Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 13, 2017	2017_508137_0018	004796-17, 004824-17	Follow up

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE FERGUS NURSING HOME
450 QUEEN STREET EAST FERGUS ON N1M 2Y7

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

MARIAN MACDONALD (137), ALI NASSER (523)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 24, 25, 28 and 29, 2017

The Follow up inspection was completed related to:
Log #'s 019479-16, 020115-16, 031240-16, follow up to Compliance Order # 001 related to assessments of residents, issued on February 24, 2017 during a Complaint Inspection # 2016_262523_0040, with a compliance date of March 31, 2017.
Log #'s 019479-16, 020115-16, 031240-16, follow up to Compliance Order # 002 related to neglect of residents, issued on February 24, 2017 during a Complaint

Inspection # 2016_262523_0040, with a compliance date of March 31, 2017.
Log #'s 032582-15, 027162-16 and 027164-16, follow up to Compliance Order # 001 and Director's Referral # 001, related to the home, furnishings and equipment were kept clean and sanitary, issued on February 24, 2017, during a Follow up Inspection # 2016_262523_0038, with a compliance date of March 31, 2017.
Log #'s 032582-15, 027162-16 and 027164-16, follow up to Compliance Order # 002 and Director's Referral # 001, related to the home, furnishings and equipment were maintained in a safe condition and in a good state of repair, issued on February 24, 2017, during a Follow up Inspection # 2016_262523_0038, with a compliance date of March 31, 2017.
Log #'s 032582-15, 027162-16 and 027164-16, follow up to Compliance Order #003 related to developing and implementing a process implemented for all residents demonstrating responsive behaviours to ensure strategies have been developed and implemented to respond to the residents' responsive behaviours, issued on February 24, 2017, during a Follow up Inspection # 2016_262523_0038, with a compliance date of March 31, 2017.
Log #'s 032582-15, 027162-16 and 027164-16, follow up to Compliance Order # 004 related to procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, issued on February 24, 2017, during a Follow up Inspection # 2016_262523_0038, with a compliance date of March 31, 2017.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing, Resident Assessment Instrument (RAI) Coordinator, Administrative Assistant, Behaviour Supports Ontario (BSO) - Registered Practical Nurse (RPN), BSO Personal Support Worker (PSW), Environmental Manager, Nurse Practitioner, Attending Physician, Physiotherapist, Restorative Care Aide, Registered Nurse, Registered Practical Nurse, three Personal Support Workers, Housekeeper, family member and ten residents.

The Inspectors also conducted a tour of the home, including resident rooms and common areas, observed resident care provision and staff/resident interactions, reviewed residents' clinical records, Risk Management Reports and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Falls Prevention
Responsive Behaviours

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Compliance Order # 001 was issued on February 24, 2017, with a compliance date of March 31, 2017, following a Complaint Inspection. The Compliance Order stated "The licensee shall ensure that staff involved in the resident's care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other".

A) Clinical record review for an identified resident showed that 16 of 30 (53.3 per cent) Post Fall Investigation forms did not include a specific impairment that had a significant impact on the resident's risk for falls.

In an interview, a Registered Staff member said that the identified resident had a specific impairment that had a significant impact on the resident's risk for falls and that the resident's assessments were not integrated, consistent with and did not complement each other.

B) Clinical record review for an identified resident showed that the resident was alert, confused/disoriented and able to follow direction, at the same time on 10 of 10 (100 per cent) Post Fall Investigation forms.
Seven of the ten corresponding Glasgow Coma Scale (GCS) assessments identified the resident as confused and three of ten GCS assessments identified the resident as oriented.

The Director of Nursing (DON) said that the identified resident could not be oriented and confused/disoriented, at the same time.
DON acknowledged that the assessments were not integrated, consistent with and did not complement each other.

C) Clinical record review for an identified resident showed that the resident was alert, confused/disoriented and able to follow direction, at the same time, on six of six (100 per cent) Post Fall Investigation forms. One corresponding GCS assessment identified the resident as oriented and one identified the resident as confused. One GCS assessment identified the resident as oriented and confused, at the same time. Three forms had no

GCS assessment completed.

D) In an interview, the DON said staff and others involved in the different aspects of residents' care were to collaborate with each other in the assessment of the residents so that their assessments were integrated, consistent with and complemented each other.

This area of non-compliance was determined to have a level two for severity, minimal harm or potential for actual harm and the scope was a level two, pattern.
The home does have a history of non-compliance in this subsection of the legislation.
It was issued as a:
Written Notification and a Compliance Order, on February 24, 2017, during a Complaint Inspection, under Inspection # 2016_262523_0040. [s. 6. (4)]

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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

Compliance Order # 001 and Director's Referral # 001 were issued on February 24, 2017, with a compliance date of March 31, 2017, following a Follow up Inspection. The Compliance Order stated "The home shall ensure that there is a process developed and

implemented for the scheduled cleaning of the home, furnishings and equipment, including window screens, light covers, ceiling tiles, privacy curtains, flooring and baseboards in resident rooms, bathrooms and common areas.
The home shall ensure a monitoring process is developed and implemented, including the staff responsible for monitoring to ensure that the home, furnishings and equipment are kept clean and sanitary".

Observations of randomly selected home areas and rooms identified:

• Window screens were dirty with cobwebs in thirteen identified resident rooms, tub room, lounge and cob webs on the small window, above the patio door in the photocopy room. Residents had access to this area, enroute to an outdoor patio.
• Privacy curtains were stained in seven identified resident rooms.
• Flooring was stained in five identified resident rooms, hallways and lounge.
• Accumulation of dark debris at baseboards in bedrooms/bathrooms of four identified resident rooms.
• Lingering, offensive odours were detected in three identified resident rooms.
• The base of two sit/stand lifts, located in the hallway, were dirty.
• Bedroom vent dusty in an identified resident room.
• Bathroom vents with significant dust in two identified resident rooms.
• Cobwebs and stain on the light fixture in an identified resident room.
• Floor fan was dusty, located in hallway, near Director of Nursing office.
• Cigarette butts were on the hallway floor, near Director of Nursing office, on two separate observations.
• Several of the resident room door frames had an accumulation of dark debris, at the floor level.

During interviews, two identified residents expressed concerns related to the cleanliness of the home.

Inspectors conducted a tour with the Administrator and Environmental Manager, to show them the identified housekeeping deficiencies.
Administrator and Environmental Manager agreed that the deficiencies existed.
Administrator said that while some work had been done, there was still a lot more to do.

During an interview, Administrator said they were responsible to review housekeeping procedures to ensure that there were methods/processes in place for monitoring the cleaning schedules but had only done it once.

The Administrator said management did not complete weekly walkabouts or audits but would be starting, as they were looking at the big picture instead.

During an interview, a Housekeeper said the current housekeeping checklists were implemented on April 1, 2017. The Housekeeper said they used different checklists before April 1, 2017, but had no idea what happened to them. Each room was to be deep cleaned once a year which included privacy curtains and window screens. Deep cleaning checklists were kept in the binder when completed and the Housekeeper did not know if the Administrator reviewed them or not.

During an interview, the Administrator said they understood that the Compliance Order was not complied with by the compliance due date of March 31, 2017, but they were going to put an action plan in place.

This area of non-compliance was determined to be a level two, minimal harm/risk or potential for actual harm/risk and the scope was a level three, widespread.
The home does have a history of non-compliance in this subsection of the legislation. It was issued as a:
• Written Notification, Compliance Order and a Director's Referral on February 24, 2017, under Inspection # 2016_262523_0038, during a Follow up Inspection;
• Written Notification and a Compliance Order on August 4, 2016, under Inspection # 2016_325568_0015, during a Resident Quality Inspection (RQI);
• Written Notification and a Compliance Order on March 16, 2016, under Inspection # 2015_448155_0020, during a Resident Quality Inspection (RQI). [s. 15. (2) (a)]

2. The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Compliance Order # 002 and Director's Referral # 001 were issued on February 24, 2017, with a compliance date of March 31, 2017, following a Follow up Inspection. The Compliance Order stated "The home shall ensure that a process is developed and implemented that identifies which staff are responsible for the monitoring and ensuring that the home, furnishings and equipment are in a safe condition and in a good state of repair".

Observations of randomly selected home areas and rooms identified:

• Several rust stains on the floor, to the left of the photocopier. Residents had access to

this area, enroute to an outdoor patio.
• Activity Room had chipped paint on the lower door, above door guard protector.
• Seven bubbled hallway tiles, located outside photocopier room entrance.
• Metal door guard protector was scraped on the treatment and clean utility room doors.
• Flooring was damaged and discolored at the nurses' desk. Chipped paint on medication room door and piece of baseboard was missing. Flooring discolored at entrance to Director of Nursing office.
• Lower wooden door was scratched to Hair Salon.
• Floor and wall were damaged in tub room and paint was blistered on the wall, below the nail clipper cabinet.
• The radiator cover was hanging off below the dining room windows. Scraped paint on a radiator below the window. Wooden base of a dining room storage cupboard was damaged. The dining room metal door guards were scraped.
• Lounge – Damaged floor tiles and wall by air vents.
• Thirteen identified resident rooms had damage such as metal strapping that secures ceiling tiles was rusted, walls needed painting, door frames damaged and/or chipped paint, damaged walls, cabinets under bathroom sinks damaged, window frames damaged, bathroom fixture rusted, plastic covering damaged on bedroom/bathroom doors, baseboard coming off near bathroom and bedroom doors and light fixture missing covers.
Several of the resident and common room door frames had chipped paint.

Inspectors conducted a tour with the Administrator and Environmental Manager to show them the identified maintenance deficiencies.
The Administrator and Environmental Manager agreed that the deficiencies existed.
The Administrator said that while some work had been done, there was still a lot more to do.
Environmental Manager said there were handyman hired to complete some repairs, at various time frames.

The Administrator and Environmental Manager acknowledged that some of the repairs were not satisfactorily completed and were not aware if anyone monitored or evaluated the finished workmanship.

The Administrator said that a process was not developed and implemented that identified which staff were responsible for the monitoring and ensuring that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

During an interview, the Administrator said they understood that the Compliance Order was not complied with by the compliance due date of March 31, 2017, but they were going to put an action plan in place.

This area of non-compliance was determined to be a level two, minimal harm/risk or potential for actual harm/risk and the scope was a level three, widespread.
The home does have a history of non-compliance in this subsection of the legislation. It was issued as a:
• Written Notification, Compliance Order and a Director's Referral on February 24, 2017, under Inspection # 2016_262523_0038, during a Follow up Inspection;
• Written Notification and a Compliance Order on March 16, 2016, under Inspection # 2015_448155_0020, during a Resident Quality (RQI) Inspection. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Compliance Order # 002 was issued on February 24, 2017, with a compliance date of March 31, 2017, following a Complaint Inspection. The Compliance Order stated "The licensee shall ensure that residents are not neglected by the licensee or staff.
The licensee shall complete a review of the falls prevention program and ensure that

residents are assessed post falls and their plan of care is updated accordingly.
The licensee shall ensure that the physician is called and informed at the time there is a change in the resident's status."

Under the Long-Term Care Homes Act, 2007, and Regulation 79/10, neglect was defined as "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".

A) Clinical record review and progress notes for an identified resident showed that the resident sustained a fall, resulting in an injury, discomfort and required assistance with care.
During an interview, the attending physician said they were not notified until they visited the home four days later. The physician said that they expected staff to call them and inform them of this change in the resident's status and that this was not the only time that they were not called by the staff for a change in a resident's condition.

In an interview, the DON said staff were to call the physician when there was a change in a resident's condition.

B) i) Clinical record review and plan of care for an identified resident directed staff to use specific fall prevention devices, to mitigate the risk for falls.

A review of the progress note showed that the identified resident sustained a fall, resulting in injury and required further medical attention.
A Post Fall Investigation form showed that there was no fall prevention device in place, at the time of the fall.
A review of progress notes showed there were incidents where the resident's fall prevention devices did not function and there were no replacements unavailable.

ii) Clinical record review for an identified resident showed that thirteen of thirty Post Fall Investigations forms had no indication of fall prevention devices being used at the time of the falls and seven unwitnessed falls had no head injury routine completed.

In an interview, the DON said staff were to complete head injury routine for unwitnessed falls or falls with head injury.

iii) An observation with a Personal Support Worker (PSW) showed that an identified

resident did not have fall prevention devices in place.
Inspectors observed an identified resident on the floor, crawling at their bedside and there were no fall prevention devices in place.
Observations with a Registered Staff member showed that an identified resident had fall prevention devices in place but they were not connected.
Observations with the DON and Inspectors showed that resident was in their chair without a fall prevention device in place.

In an interview, the DON said appropriate fall prevention devices were to be applied and the interventions in the plan of care be implemented.

C) i) Clinical record review and plan of care for another identified resident directed staff to have fall prevention devices in place.
A review of progress notes showed incidents where the fall prevention devices, for an identified resident, were not functioning and replacements were not available.

ii) Clinical record review for an identified resident showed that fourteen of twenty-six Post Fall Investigation forms had no indication that a specific fall prevention device was in use at the time of the falls, twenty-one of twenty-six forms had no indication that a fall prevention device was in use at the time of the falls and six unwitnessed falls had no head injury routine completed.

In an interview, the DON said staff were to complete head injury routine for unwitnessed falls or falls with head injury.

iii) Observations with a PSW showed that identified resident was in bed and fall prevention devices were not in place and those observed were not functioning.

Inspectors observed an identified resident in bed, the proper fall preventions devices were not in place and the devices, that were in place, were not functioning.

D) i) Clinical record review and plan of care for a third identified resident directed staff to ensure identified fall prevention devices were in place.
A review of progress notes showed incidents where that staff were not able to locate the fall prevention device, device did not function and there were none were available so a device was borrowed from another resident.

ii) Clinical record review for an identified resident showed that two of four Post Fall

Investigation forms had no indication that a fall prevention device was in place at the time of the falls.
A progress note review showed the identified resident sustained a fall with injury but there was no post fall investigation or Head Injury Routine (HIR) completed for this fall.

The DON said staff were to complete head injury routine for unwitnessed falls or falls with head injury.

iii) Inspectors observed that the fall prevention device, for an identified resident, was disconnected, not properly applied and, when connected, did not function.
Observation with DON showed that the device was not connected, that this put the resident at risk and that their expectation was for the staff to implement the interventions specified in the plan of care.

Observations with two Registered Staff members showed that an identified resident did not have the proper fall prevention devices in place. The staff members explained that this was not effective, as this put the resident at high risk for falls and the resident would be able to get out of bed without, triggering the alarm.

E) i) In an interview,a PSW said that the fall prevention devices frequently did not function and were not readily available for residents that needed them.

ii) In an interview, a Registered Staff member said that they do not have functioning or appropriate fall prevention devices in place. Residents did not have the appropriate fall prevention devices specified in the plan of care, which put the residents at risk. Residents did not have the appropriate fall prevention devices applied, which also puts them at risk. Residents continue to fall because staff were not able to apply the correct safety equipment for them.

iii) In an interview, a Registered Staff member said that residents were put at risk because necessary safety equipment was not available or not functional. Residents that required to have those fall prevention devices continued to fall and injure themselves, as those fall prevention devices were not present at the time of falls. There were very old fall prevention devices and some were past the expiry dates but still being used. Also they were not checked or maintained.
The management of the home was informed but fall prevention devices were not maintained or new fall prevention devices were not purchased.

iv) In an interview, the Physiotherapist (PT) said that they were aware of the shortages of fall prevention devices in the home. PT said that last week they wanted to put a device on a resident but were told that there were none in the building.
PT also said that they were aware of malfunctioning fall prevention devices, they witnessed a resident getting out of bed with device connected and the device did not function.

v) In an interview, a Registered Staff member said that they did not complete assessments on residents. The nurses would assess residents and then the Registered staff member would update the care plan. Registered Staff did not monitor the implementation or evaluate the interventions in the plan of care.
The Registered Staff member said that they were not aware that fall prevention devices were not being used and this would be what the RCC or DON would monitor.

vi) In a telephone interview, the manufacturer representative said that the fall prevention devices were considered expired after two years of use. The date on the fall prevention device was the date they were put into use and needed to be replaced two years after that date. One Inspector observed an outdated fall prevention device and a photograph was taken as supportive evidence.

vii) The DON said that the PSW staff would monitor if the alarms were functional or not. DON said that they were not aware of the expiry dates on the alarms. They said that there was no record of checks or maintenance completed for the bed/chair or Posey alarms.

F) DON said that the home did not complete a review of the falls prevention program. DON acknowledged that the review of the falls prevention program was part of the Compliance Order and that it was not completed as of yet.

G) A clinical record review, progress note for an identified resident an identified resident sustained a fall with injury and required further medication attention.
The resident was not assessed and the plan of care had not been reviewed or revised when the resident had a change in health status.

A Registered Staff member was not able to answer why the plan of care was not updated or why the resident was not assessed.

The DON acknowledged that the resident was not reassessed when they had a change in condition and the plan of care was not updated, although staff indicated in the progress note that the care plan was updated.
The DON said the resident was to be reassessed and the plan of care reviewed and revised when a goal in the plan was met, the resident's care needs changed, care set out in the plan was no longer necessary or if the care set out in the plan has not been effective.

This area of non-compliance was determined to have a severity of level three, actual harm/risk and the scope was a level three, widespread, as three of three (100 per cent) residents were affected.
The home does have a history of non-compliance in this subsection of the legislation.
It was issued as a:
Written Notification and a Compliance Order, on February 24, 2017, Inspection # 2016_262523_0040, during a Complaint Inspection. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident were identified, where possible;
(b) strategies were developed and implemented to respond to these behaviours, where possible; and
(c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Compliance Order # 003 was issued on February 24, 2017, with a compliance date of March 31, 2017, following a Follow up Inspection. The Compliance Order stated that "The licensee shall ensure there is a process developed and implemented for all residents demonstrating responsive behaviours to ensure strategies had been developed and implemented to respond to the residents' responsive behaviours.
The process shall include staff roles and responsibilities including which staff are responsible for monitoring the implementation of the strategies".

During an interview, the Director of Nursing (DON) said they were not aware if a process had been developed and implemented for all residents demonstrating responsive behaviours to ensure strategies have been developed and implemented to respond to the residents' responsive behaviours, including staff roles and responsibilities, as well as who was responsible for monitoring the implementation of the strategies. DON was not aware if Head Office had developed anything.
Director of Nursing said the Resident Care Coordinator had been responsible for the Behaviour Supports Ontario (BSO) team but was no longer employed at the home. The When asked what assessment tools were used in the home, DON said a BSO team member would be able to provide what the BSO team used.

During an interview, a Registered Staff member said a process had not been developed and implemented for all residents demonstrating responsive behaviours to ensure strategies had been developed and implemented to respond to the residents' responsive behaviours, including staff roles and responsibilities, as well as who was responsible for monitoring the implementation of the strategies.

The Registered Staff member said a Canadian Mental Health Association Consultant visited the home, approximately every six months and as needed, if requested. The

Consultant provided assessment tools for the home to use which were kept in a BSO binder for the BSO team to access.
The Registered Staff member said they were familiar with what was expected of them but there was no formal Behaviour Management Program, no process in place that outlines the role and responsibilities of the BSO team members and no process that identified who was responsible for monitoring the implementation strategies related to responsive behaviours.
The Registered Staff member said they were not familiar with the legislative requirements, related to responsive behaviours.

During an interview, the DON said that the Responsive Behaviour Program needed improvement as it did not meet the legislative requirements and they understood that the compliance order was not complied with by the compliance due date of March 31, 2017.
The Administrator and DON said they would check with Head Office and other homes for assistance related to strengthening their responsive behavior policy/program.

This area of non-compliance was determined to be a level two, minimal harm/risk or potential for actual harm/risk and the scope was a level three, widespread.
The home does have a history of non-compliance in this subsection of the legislation.
It was issued as a:
• Written Notification and a Compliance Order on February 24, 2017, under Inspection # 2016_262523_0038, during a Follow up Inspection;
• Written Notification and a Compliance Order on August 4, 2016, under Inspection # 2016_325568_0015, during a Resident Quality Inspection (RQI). [s. 53. (4)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that, (a) procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff were advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours posed a potential risk to the resident or others.

Compliance Order # 004 was issued on February 24, 2017, with a compliance date of March 31, 2017, following a Follow up Inspection. The Compliance Order stated that "The licensee shall ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents".

A review of the Resident Behaviour Management Policy, review date July 2016, showed there was no documented evidence that it included procedures and interventions to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

During interviews, with DON and a Registered Staff member, both said that procedures and interventions had not been developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. The DON was unsure if Head Office had developed anything.

During an interview, the DON said that the Responsive Behaviour Program needed improvement, as it did not meet the legislative requirements and they understood that the Compliance Order was not complied with by the compliance due date of March 31, 2017.

This area of non-compliance was determined to be a level two, minimal harm/risk or potential for actual harm/risk and the scope was a level three, widespread.
The home does have a history of non-compliance in this subsection of the legislation.
It was issued as a:
• Written Notification and a Compliance Order on February 24, 2017, under Inspection # 2016_262523_0038, during a Follow up Inspection.
• Written Notification and a Compliance Order on August 4, 2016, under Inspection # 2016_325568_0015, during a Resident Quality Inspection (RQI). [s. 55. (a)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed when a resident had an incident that caused an injury for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Clinical record review for an identified resident showed that the resident sustained a fall with injury, required further medical attention and had a significant change in their health status

In an interview, the DON acknowledged that the resident had a change in their condition and was not aware that this was not reported to the Director.
The DON said incidents that caused an injury for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, should be reported to the Director. [s. 107. (3) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is informed when a resident has an incident that causes an injury for which the resident is taken to a hospital and that results in a significant change in the resident's health condition, to be implemented voluntarily.

Issued on this 28th day of September, 2017

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

Original report signed by the inspector.

Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIAN MACDONALD (137), ALI NASSER (523)
Inspection No. / No de l'inspection :	2017_508137_0018
Log No. / No de registre :	004796-17, 004824-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 13, 2017
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE FERGUS NURSING HOME 450 QUEEN STREET EAST, FERGUS, ON, N1M-2Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Charlie Warren

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, 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)

Linked to Existing Order / Lien vers ordre existant: 2016_262523_0040, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee shall ensure that the staff involved in the residents' care collaborate with each other in the assessment of the residents so that their assessments are integrated, consistent with and complement each other, including post fall assessments.

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were collaborated, consistent with and complemented each other.

Compliance Order # 001 was issued on February 24, 2017, with a compliance date of March 31, 2017, following a Complaint Inspection. The Compliance Order stated "The licensee shall ensure that staff involved in the resident's care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other".

A) Clinical record review for an identified resident showed that 16 of 30 (53.3 per cent) Post Fall Investigation forms did not include a specific impairment that had a significant impact on the resident's risk for falls.

In an interview, a Registered staff member said that the identified resident had a specific impairment that had a significant impact on the resident's risk for falls and that the resident's assessments were not integrated, consistent with and did not complement each other.

B) Clinical record review for an identified resident showed that the resident was alert, confused/disoriented and able to follow direction, at the same time on 10 of 10 (100 per cent) Post Fall Investigation forms.
Seven of the ten corresponding Glasgow Coma Scale (GCS) assessments identified the resident as confused and three of ten GCS assessments identified the resident as oriented.

The Director of Nursing (DON) said that the identified resident could not be oriented and confused/disoriented, at the same time.
DON acknowledged that the assessments were not integrated, consistent with and did not complement each other.

C) Clinical record review for an identified resident showed that the resident was alert, confused/disoriented and able to follow direction, at the same time, on six of six (100 per cent) Post Fall Investigation forms. One corresponding GCS assessment identified the resident as oriented and one identified the resident as confused. One GCS assessment identified the resident as oriented and confused, at the same time. Three forms had no GCS assessment completed.

D) In an interview, the DON said staff and others involved in the different aspects of residents' care were to collaborate with each other in the assessment of the residents so that their assessments were integrated, consistent with and complemented each other.

This area of non-compliance was determined to have a level two for severity, minimal harm or potential for actual harm and the scope was a level two, pattern.
The home does have a history of non-compliance in this subsection of the legislation.
It was was issued as a:
Written Notification and a Compliance Order, issued on February 21, 2017, during a Complaint Inspection, under Inspection # 2016_262523_0040. (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant:
2016_262523_0038, CO #001;
2016_262523_0038, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The home shall ensure that there is a process developed and implemented for the scheduled cleaning of the home, furnishings and equipment, including window screens, light covers, ceiling tiles, privacy curtains, flooring and baseboards in resident rooms, bathrooms and common areas.
The home shall ensure a monitoring process is developed and implemented, including the staff responsible for monitoring, to ensure that the home, furnishings and equipment are kept clean and sanitary.
The home shall ensure that a process is developed and implemented that identifies which staff are responsible for the monitoring and ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Grounds / Motifs :

1. The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

Compliance Order # 001 and Director's Referral # 001 were issued on February 24, 2017 with a compliance date of March 31, 2017, following a Follow up Inspection. The compliance order stated that "The home shall ensure that there is a process developed and implemented for the scheduled cleaning of the home, furnishings and equipment, including window screens, light covers, ceiling

tiles, privacy curtains, flooring and baseboards in resident rooms, bathrooms and common areas.
The home shall ensure a monitoring process is developed and implemented, including the staff responsible for monitoring to ensure that the home, furnishings and equipment are kept clean and sanitary".

Observations of randomly selected home areas and rooms identified:

• Window screens were dirty with cobwebs in thirteen identified resident rooms, tub room, lounge and cob webs on the small window, above the patio door in the photocopy room. Residents had access to this area, enroute to an outdoor patio.
• Privacy curtains were stained in seven identified resident rooms.
• Flooring was stained in five identified resident rooms, hallways and lounge.
• Accumulation of dark debris at baseboards in bedrooms/bathrooms of four identified resident rooms.
• Lingering, offensive odours were detected in three identified resident rooms.
• The base of two sit/stand lifts, located in the hallway, were dirty.
• Bedroom vent dusty in an identified resident room.
• Bathroom vents with significant dust in two identified resident rooms.
• Cobwebs and stain on the light fixture in an identified resident room.
• Floor fan was dusty, located in hallway, near Director of Nursing office.
• Cigarette butts were on the hallway floor, near Director of Nursing office, on two separate observations.
• Several of the resident room door frames had an accumulation of dark debris, at the floor level.

During interviews, two identified residents expressed concerns related to the cleanliness of the home.

Inspectors conducted a tour with the Administrator and Environmental Manager, to show them the identified housekeeping deficiencies.
Administrator and Environmental Manager agreed that the deficiencies existed.
Administrator said that while some work had been done, there was still a lot more to do.

During an interview, Administrator said they were responsible to review housekeeping procedures to ensure that there were methods/processes in place for monitoring the cleaning schedules but had only done it once.
The Administrator said management did not complete weekly walkabouts or

audits but would be starting, as they were looking at the big picture instead.

During an interview, a Housekeeper said the current housekeeping checklists were implemented on April 1, 2017. The Housekeeper said they used different checklists before April 1, 2017, but had no idea what happened to them. Each room was to be deep cleaned once a year which included privacy curtains and window screens. Deep cleaning checklists were kept in the binder when completed and the Housekeeper did not know if the Administrator reviewed them or not.

During an interview, the Administrator said they understood that the Compliance Order was not complied with by the compliance due date of March 31, 2017, but they were going to put an action plan in place.

This area of non-compliance was determined to be a level two, minimal harm/risk or potential for actual harm/risk and the scope was a level three, widespread.
The home does have a history of non-compliance in this subsection of the legislation.
It was issued as a:
• Written Notification, Compliance Order and a Director's Referral on February 24, 2017, under Inspection # 2016_262523_0038, during a Follow up Inspection.
• Written Notification and a Compliance Order on August 4, 2016, under Inspection # 2016_325568_0015, during a Resident Quality Inspection (RQI);
• Written Notification and a Compliance Order on March 16, 2016, under Inspection # 2015_448155_0020, during a Resident Quality Inspection (RQI).
(137)

2. The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Compliance Order # 002 and Director's Referral # 001 were issued on February 24, 2017 with a compliance date of March 31, 2017, following a Follow up Inspection.
The Compliance Order stated "The home shall ensure that a process is developed and implemented that identifies which staff are responsible for the monitoring and ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair".

Observations of randomly selected home areas and rooms identified:

• Several rust stains on the floor, to the left of the photocopier. Residents had access to this area, enroute to an outdoor patio.
• Activity Room had chipped paint on the lower door, above door guard protector.
• Seven bubbled hallway tiles, located outside photocopier room entrance.
• Metal door guard protector was scraped on the treatment and clean utility room doors.
• Flooring was damaged and discolored at the nurses' desk. Chipped paint on medication room door and piece of baseboard was missing. Flooring discolored at entrance to Director of Nursing office.
• Lower wooden door was scratched to Hair Salon.
• Floor and wall were damaged in tub room and paint was blistered on the wall, below the nail clipper cabinet.
• The radiator cover was hanging off below the dining room windows. Scraped paint on a radiator below the window. Wooden base of a dining room storage cupboard was damaged. The dining room metal door guards were scraped.
• Lounge – Damaged floor tiles and wall by air vents.
• Thirteen identified resident rooms had damage such as metal strapping that secures ceiling tiles was rusted, walls needed painting, door frames damaged and/or chipped paint, damaged walls, cabinets under bathroom sinks damaged, window frames damaged, bathroom fixture rusted, plastic covering damaged on bedroom/bathroom doors, baseboard coming off near bathroom and bedroom doors and light fixture missing covers.
Several of the resident and common room door frames had chipped paint.

Inspectors conducted a tour with the Administrator and Environmental Manager to show them the identified maintenance deficiencies.
The Administrator and Environmental Manager agreed that the deficiencies existed.
The Administrator said that while some work had been done, there was still a lot more to do.
Environmental Manager said there were handyman hired to complete some repairs, at various time frames.

The Administrator and Environmental Manager acknowledged that some of the repairs were not satisfactorily completed and were not aware if anyone

monitored or evaluated the finished workmanship.

The Administrator said that a process was not developed and implemented that identified which staff were responsible for the monitoring and ensuring that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

During an interview, the Administrator said they understood that the Compliance Order was not complied with by the compliance due date of March 31, 2017, but they were going to put an action plan in place.

This area of non-compliance was determined to be a level two, minimal harm/risk or potential for actual harm/risk and the scope was a level three, widespread.
was previously related non-compliance.
The home does have a history of non-compliance in this subsection of the legislation
It was issued as a:
• Written Notification, Compliance Order and a Director's Referral on February 24, 2017, under Inspection # 2016_262523_0038, during a Follow up Inspection;
• Written Notification and a Compliance Order on March 16, 2016, under Inspection # 2015_448155_0020 , during a Resident Quality Inspection (RQI).

(137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_262523_0040, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that residents are not neglected by the licensee or staff.
The licensee shall complete a review of the falls prevention program and ensure that residents are assessed post falls and their plan of care is updated accordingly.
The licensee shall ensure that the physician is called and informed at the time there is a change in the resident's status.
The licensee shall develop and implement a process to ensure there is an adequate supply of fall prevention devices to meet the needs of all residents at a risk of falls and identify who will be responsible for maintaining these fall prevention devices, to ensure they are in good working order and removed from use when expired.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Compliance Order # 002 was issued on February 24, 2017 with a compliance date of March 31, 2017, following a Complaint Inspection. The compliance order stated "The licensee shall ensure that residents are not neglected by the licensee or staff.
The licensee shall complete a review of the falls prevention program and ensure that residents are assessed post falls and their plan of care is updated accordingly.
The licensee shall ensure that the physician is called and informed at the time

there is a change in the resident's status".

Under the Long-Term Care Homes Act, 2007, and Regulation 79/10, neglect was defined as "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".

A) Clinical record review and progress notes for an identified resident showed that the resident sustained a fall, resulting in an injury, discomfort and required assistance with care.
During an interview, the attending physician said they were not notified until they visited the home four days later. The physician said that they expected staff to call them and inform them of this change in the resident's status and that this was not the only time that they were not called by the staff for a change in a resident's condition.

In an interview, the DON said staff were to call the physician when there was a change in a resident's condition.

B) i) Clinical record review and plan of care for an identified resident directed staff to use specific fall prevention devices, to mitigate the risk for falls.

A review of the progress note showed that the identified resident sustained a fall, resulting in injury and required further medical attention.
A Post Fall Investigation form showed that there was no fall prevention device in place, at the time of the fall.
A review of progress notes showed there were incidents where the resident's fall prevention devices did not function and there were no replacements unavailable.

ii) Clinical record review for an identified resident showed that thirteen of thirty Post Fall Investigations forms had no indication of fall prevention devices being used at the time of the falls and seven unwitnessed falls had no head injury routine completed.

In an interview, the DON said staff were to complete head injury routine for unwitnessed falls or falls with head injury.

iii) An observation with a Personal Support Worker (PSW) showed that an

identified resident did not have fall prevention devices in place.
Inspectors observed an identified resident on the floor, crawling at their bedside and there were no fall prevention devices in place.
Observations with a Registered Staff member showed that an identified resident had fall prevention devices in place but they were not connected.
Observations with the DON and Inspectors showed that resident was in their chair without a fall prevention device in place.

In an interview, the DON said appropriate fall prevention devices were to be applied and the interventions in the plan of care be implemented.

C) i) Clinical record review and plan of care for another identified resident directed staff to have fall prevention devices in place.
A review of progress notes showed incidents where the fall prevention devices, for an identified resident, were not functioning and replacements were not available.

ii) Clinical record review for an identified resident showed that fourteen of twenty-six Post Fall Investigation forms had no indication that a specific fall prevention device was in use at the time of the falls, twenty-one of twenty-six forms had no indication that a fall prevention device was in use at the time of the falls and six unwitnessed falls had no head injury routine completed.

In an interview, the DON said staff were to complete head injury routine for unwitnessed falls or falls with head injury.

iii) Observations with a PSW showed that identified resident was in bed and fall prevention devices were not in place and those observed were not functioning.

Inspectors observed an identified resident in bed, the proper fall preventions devices were not in place and the devices, that were in place, were not functioning.

D) i) Clinical record review and plan of care for a third identified resident directed staff to ensure identified fall prevention devices were in place.
A review of progress notes showed incidents where that staff were not able to locate the fall prevention device, device did not function and there were none were available so a device was borrowed from another resident.

ii) Clinical record review for an identified resident showed that two of four Post Fall Investigation forms had no indication that a fall prevention device was in place at the time of the falls.
A progress note review showed the identified resident sustained a fall with injury but there was no post fall investigation or Head Injury Routine (HIR) completed for this fall.

The DON said staff were to complete head injury routine for unwitnessed falls or falls with head injury.

iii) Inspectors observed that the fall prevention device, for an identified resident, was disconnected, not properly applied and, when connected, did not function. Observation with DON showed that the device was not connected, that this put the resident at risk and that their expectation was for the staff to implement the interventions specified in the plan of care.

Observations with two Registered Staff members showed that an identified resident did not have the proper fall prevention devices in place. The staff members explained that this was not effective, as this put the resident at high risk for falls and the resident would be able to get out of bed without, triggering the alarm.

E) i) In an interview, a PSW said that the fall prevention devices frequently did not function and were not readily available for residents that needed them.

ii) In an interview, a Registered Staff member said that they do not have functioning or appropriate fall prevention devices in place. Residents did not have the appropriate fall prevention devices specified in the plan of care, which put the residents at risk. Residents did not have the appropriate fall prevention devices applied, which also puts them at risk. Residents continue to fall because staff were not able to apply the correct safety equipment for them.

iii) In an interview, a Registered Staff member said that residents were put at risk because necessary safety equipment was not available or not functional. Residents that required to have those fall prevention devices continue to fall and injure themselves, as those fall prevention devices were not present at the time of falls. There were very old fall prevention devices and some were past the expiry dates but still being used. Also they were not checked or maintained. The management of the home was informed but fall prevention devices were not

maintained or new fall prevention devices were not purchased.

iv) In an interview, the Physiotherapist (PT) said that they were aware of the shortages of fall prevention devices in the home. PT said that last week they wanted to put a device on a resident but were told that there were none in the building.
PT also said that they were aware of malfunctioning fall prevention devices, they witnessed a resident getting out of bed with device connected and the device did not function.

v) In an interview, a Registered Staff member said that they did not complete assessments on residents. The nurses would assess residents and then the Registered Staff member would update the care plan. Registered Staff did not monitor the implementation or evaluate the interventions in the plan of care. The Registered staff member said that they were not aware that fall prevention devices were not being used and this would be what the RCC or DON would monitor.

vi) In a telephone interview, the manufacturer representative said that the fall prevention devices were considered expired after two years of use. The date on the fall prevention device was the date they were put into use and needed to be replaced two years after that date. One Inspector observed an outdated fall prevention device and a photograph was taken as supportive evidence.

vii) The DON said that the PSW staff would monitor if the alarms were functional or not. DON said that they were not aware of the expiry dates on the alarms. They said that there was no record of checks or maintenance completed for the bed/chair or Posey alarms.

F) DON said that the home did not complete a review of the falls prevention program.
DON acknowledged that the review of the falls prevention program was part of the Compliance Order and that it was not completed as of yet.

G) A clinical record review, progress note for an identified resident an identified resident sustained a fall with injury and required further medication attention. The resident was not assessed and the plan of care had not been reviewed or revised when the resident had a change in health status.

A Registered Staff member was not able to answer why the plan of care was not updated or why the resident was not assessed.

The DON acknowledged that the resident was not reassessed when they had a change in condition and the plan of care was not updated, although staff indicated in the progress note that the care plan was updated.
The DON said the resident was to be reassessed and the plan of care reviewed and revised when a goal in the plan was met, the resident's care needs changed, care set out in the plan was no longer necessary or if the care set out in the plan has not been effective.

This area of non-compliance was determined to have a severity of a level three, actual harm/risk and the scope was a level three, widespread, as three of three (100 per cent) residents were affected.
The home does have a history of non-compliance in this subsection of the legislation.
It was issued as a:
Written Notification and a Compliance Order on February 24, 2017, during a Complaint Inspection, under Inspection # 2016_262523_0040.

(523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2016_262523_0038, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee shall ensure there is a process developed and implemented for all residents demonstrating responsive behaviours to ensure strategies have been developed and implemented to respond to the residents' responsive behaviours. The process shall include staff roles and responsibilities including which staff are responsible for monitoring the implementation of the strategies.

Grounds / Motifs :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident were identified, where possible;
(b) strategies were developed and implemented to respond to these behaviours, where possible; and
(c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Compliance Order # 003 was issued on February 24, 2017 with a compliance date of March 31, 2017, following a Follow up Inspection. The Compliance Order stated that "The licensee shall ensure there is a process developed and implemented for all residents demonstrating responsive behaviours to ensure

strategies have been developed and implemented to respond to the residents' responsive behaviours.
The process shall include staff roles and responsibilities including which staff are responsible for monitoring the implementation of the strategies".

During an interview, the Director of Nursing (DON) said they were not aware if a process had been developed and implemented for all residents demonstrating responsive behaviours to ensure strategies have been developed and implemented to respond to the residents' responsive behaviours, including staff roles and responsibilities, as well as who was responsible for monitoring the implementation of the strategies. DON was not aware if Head Office had developed anything.
Director of Nursing said the Resident Care Coordinator had been responsible for the Behaviour Supports Ontario (BSO) team but was no longer employed at the home. The
When asked what assessment tools were used in the home, DON said a BSO team member would be able to provide what the BSO team used.

During an interview, a Registered Staff member said a process had not been developed and implemented for all residents demonstrating responsive behaviours to ensure strategies had been developed and implemented to respond to the residents' responsive behaviours, including staff roles and responsibilities, as well as who was responsible for monitoring the implementation of the strategies.

The Registered Staff member said a Canadian Mental Health Association Consultant visited the home, approximately every 6 months and as needed, if requested. The Consultant provided assessment tools for the home to use which were kept in a BSO binder for the BSO team to access.
The Registered Staff Member said they were familiar with what was expected of them but there was no formal Behaviour Management Program, no process in place that outlines the role and responsibilities of the BSO team members and no process that identified who was responsible for monitoring the implementation strategies related to responsive behaviours.
The Registered Staff member said they were not familiar with the legislative requirements, related to responsive behaviours.

During an interview, the DON said that the Responsive Behaviour Program needed improvement as it did not meet the legislative requirements and they

understood that the compliance order was not complied with by the compliance due date of March 31, 2017.
The Administrator and DON said they would check with Head Office and other homes for assistance related to strengthening their responsive behavior policy/program.

This area of non-compliance was determined to be a level two, minimal harm/risk or potential for actual harm/risk and the scope was a level three, widespread.
The home does have a history of non-compliance in this subsection of the legislation.
It was issued as a:
• Written Notification and a Compliance Order on February 24, 2017, under Inspection # 2016_262523_0038, during a Follow up Inspection;
• Written Notification and a Compliance Order on August 4, 2016, under Inspection # 2016_325568_0015, during a Resident Quality Inspection (RQI).
(137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2016_262523_0038, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee shall ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Grounds / Motifs :

1. The licensee failed to ensure that, (a) procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff were advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours posed a potential risk to the resident or others.

Compliance Order # 004 was issued on February 24, 2017 with a compliance

date of March 31, 2017, following a Follow up Inspection. The Compliance Order stated that "The licensee shall ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents".

A review of the Resident Behaviour Management Policy, review date July 2016, showed there was no documented evidence that it included procedures and interventions to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

During interviews, with DON and a Registered Staff member, both said that procedures and interventions had not been developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. The DON was unsure if Head Office had developed anything.

During an interview, the DON said that the Responsive Behaviour Program needed improvement, as it did not meet the legislative requirements and they understood that the Compliance Order was not complied with by the compliance due date of March 31, 2017.

This area of non-compliance was determined to be a level two, minimal harm/risk or potential for actual harm/risk and the scope was a level three, widespread.
The home does have a history of non-compliance in this subsection of the legislation.
It was issued as a:
• Written Notification and a Compliance Order on February 24, 2017, under Inspection # 2016_262523_0038, during a Follow up Inspection;
• Written Notification and a Compliance Order on August 4, 2016, under Inspection # 2016_325568_0015, during a Resident Quality Inspection. (137)

Ontario

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2017

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 13th day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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Name of Inspector /
Nom de l'inspecteur : MARIAN MACDONALD

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