours later. The resident was transferred and admitted to hospital. The home completed an internal investigation of the incident. The home determined that a Registered Nurse (RN) (S107) had neglected the resident by her/his inaction and had placed the resident's health, safety and well being at risk. The RN was called to assist a Registered Practical Nurse and had failed to complete a thorough assessment of the resident and to document her/his findings. The internal investigation further indicated that the RN failed to follow up with the resident, failed to conduct and document an assessment and failed to provide guidance and assistance to the Registered Practical Nurse. The RN received progressive discipline. While completing this investigation the inspector was advised by the Administrator that the RN had neglected the resident.

Ontario Regulation 79/10 section 5 indicates the following: For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.
Ontario Regulation 79/10 section 104. (3) indicates the following: If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.
On March 28th, 2012 the Acting Director provided a memorandum to the long term care homes that identified the period of time for a final report as 21 days.

Bendale Acres submitted a Critical Incident Report to the Ministry of Health and Long Term Care indicating an injury resulting in a transfer to a hospital. The amended report did not make reference to any allegations of abuse or neglect.
On December 11th, 2013 the Administrator advised the inspector that she had not reported the results of her abuse or neglect investigation to the Director or any long term care homes inspector.

The licensee has failed to comply with the Long Term Care Homes Act 2007 section 23. (2) by not reporting the results of a neglect investigation. [s. 23. (2)]

WN #3: 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. On a specified date Resident #1 had a fall. The resident was observed and attended to by a Registered Nurse (S107) and a Registered Practical Nurse (S108). A review of Resident #1 health care record indicated that there was no evidence to support that a post fall assessment had been completed by either S107 or S108 at the time of the incident.

The licensee has failed to comply with Ontario Regulation 79/10 section 49.(2) by not ensuring that when a resident has fallen that a post-fall assessment is conducted. [s. 49. (2)]

Issued on this 17th day of January, 2014

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

Paul Miller

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

Ministére 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PAUL MILLER (143)
Inspection No. / No de l'inspection :	2013_049143_0058
Log No. / Registre no:	O-000830-13
Type of Inspection / Genre d' inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 13, 2013
Licensee / Titulaire de permis :	TORONTO LONG-TERM CARE HOMES AND SERVICES 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	BENDALE ACRES 2920 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1P-2T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARGARET AEROLA

To TORONTO LONG-TERM CARE HOMES AND SERVICES, 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) (b)

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 shall prepare, submit and implement a plan for achieving compliance to meet the requirement that the homes Falls Prevention and Management program is complied with.
The plan shall include an educational component to ensure that all Registered Nursing Staff are knowledgeable of the requirements of the falls prevention program including post falls assessment, documentation requirements and hospital transfers as required.

The plan is to be submitted in writing by January 2, 2014 to Nursing Inspector, Paul Miller at 347 Preston Street, 4th floor, Ottawa, Ontario K1S 3J4 or by fax at 1-613-569-9670

Grounds / Motifs :

1. Ontario Regulation 79/10 section 48.(1) states that every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and risk of injury.

A review of the homes Falls Prevention and Management policy (RC-0518-20, review date 01-04-13) was completed.

Procedure A. Falls risk assessment (page 2 of 6) procedure 3 RN/RPN states: After each fall, convene the care team to identify root causes for the fall by completing the Post Fall Assessment Huddle.

Procedure C. Post Fall Management (page 5 of 6) states:
1. Initiate Head Injury Routine qhr x 24 hrs or as ordered by physician (including through the night) and assess the resident's level of consciousness and any potential injury associated with the fall.
2. Document resident's health status q 8 hrs x 24 hrs post fall.
3. Notify the attending Physician and ensure immediate treatment after the fall. Inform the physician if resident is receiving heparin, coumadin or aspirin.
4. Complete incident report and detailed progress note.
6. Conduct Post Fall Assessment Huddle meeting with the interdisciplinary Care Team present on the unit at the time of the fall. Identify root causes for the fall and preventative strategies for future fall and injury prevention. Document the meeting on the Post Fall Assessment Huddle Form.
9. Communicate to all shifts in the 24 Hour Report that resident has fallen and is at risk to fall.
10. Monitor the resident for 48 hours after a fall and if resident is receiving anticoagulants document results and report immediately to physician any signs of bleeding.
11. Monitor implementation of preventative measures identified during the Post Fall Assessment Huddle.

Resident #1 plan of care indicates that the resident is at high risk for falls. The resident receives coumadin once a day to prevent blood clots.

On a specified date Resident #1 fell. Registered Nurse (S107) and a Registered Practical Nurse (S108) were called to assess the resident. S108 documented in the progress notes that the resident fell. S108 further documented vital signs and resident had no complaints.

A review of the health care record indicated that there was no evidence to indicate that the RN S107 completed a documented assessment of the resident. S107 failed to notify the attending physician of resident #1's fall and inform the physician that the resident was on an anticoagulant. S107 failed to complete a Post Fall Assessment Huddle, failed to identify that the resident was at risk for a bleed, did not initiate and direct the RPN S108 to implement the head injury routine and monitor the resident hourly. There is no evidence to suggest that

S107 implemented preventative measures to decrease the risk of Resident #1 having another fall, which occurred approximately 6 and 1/2 hours later.
In addition to this there is no documented evidence that Registered Practical Nurse S108 implemented the head injury routine and completed hourly assessments as required within policy RC-0518-20.

On a specified date Resident #1 sustained another fall (approximately 6 and one half hours later) and was assessed by a Registered Practical Nurse S109. S109 documented that resident #1 was found on her/his back on the floor, sustained an injury and was assessed with no complaints of pain and head injury routine started. S109 initiated the head injury routine and completed documentation for level of consciousness, vital signs and pupil reaction and size. S109 completed additional documentation on the Head Injury Routine form approximately every 2 hours.

A review of the health care record indicated that S109 failed to monitor, assess and document Resident #1 condition hourly as per policy RC-0518-20.

On a specified date RN (S110) documented that resident had dry blood noted on her/his injury and bruising, awake and responded well to verbal instructions. At a specified date and time S110 documented that ambulance called and to send to Hospital for further assessment and resident is on coumadin.

Resident #1 was admitted to hospital and assessed for an injury. On a specified date resident #1 returned to the nursing home.

The home completed an internal investigation of the incident. This internal investigation indicated that S108 (RPN) and S107 (RN) had observed on a specified date a large hole and an indentation in a wall and had discussed the cause of the damage wall. The Inspector was provided by the complainant a picture of this hole and it was determined that the size of the hole was approximately 10 to 15 centimetres (cm) in diameter with a lateral crack of approximately 6-10 cms in the drywall. The homes internal investigation determined that Resident #1 had sustained an injury as a result of striking the wall and not from the second fall.

Management staff at the home completed an internal investigation and staff received progressive discipline.
It is noted that at the time of this inspection Bendale Acres had revised and

updated the Falls Prevention and Management Policy with a published and approval history date of August 1st, 2013.

The licensee has failed to comply with Ontario Regulation 79/10 section 8.(1)(b) by not complying with the homes falls prevention and management policy. (143)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 28, 2014

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu' il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 13th day of December, 2013

Signature of Inspector / Signature de l'inspecteur : Paul Miller

Name of Inspector / Nom de l'inspecteur : PAUL MILLER

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