Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 08, 2020	2019_549107_0011 (A1)	014961-19, 015464-19	Critical Incident System

Licensee/Titulaire de permis

Blackadar Continuing Care Centre Inc.
101 Creighton Road DUNDAS ON L9H 3B7

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

Blackadar Continuing Care Centre
101 Creighton Road DUNDAS ON L9H 3B7

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

Amended by MICHELLE WARRENER (107) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee requested amendment to compliance due date. Compliance date has been extended to January 31, 2020.

Issued on this 8 th day of January, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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101 Creighton Road DUNDAS ON L9H 3B7

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

Amended by MICHELLE WARRENER (107) - (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): August 22, 23, 26, 27, 28, 29, September 3, 4, 5, 6, 10, 11, 2019.

This Critical Incident System Inspection was completed concurrently with the following inspections:

Follow Up Inspection 2019_549107_0012 / 010184-19, 010185-19,

Complaint Inspection 2019_549107_0010 / 026278-18, 031218-18.

The following Critical Incidents were included in this Critical Incident System Inspection:

Log #014961-19, CIS #2641-000012-19 related to fall with injury

Log #015464-19, CIS #2641-000013-19 related to fall with injury

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 6(7) and a Written Notification and Voluntary Plan of Correction were identified in this inspection and have been issued in Inspection Report 2019_549107_0012 / 010184-19, 010185-19, which was conducted concurrently with this inspection on the same dates.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care, Registered Nursing Staff (RN, RPN), Personal Support Workers (PSW), RAI-Co-ordinator, Physiotherapist (PT), Quality Manager, and the Dietary and Environmental Manager.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

5 WN(s)
2 VPC(s)
1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. A. The licensee failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the resident's care needs changed related to fall prevention and management.

The following information was identified in resident #001's clinical health record, including progress notes, care plan, and physiotherapy assessments, documentation provided to the Ministry of Health and Long Term Care through the Critical Incident System, and staff interviews:

Resident #001 had a fall on a specified date, and another fall that resulted in injury to the resident. The resident had a change in the level of assistance required for mobility and transferring as per documentation in the resident's clinical health record. The resident's needs changed again after the second injury according to a Physiotherapy assessment.

The resident's written plan of care was not revised to include the changes to the resident's mobility and transferring needs and several sections of the written plan of care were incomplete (generic blank spaces). During interview with Inspector #107, the Physiotherapist (#125) stated they updated the Physiotherapy section of the written plan of care and consulted with nursing staff related to their recommendations. During interview with Inspector #107, RN #113 confirmed that the Physiotherapist consulted with nursing staff related to the physiotherapy strategies required and stated nursing staff were responsible for updating the information on the rest of the resident's plan of care related to activities of daily living and other care areas.

During interview with Inspector #107, the Director of Care (#102) confirmed that

nursing staff were not consistently updating the resident's plan of care when care needs changed and that the information included in the plan for resident #001 was not reflective of the resident's physical status after the injuries and decline in condition.

B. The licensee failed to ensure that resident #013 was reassessed and the plan of care reviewed and revised when the resident's care needs changed after a decline in condition and hospitalization.

On a specified date, Inspector #107 observed resident #013. Personal Support Worker #123 stated that the resident had a significant decline in condition.

During interview with Inspector #107, RN #113 stated that resident #013 had been declining. According to the resident's plan of care and information provided by RN #113, the resident had a significant change in the level of assistance required for mobility, transferring, and eating.

The Physiotherapist completed an assessment of the resident after the decline in condition and identified the resident required increased assistance with mobility and transfers.

During interview with Inspector #107, RN #113 confirmed that nursing staff were responsible for updating the information on the resident's written plan of care related to activities of daily living and other care areas when there were changes in the resident's condition. The RN confirmed with Inspector #107 that the resident's plan of care had not been updated to reflect the decline in status with one exception.

During interview with Inspector #107, PSW #123 confirmed that the written plan of care for resident #013 that was available to the PSWs was not current and did not reflect the current needs of the resident. The PSW stated that the change in care needs had been communicated verbally; however, had not been updated in the resident's written plan of care.

During interview with Inspector #107, RN #113 confirmed that nursing staff were not consistently updating residents' written plans of care when the care needs changed and that the information included in the plan for resident #013 was not reflective of the resident's physical status and care needs for activities of daily living.

C. The licensee failed to ensure that resident #014 was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

On a specified date, Inspector #107 observed resident #014 using an assistive device for mobility. The resident indicated the device was new.

The resident's written plan of care identified the resident used a different device for assistance with mobility. The written plan of care also identified additional concerns and strategies related to the resident's mobility and safety.

During interview with Inspector #107, RN #113 identified that the resident had had a decline in status and was now using the device that was observed by Inspector #107. The resident no longer had the additional concerns and did not require the previous strategies related to the resident's mobility and safety. RN #113 confirmed that nursing staff were not consistently updating residents' written plans of care and that the information included in the plan for resident #014 was not reflective of the resident's current care needs for activities of daily living after the decline in the resident's condition. [s. 6. (10) (b)]

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 / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: 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 failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol and procedure, the policy, protocol and procedure was complied with.

1. In accordance with O.Reg.79/10, s. 48(1)1 and in reference to O.Reg. 79/10, s. 49(2), the licensee was required to have a falls prevention and management program that included a post-fall assessment using a clinically appropriate assessment instrument that was specifically designed for falls.

A. Specifically, staff did not comply with the licensee's Fall Prevention and Management Program RC-15-01-01, updated February 2017, that required staff to complete a "Clinical Monitoring Record" as part of the post fall assessment process after any un-witnessed falls or suspected head injury. The "Clinical Monitoring Record – Appendix 10", updated February 2017, directed staff to monitor the following every hour for four hours then every eight hours for 72 hours: neurovital signs (if head/brain injury suspected or the fall was un-witnessed), vital signs (temperature, pulse, respiration, blood pressure, oxygen saturation), assess for pain, and monitor for changes in behaviour. The Fall Prevention and Management Program policy also directed staff to notify the Physician/Nurse Practitioner if there was a sudden change in vital signs and/or neurological assessment and to document the fall and results of all fall assessments and actions taken during the 72 hour post-fall follow-up.

i) Staff did not complete all the required sections on the Clinical Monitoring Record every hour for four hours then every eight hours for 72 hours, as required by the home's policy for resident #001.

According to documentation in the resident's clinical health record resident #001 had a fall on a specified date. Staff identified in the progress notes that the resident fell and that clinical monitoring for head injury recorded on the Clinical Monitoring Record was required. Clinical Monitoring Records completed every hour after the fall for four hours did not consistently include all of the required information.

Documentation in the resident's clinical health record identified the resident had another fall on a specified date, and staff identified it was an un-witnessed fall that required clinical monitoring for head injury on the Clinical Monitoring Record. Clinical Monitoring Records did not consistently include an assessment of pain. Documentation in the resident's progress notes indicated the resident complained of pain at the time of the fall, however, subsequent monitoring records did not include any assessment of the resident's pain level.

During interview with Inspector #107, Director Of Care (DOC) #102 confirmed that not all sections of the Clinical Monitoring Records were completed as required by the licensee's policy.

ii) According to documentation in the resident's clinical health record, resident #013 had an un-witnessed fall on a specified date. Nursing staff initiated a Falls Management – Clinical Monitoring Record, however, not all of the monitoring records were completed as per the home's policy.

The Clinical Monitoring Records were incomplete for five dates/times. On one of the assessments, staff did not complete an assessment of all of the required neurovitals.

The Clinical Monitoring Record for an identified date identified changes in neurovitals from the previous assessment. Documentation in the assessment, clinical progress notes, and Physician orders, did not indicate that this was reported to the resident's Physician or the Nurse Practitioner. During interview with Inspector #107, RN #113 confirmed that the change in neurovital signs indicated in the monitoring record would have been something that required reporting to the resident's Physician or NP, as per the home's policy.

According to documentation in the resident's clinical health record, the resident had significant swings in their vital signs during the monitoring duration. The vitals section on the home's computerized documentation system flagged pulse rates

higher or lower than a specific number. Registered Nurse #113 identified that the resident had a medical condition and that changes in the resident's vitals would not be flagged or reported to the Physician and the Physician would review the vitals at the three month medication review. Direction was not provided for staff related to when to notify the Physician related to changes in the resident's vitals after a fall when the direction was different than that identified through the home's flagging system and policy direction.

iii) Staff did not complete all the required sections on the Clinical Monitoring Record every hour for four hours then every eight hours for 72 hours, as required by the home's policy for resident #014.

According to documentation in the resident's clinical health record, resident #014 had an un-witnessed fall on a specified date. A Post Fall Assessment was completed with vitals recorded. The next Clinical Monitoring Record was recorded the next calendar day. Neurovital signs, vital signs, pain assessments or changes in behaviour were not recorded in the progress notes, or "Vitals" or "Assessment" tabs in Point Click Care electronic documentation system between the time of the Post Fall Assessment and the next calendar day. During interview with Inspector #107, RN #113 confirmed that resident #014 sustained an un-witnessed fall that would have required monitoring on the Clinical Monitoring Record as per the home's policy and that the monitoring was not available until the next calendar day.

B. Specifically, staff did not comply with the licensee's Fall Prevention and Management Program RC-15-01-01, updated February 2017, that required staff to complete a "Scott Fall Risk Screen Appendix 4" on admission, annually, with a change in condition that could potentially increase the resident's risk of falls/fall injury, or after a serious fall injury or multiple falls.

The licensee's Fall Prevention and Management Program RC-15-01-01, updated February 2017, identified several factors that would place a resident at immediate risk for falls.

According to documentation in the resident's clinical health record, resident #001 had a change in condition that would increase their risk of falling and the resident also had a history of previous falls with injury.

A Scott Fall Risk Screen was completed on a specified date. The assessment did not include several risk areas that were identified in the resident's clinical health record, which would have changed the risk screen score. The Scott Fall Risk Screen tool directed staff to follow a universal fall prevention plan, however, additional strategies for fall prevention would have been indicated based on the risk factors identified in the resident's clinical health record.

After the Scott Fall Risk Screen was completed, resident #001 fell and it resulted in an injury to the resident, as per documentation in the resident's progress notes.

During interview with Inspector #107, the Director of Care (#101) and Administrator (#100) confirmed that the Scott Fall Risk Screen was not completed according to the home's policy. The assessment did not include all the risk factors present and did not reflect the level of risk associated with the resident's change in condition.

2. In accordance with O.Reg.79/10, s. 48(1)4 and in reference to O.Reg. 79/10, s. 52(1)2,4, the licensee was required to have a pain management program that included strategies to manage pain and monitoring of residents' responses to and the effectiveness of the pain management strategies.

A. Specifically, staff did not comply with the licensee's policy, "RC-19-01-01 Pain Identification and Management", updated February 2017. The policy directed staff to assess residents for pain using the Pain Flow Note in Point Click Care (PCC) or PAINAD if verbally or cognitively impaired, for residents who stated they had pain or any change in condition that had the potential to impact the resident's pain level.

i) According to documentation in the resident's clinical health record, resident #001 had an un-witnessed fall on a specified date. Progress notes related to the event identified the resident complained of pain. The progress note did not identify where the pain was located, and did not identify if pain strategies were initiated or effective. The resident did not have a Pain Flow Note in PCC and no pain assessment, treatment, or monitoring was noted in the resident's clinical record.

During interview with Inspector #107, Director of Care #101 confirmed that when pain was identified in a Clinical Monitoring Record that staff were required to

complete a pain assessment note in Point Click Care and that strategies to reduce pain were to be offered to the resident and documented in the progress notes. The Director of Care (#101) confirmed that the home's policy related to pain identification and management was not followed by staff.

ii) According to documentation in the resident's clinical health record, resident #013 had an un-witnessed fall on a specified date. During the post fall follow up period, it was identified on a Clinical Monitoring Record that the resident stated they had pain. The resident did not have a Pain Flow Note in PCC and no pain assessment or treatment was noted in the resident's clinical record. During interview with Inspector #107, RN #113 confirmed that pain assessments were required to be documented every hour after a fall with a verbal report of pain and that documentation did not reflect the required pain monitoring. [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 with ensuring that 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,
(b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the Falls Prevention and Management Program was evaluated and updated at least annually in accordance with evidence-based practices.

During interview with Inspector #107, the Administrator (#100) confirmed that an annual evaluation of the home's Fall Prevention and Management Program was not completed for 2018 and had not yet been completed for 2019. The annual evaluation was scheduled for August 2018, however, was not completed according to the schedule. [s. 30. (1) 3.]

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 with O.Reg. 79/10, s. 30. (1) 3 The Falls Prevention and Management program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee did not ensure that all doors leading to non-residential areas were kept closed and locked, to restrict unsupervised access, when they were not being supervised by staff.

On a specified date, Inspector #107 was walking in the hallway and observed the door to the "Boiler Room" was propped open, unsupervised, and unrestricted. Residents were in the area within the same hallway. Inspector #107 was able to enter the room and confirmed that it was unoccupied and unsupervised.

The door to the room had been propped open and secured in the open position with a white cord/rope that was attached to both the wall and door handle. A man returned to the room about five minutes later and identified themselves as a contracted service provider at the home to do routine maintenance. The man was unaware of the need to keep the door secure when the area was unsupervised. The door was secured when the man left the area.

Approximately ten minutes later, Inspector #129 confirmed with the Environmental Services Manager (#117) that the man was a contracted service provider and that the door was required to be closed and locked when the area was not being supervised by staff. [s. 9. (1) 2.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of an incident that caused an injury to resident #001, for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

According to documentation in the resident's clinical health record, resident #001 had an un-witnessed fall on a specified date. The resident sustained an injury and was taken to hospital. During interview with Inspector #107, Director of Care (DOC) #101 confirmed the injury resulted in a significant change in the resident's health condition.

A critical incident report related to this fall was submitted to the Ministry of Health and Long Term Care (MOHLTC) eights days after the resident was sent to hospital. During interview with Inspector #107, both the Director of Care (DOC) (#101) and the Administrator (#100) confirmed that the Director was not informed within one business day of the incident where resident #001 was taken to hospital with an injury that resulted in a significant change in the resident's health status.

The Director of Care (#101) stated that they were away from the building at the time of the fall and that the home's computer system was not consistently working. The Director was informed of the incident through the Critical Incident System upon the Director of Care's return to the building. The Director of Care (#101) and Administrator (#100) both confirmed that staff did not call the MOHLTC to inform them of the injury when the computer system was not working and did not follow the home's process for reporting critical incidents while the Director of Care was away from the building. [s. 107. (3) 4.]

Issued on this 8 th day of January, 2020 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MICHELLE WARRENER (107) - (A1)
Inspection No. / No de l'inspection :	2019_549107_0011 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	014961-19, 015464-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 08, 2020(A1)
Licensee / Titulaire de permis :	Blackadar Continuing Care Centre Inc. 101 Creighton Road, DUNDAS, ON, L9H-3B7
LTC Home / Foyer de SLD :	Blackadar Continuing Care Centre 101 Creighton Road, DUNDAS, ON, L9H-3B7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shelly Desgagne

To Blackadar Continuing Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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 # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s. 6(10)(b).

Specifically the licensee must:
A) Complete a review of all resident written plans of care available to staff for the provision of care, including residents #013 and #014, to determine if the care needs identified in the plans of care are current and reflective of resident needs.
B) Keep a documented record of the review.
C) Develop and implement a process to ensure that resident plans of care remain current and are updated when resident care needs change
D) Conduct an audit, at a schedule of the homes choosing, to ensure that resident plans of care are revised when care needs change and are reflective of current care needs.
E) Keep a documented record of the audit.

Grounds / Motifs :

1. A. The licensee failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the resident's care needs changed related to fall prevention and management.

The following information was identified in resident #001's clinical health record, including progress notes, care plan, and physiotherapy assessments, documentation provided to the Ministry of Health and Long Term Care through the Critical Incident System, and staff interviews:

Resident #001 had a fall on a specified date, and another fall that resulted in injury to the resident. The resident had a change in the level of assistance required for mobility and transferring as per documentation in the resident's clinical health record. The resident's needs changed again after the second injury according to a Physiotherapy assessment.

The resident's written plan of care was not revised to include the changes to the resident's mobility and transferring needs and several sections of the written plan of care were incomplete (generic blank spaces). During interview with Inspector #107, the Physiotherapist (#125) stated they updated the Physiotherapy section of the written plan of care and consulted with nursing staff related to their recommendations. During interview with Inspector #107, RN #113 confirmed that the Physiotherapist consulted with nursing staff related to the physiotherapy strategies required and stated nursing staff were responsible for updating the information on the rest of the resident's plan of care related to activities of daily living and other care areas.

During interview with Inspector #107, the Director of Care (#102) confirmed that nursing staff were not consistently updating the resident's plan of care when care needs changed and that the information included in the plan for resident #001 was not reflective of the resident's physical status after the injuries and decline in condition.

B. The licensee failed to ensure that resident #013 was reassessed and the plan of care reviewed and revised when the resident's care needs changed after a decline in condition and hospitalization.

On a specified date, Inspector #107 observed resident #013. Personal Support Worker #123 stated that the resident had a significant decline in condition.

During interview with Inspector #107, RN #113 stated that resident #013 had been declining. According to the resident's plan of care and information provided by RN

#113, the resident had a significant change in the level of assistance required for mobility, transferring, and eating.

The Physiotherapist completed an assessment of the resident after the decline in condition and identified the resident required increased assistance with mobility and transfers.

During interview with Inspector #107, RN #113 confirmed that nursing staff were responsible for updating the information on the resident's written plan of care related to activities of daily living and other care areas when there were changes in the resident's condition. The RN confirmed with Inspector #107 that the resident's plan of care had not been updated to reflect the decline in status with one exception.

During interview with Inspector #107, PSW #123 confirmed that the written plan of care for resident #013 that was available to the PSWs was not current and did not reflect the current needs of the resident. The PSW stated that the change in care needs had been communicated verbally; however, had not been updated in the resident's written plan of care.

During interview with Inspector #107, RN #113 confirmed that nursing staff were not consistently updating residents' written plans of care when the care needs changed and that the information included in the plan for resident #013 was not reflective of the resident's physical status and care needs for activities of daily living.

C. The licensee failed to ensure that resident #014 was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

On a specified date, Inspector #107 observed resident #014 using an assistive device for mobility. The resident indicated the device was new.

The resident's written plan of care identified the resident used a different device for assistance with mobility. The written plan of care also identified additional concerns and strategies related to the resident's mobility and safety.

During interview with Inspector #107, RN #113 identified that the resident had had a decline in status and was now using the device that was observed by Inspector #107. The resident no longer had the additional concerns and did not require the

previous strategies related to the resident's mobility and safety. RN #113 confirmed that nursing staff were not consistently updating residents' written plans of care and that the information included in the plan for resident #014 was not reflective of the resident's current care needs for activities of daily living after the decline in the resident's condition. [s. 6. (10) (b)]

The severity of this issue was determined to be a level 1 as there was no actual harm to the residents. The scope of the issue was a level 3 as it related to three of three residents reviewed for falls management. The home had a level 3 history of previous non-compliance with the same subsection of the Act that included:
Voluntary Plan of Correction (VPC) issued February 13, 2018, (2017_555506_0027)

Additionally, the LTCH has a history of nine other compliance orders in the last 36 months.

(107)

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 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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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 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 8 th day of January, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by MICHELLE WARRENER (107) - (A1)

Ontario

Ministry of Long-Term Care

Ministère 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 : Hamilton Service Area Office