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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 30, 2015	2015_293554_0009	O-001244-14	Critical Incident System

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

KELLY BURNS (554)

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): June 09 -11, 2015

Inspection was specific to Intake #O-001244-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing Services (DONS), Director of Care (DOC), Director of Quality Nursing, Staff Educator, Resident Care Area Managers (RCAM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Support Staff (BSO), Housekeeping Staff, Physio Assistant, Dietary Aide(s), Residents, and Family.

During the course of the inspection, the inspector also reviewed health records for specific resident(s), reviewed the home's investigation documentation, reviewed critical incident report, reviewed staff education relating to Falls Prevention, and reviewed the home's policies specific to Falls Prevention and Management, Complaints, Responsive Behaviours

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Hospitalization and Change in Condition

During the course of this 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	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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 6 (2), by ensuring the plan of care is based on an assessment of the resident and the resident's needs and preferences, relating to Falls Management.

Resident #01 has a diagnosis that includes cognition impairment. A review of the clinical health record indicates that resident has a known history of falls risk and is described as being at "extreme high risk for falls". The Health Care Directive for this resident, as expressed by resident's Power Attorney for Care is a Level 3, which indicated if there is a change in the resident's condition, resident is to be transferred to an acute care hospital.

According to the Critical Incident Report (CIR), Resident #01 had an unwitnessed fall on a specific date and at a specific time; Resident #01 was found on the floor in a pool of blood, with blood noted to extremities, night gown and the bedside drapes. The CIR, resident incident report and progress notes all indicated resident sustained substantial injuries, as a result of the fall.

Registered Practical Nurse #37, who was working at the time of the incident, indicated he/she had assessed Resident #01, noting the specific injuries; RPN #37 indicated cleansing and dressing the injuries post fall, and further indicated that RN #38, who was the supervisor on duty, did not assess the injuries prior to bandages being applied.

Progress notes and resident incident report, reviewed for a specific date, failed to provide evidence of RN #38 completing an assessment nor documenting specifics relating to Resident #01's fall, injuries or monitoring during the remainder of the shift. Director of Nursing Services confirmed that there was no documentation by RN #38.

Registered Practical Nurse #37 indicated he/she had communicated (via phone) to RN #38, supervisor on shift, that Resident #01's dressing had been changed twice post fall (and subsequent to the initial dressing), as the bandages had been saturated with blood, but was told, by RN #38, nursing supervisor on duty, to continue to monitor Resident #01. Registered Practical Nurse #37 indicated that he/she felt that Resident #01 needed to be transferred to hospital due to injuries sustained and amount of blood loss, but indicated Registered Nurse #38's directive was to monitor Resident #01 at the long term care home. RPN #37 indicated he/she disagreed with Registered Nurse's decision, but did not communicate this concern to any other Registered Nursing Staff nor the Director of Care.

Registered Practical Nurse #37 indicated that the physician was not notified of the fall and resulting injuries. Registered Practical Nurse #37 indicated he/she did not contact the physician as he/she was fearful of waking physician during the night and his/her direction from RN #38 was to monitor Resident #01. RPN #37 indicated he/she had communicated his/her concerns to RN #38.

Registered Nurse #38 indicated he/she had not communicated the incident with injury to the physician as he/she was not aware that Resident #01 had bruising nor continued blood loss from the injuries; RN indicated, Resident #01 was stable and did not need to be transferred to the hospital for medical treatment.

Resident #01 was assessed by the oncoming Resident Care Area Manager (shift supervisor), at which time, the family of the resident was contacted (approximately seven hours later) and a decision was made to transfer Resident #01 to hospital for assessment and treatment.

The home's policy Resident Safety-Falls Prevention (#RSL-SAF-055), directs Registered Nursing Staff to do the following for a Fall resulting in injury, notify the physician immediately if the resident has suffered an injury; in the absence of the physician, the registered nursing staff will exercise clinical judgement in calling 911 to arrange for transportation to the hospital.

Resident #01 was transferred to the hospital on a specific date, approximately seven hours post fall and treated for injuries sustained.

During this Inspection, a Critical Incident Report (CIR) was inspected, the CIR details Resident #01 having had an unwitnessed fall, on a specific date and at a specific time. Resident #01 sustained substantial injuries. Registered Practical Nurse indicated the bandages covering resident's injuries required changing twice due to blood saturating the dressing. Registered Practical Nurse #37 and Registered Nurse #38 both indicated the physician had not been notified of the fall and resulting injury. Resident #01 was not transferred to the hospital for assessment and treatment until approximately seven hours later, at which time, resident was treated for his/her injuries.[s. 6. (2)]

2. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring the care set out in the plan of care was provided to the resident as specified in the plan, related to Falls Prevention and Management.

Resident #01 has a diagnosis that includes cognition impairment. Resident has been identified as a falls risk 'extreme high risk'. Resident #01 had falls in the previous year, which included, one fall incident that occurred on a specific date, which resulted in a Critical Incident Report being submitted due to, resident's fall resulting in substantial injury and need for hospital transfer, assessment and treatment.

Progress notes and incidents reports indicated Resident #01 has had five falls to date for the current year, one of which resulted in injury.

The Plan of Care (in place at time of inspection) indicates the following:

- Toileting – assistance required, includes transferring, hygiene and clothing adjustments. Interventions include, call bell to be within reach; staff to encourage resident to call for staff assistance; do not leave unattended on the toilet; one person physical assistance; staff to assist resident to use the toilet at specified times; staff to toilet resident every two hours during a specific shift; staff to accompany resident back from the dining room and toilet resident after all meals.

- Transferring – extensive assistance required. Interventions include, remind resident to request assistance before all transfers; bed sensor pad in place to prevent self-transfer; when alarm is sounding, staff to attend to alarm and transfer resident into chair.

- Walk in Room/Corridor – Interventions include, resident will be supported by staff when walking; will be returned to wheelchair when found walking in resident's room; ensure chair and bed alarm is on at all times and ensure alarm is in working order.

- Locomotion On and Off Unit – Interventions include, total assistance by staff; staff to push resident's wheelchair.

- Aids to Daily Living / Safety Devices – Interventions include, staff to porter resident to and from dining room; chair and bed alarm should be in place and attached to resident at all times; ensure chair alarm is transferred from wheelchair to bed when resident is resting; ensure bed and chair alarms are on and are working.

- Falls and or Balance – High Risk for falls. Interventions include, ensure call bell within reach at all times; ensure bed senor pad is on and working; resident to be monitored hourly; falls mat at bedside; resident to be toileted at specific times (indicated in plan of

care) by one staff; to be toileted every two hours on a specific shift; staff to respond to floor mat alarm as soon as hear alarm.

The following observations were made during a two day period, during this inspection:

- During the morning of a specific date (over a three hour time period) Resident #01's bed/chair alarms sounded eight separate times without staff intervening (alarm turned off on own). Resident #01 was seen returning from the washroom on at least one occasion without staff support. Staff were not observed entering the room to toilet Resident #01 despite scheduled toileting times.

- Resident #01 was observed in the dining room, on a specific date, during a scheduled meal time, resident's personal chair alarm was not attached to the resident or turned on.

- Resident #01 was observed on a specific date, self-propelling his/her own wheel chair, staff were not in attendance. Resident was seen wheeling self, down the hallway and was observed standing up in wheelchair, the chair alarm was not heard alarming; resident seated self safely back into the chair. A few minutes later, Resident #01 entered his/her room, the bed sensor mat was heard sounding, while a Registered Practical Nurse and two Personal Support Workers walked within the same vicinity as resident's room, without responding to the bed/chair alarm; the alarm was responded to by another Personal Support Worker.

Staff #30, assigned to care for Resident #01, indicated no awareness of the need for staff to accompany Resident #01 to and from the dining room, indicating resident is able to take self to and from meals. Staff #30 indicated that often the floor sensor mat isn't working, therefore, staff don't always know that resident has gotten out of bed and toileted his/herself. Staff #30 indicated no awareness of the need to transfer the chair alarm from wheelchair to bed while resident is resting.

Registered Practical Nurse #37, who supervises the resident home area during the night, indicates that staff do not toilet Resident #01 during the night as the unit is too busy and the toileting time expectations are unrealistic. RPN #37 indicated that often staff do not transfer the chair alarm to resident's bed, adding there are already two alarms on the bed, although the sensor floor mat is usually not working.

Resident Care Area Manager (RCAM), who supervise the home area where Resident #01 resides, indicated that he/she didn't think the chair alarm needed to be transferred

from wheelchair to bed while resident was resting, as Resident #01 already had two bed alarms in place; RCAM agreed it was an intervention listed in the plan of care. RCAM also indicated awareness that the floor sensor mat is often not working, indicating the home was looking into alternative equipment (e.g. alarms).

Resident Care Area Manager, Director of Care and Director of Nursing Services all indicated the plan of care for each resident is to be followed. RCAM and Director of Nursing Services both indicated Resident #01 remains at extreme falls risk and not following the plan of care places resident at risk of further falls and or potential injury.

A Critical Incident Inspection was conducted concurrently with this inspection. A Written Notification, for LTCHA, 2007, s. 6 (7) was included in Compliance Order #001, under LTCHA, 2007 s. 19 (1) was issued in an identified inspection. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 87 (2) (d), by ensuring that procedures are developed and implemented for addressing incidents of lingering offensive odours.

During the inspection dates of June 03-05, June 09-12 and June 15, 2015, a pervasive malodour was smelt throughout hallway on a resident Home area (RHA), in the front foyer, in the hallway by the managerial offices (near Executive Director and Director of Nursing Services) and in the hallway leading toward the main dining room (off of Maple RHA). The pervasive odour could be smelt continuously during the hours of approximately 08:30 hours through to the 14:30 hours, but was extremely noticeable from approximately 13:00 – 1430 hours. The offensive odour was noted during the above dates by Inspector #111 and #554.

A Housekeeping Aide working in the identified resident home area indicated that the lingering odour was not unusual for the home area. [s. 87. (2) (d)]

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 there is a process in place and monitored to ensure that incidents of lingering offensive odours are addressed and managed, to be implemented voluntarily.

WN #3: 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).

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 107 (3) 4., by ensuring the Director was informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

The Director of Care submitted a Critical Incident Report (CIR) on a specific date, with regards to an incident that caused injury to a resident for which the resident was taken to hospital and which results in a significant change in the resident's health status. The incident was said to have occurred on a specific date.

The CIR outlines the following details:

- Resident #01 was found lying on the bedroom floor at a specific time, resident was alert but confused; resident was lying in and was covered in blood (to extremities, nightgown and bedside drapes). Resident #01 was assessed by registered nursing staff to have substantial injuries.

According to the CIR and progress notes (date of injury) Resident #01 was transferred to hospital for assessment and treatment.

Resident Care Area Manager indicated that the injury on a specific date, resulted in a significant change in resident's health status, which intern affected resident's ability to

participate in his/her activities of daily living, especially noting the injuries were to the resident's dominant extremity. RCAM indicated he/she did not contact the Director (MOHLTC) of this incident and further indicated no awareness of the need to contact the Director (MOHLTC) of this incident.

Director of Care (now Director of Nursing Services) indicated he/she thought he/she had contacted the Director (MOHLTC) of this incident, but had no evidence to support such contact.

Centralized Intake Assessment Triage Team (C.I.A.T.T) and Spills Action Centre (SAC) both indicated via email that neither the Director of Care nor any other member of the home had contacted them of the incident on a specific date; the first notification of this incident was two days later (post-incident). [s. 107. (3) 4.]

2. The licensee failed to comply with O. Reg. 79/10, s. 107 (5), by ensuring that the resident’s substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

Resident #01 has a diagnosis that includes cognitive impairment, and has had multiple injuries related to falls. Resident is indicated at being at high falls risk. Resident #01’s Health Care Directive, expressed by resident and family is a Level 3, which indicates, resident is to be transferred to hospital if health condition changes.

Resident #01 had an unwitnessed fall on a specific date and time; Resident #01 was found lying in a pool of blood with blood noted to extremities, night gown and the bedside drapes. According to the Critical Incident Report, resident incident report and progress notes, Resident #01 sustained substantial injuries; injuries of Resident #01 were noted by Registered Practical Nurse.

Progress notes, dated on a specific date and time, indicated the family of Resident #01 was not notified of the fall with injury until approximately seven hours later (as per the Resident Care Area Manager), when a decision was made to transfer Resident #01 to hospital for assessment and treatment.

Resident was assessed and treated at hospital for injuries substained.

Interviews with Resident Care Area Manager (RCAM), Registered Practical Nurse and Director of Nursing Services (formerly Director of Nursing) all indicated the family of Resident #01 voiced displeasure at not being contacted by the long term care home sooner of the fall and resulting injury.

Director of Nursing Services and the Administrator, both indicated the expectation would be to immediately contact the substitute decision maker or other designate of a resident incident which resulted in injury, such would have been the expectation involving Resident #01's incident. [s. 107. (5)]

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 there is a process in place and monitored, ensuring the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified, to be implemented voluntarily.

WN #4: 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 comply with O. Reg. 79/10, s. 8 (1), by ensuring that any plan,

policy, protocol, procedure, strategy or system instituted or otherwise put in place, is complied with, specific to Falls Prevention and Management.

Under O. Reg. 79/10, s. 48 (1) 1, every licensee of a long term care home shall ensure that the following interdisciplinary programs area developed and implemented in the home, a falls prevention and management program to reduce the incidence of falls and risk of injury.

The home's policy Resident Safety-Falls Prevention (#RSL-SAF-055), directs Registered Nursing Staff to do the following for a Fall resulting in injury, notify the physician immediately if the resident has suffered an injury; in the absence of the physician, the registered nursing staff will exercise clinical judgement in calling 911 to arrange for transportation to the hospital; inform the Power of Attorney of the injury and transfer to hospital at the earliest convenient opportunity following immediate assessment and intervention; and the registered nursing staff will report to the Manager on Call and or the Director of Care immediately by telephone.

The clinical health record (progress notes, incident report) and Critical Incident Report (CIR) indicate Resident #01 had an unwitnessed fall on a specific date and at a specific time. Resident sustained substantial injuries; resident was placed on enhanced monitoring. Resident #01 was later transferred to hospital for assessment and treatment relating to injuries sustained.

The home's policy, Falls Prevention was not complied with as evidenced by the following:

- progress notes indicate, the family of Resident #01 was not notified of the fall with injury until approximately seven hours post fall on a specific date;
- progress notes, further, indicate Resident #01 was not transferred to the hospital until approximately seven hours later, despite substantial injuries, and blood loss;
- Physician was not contacted of the fall with injury, until approximately seven hours post-incident;
- Registered Practical Nurse #37 indicated he/she did not agree with Registered Nurse #38's decision not to send to Resident #01 to hospital, but did not communicate concerns to other registered nursing staff at the time of the incident nor Director of Care.
- Director of Care (now Director of Nursing Services) indicated he/she had not been notified of the fall with injury until the next business day, following the incident. [s. 8. (1)]

2. The home's policy, Falls Prevention and Management Program – Resident Quality

Indicators (#RESI-10-02-01) directs that the home will establish a flagging system to clearly identify to all staff the residents that area at high risk for falls (e.g. falling star, falling leaf or colour coded arm bracelets, etc.). The policy identifies that the Registered Nursing Staff are to initiate the flagging system for all high risk resident's for falls.

Resident Care Area Manager #25, who oversees the Falls Prevention and Management Program indicated that all staff were provided education specific to the new policy #RESI-10-02-01, specific to Falls Prevention and Management, during two specific dates, during this year, and that a collaborative decision was that all residents who were identified as being at 'high risk' for falls would be identified by wearing a green plastic bracelet. RCAM indicated that all staff are aware of the high falls risk identifier.

Resident #01 was observed during the dates during a specific period not wearing a green plastic bracelet on his/her arm (or on resident's wheelchair). Resident is indicated in his/her plan of care as being at extreme high risk of falls. There is no indication in the plan of care that resident was to wear a falls identification bracelet.

Staff #30, 31 and 34 all working on Resident #01's home area all indicated no awareness of green bracelets nor any other identification tool used by the home to identify those resident's being at high risk for falls. Staff #30, 31 and 34 all indicated receiving falls prevention and management education during a specific month, during the current year.

Resident Care Area Manger (RCAM) #25 and #26 both indicated Resident #01 was indicated as being at extreme high risk of falls and should be wearing a green bracelet to identify such. Resident Care Area Manager #26 indicated that Resident #01 may have removed the green bracelet; RCAM was unsure if staff knew Resident #01 removes the bracelet and were unsure if staff on the unit knew to check for the bracelet on a regular basis.

The Director of Nursing Services (DONS) indicated that the expectation is that all staff follow the home's policy and procedures, especially as such relates to Falls Prevention and Management. DONS indicated if the Resident Care Area Manager (and or other staff) were aware that Resident #01 removes the falls risk identification bracelet, then this should be noted in the plan of care and monitored. [s. 8. (1) (a),s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 103 (1), by ensuring that a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1).

Under LTCHA, 2007, s. 24 (1), a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that result in harm or a risk of harm to the resident.

The Director of Care (now Director of Nursing Services) indicated receiving a written correspondence (email) from the Family of Resident #01 on a specific date voicing displeasure and concern regarding care lacking following a falls incident, in which Resident #01 sustained substantial injuries.

The incident occurred on a specific date, and at a specific hour; resident’s family was not notified until approximately seven hours later, at which time a decision was made to transfer resident to hospital for assessment. Resident was assessed and treated for substantial injuries and later returned to the long term care home.

The letter, written by the family of Resident #01, was reviewed by the inspector during this inspection, in the letter, the family questioned the care provided to Resident #01, during a specific time period and why there had been delay's in transferring resident to

hospital for assessment and treatment of injuries, specific to a falls incident.

Family indicated in the letter, written to the Director of Care, that the care their love one had received was unacceptable.

Director of Nursing Services (formerly Director of Care) indicated receipt of the letter from the Family of Resident #01 and stated that care provided to resident post-falls incident, on a specific date, was unacceptable and constituted improper care; Director of Nursing Services indicated registered nursing staff involved were provided re-instruction and discipline.

Director of Nursing Services (DONS) indicated that the letter from the Family of Resident #01 was not forwarded to the Director (MOHLTC). DONS commented that the letter from the family implied neglect of care, but indicated not being aware that the letter at the time should have been sent to the Director (Ministry of Health and Long-Term Care).

Administrator indicated no awareness of the letter from the Family of Resident #01, indicating if he/she knew of such, the letter would have been forwarded to the Ministry of Health and Long Term Care.

A Critical Incident Inspection was conducted concurrently with this inspection. A Written Notification, for O.Reg. 79/10, s. 103 (1) was included in Compliance Order #001, under LTCHA, 2007 s. 19 (1) was issued in the identified inspection. [s. 103. (1)]

Issued on this 11th day of September, 2015

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

Original report signed by the inspector.

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY BURNS (554)
Inspection No. / No de l'inspection :	2015_293554_0009
Log No. / Registre no:	O-001244-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 30, 2015
Licensee / Titulaire de permis :	CVH (No.6) GP Inc. as general partner of CVH (No.6) LP c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mona Babb

To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The Licensee shall:

1) Review and update the plan of care for Resident #01 and all other residents who are at high risk for falls, to ensure the planned care is individualized and meeting the needs of the resident.

2) Implement measures and a monitoring process to ensure that the care set out in the plan of care, especially for those residents at high risk for falls, is followed, and that appropriate and timely action is taken when the needs of the resident(s) are not met.

3) Provide re-instruction to all registered nursing staff of the importance of following the home's policies, specifically, Falls Prevention and Falls Prevention and Management Program, especially when a resident is exhibiting a change in health status.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, 2007, s. 6 (2), by ensuring the plan of care is based on an assessment of the resident and the resident's needs and preferences, relating to Falls Management.

Resident #01 has a diagnosis that includes cognition impairment. A review of the clinical health record indicates that resident has a known history of falls risk and is described as being at "extreme high risk for falls". The Health Care Directive for this resident, as expressed by resident's Power Attorney for Care is a Level 3, which indicated if there is a change in the resident's condition, resident is to be transferred to an acute care hospital.

According to the Critical Incident Report (CIR), Resident #01 had an unwitnessed fall on a specific date and at a specific time; Resident #01 was found on the floor in a pool of blood, with blood noted to extremities, night gown and the bedside drapes. The CIR, resident incident report and progress notes all indicated resident sustained substantial injuries, as a result of the fall.

Registered Practical Nurse #37, who was working at the time of the incident, indicated he/she had assessed Resident #01, noting the specific injuries; RPN #37 indicated cleansing and dressing the injuries post fall, and further indicated that RN #38, who was the supervisor on duty, did not assess the injuries prior to bandages being applied.

Progress notes and resident incident report, reviewed for a specific date, failed to provide evidence of RN #38 completing an assessment nor documenting specifics relating to Resident #01's fall, injuries or monitoring during the remainder of the shift. Director of Nursing Services confirmed that there was no documentation by RN #38.

Registered Practical Nurse #37 indicated he/she had communicated (via phone) to RN #38, supervisor on shift, that Resident #01's dressing had been changed twice post fall (and subsequent to the initial dressing), as the bandages had been saturated with blood, but was told, by RN #38, nursing supervisor on duty, to continue to monitor Resident #01. Registered Practical Nurse #37 indicated that he/she felt that Resident #01 needed to be transferred to hospital due to injuries sustained and amount of blood loss, but indicated Registered Nurse #38's directive was to monitor Resident #01 at the long term care home. RPN #37 indicated he/she disagreed with Registered Nurse's decision, but did not communicate this concern to any other Registered Nursing Staff nor the Director of Care.

Registered Practical Nurse #37 indicated that the physician was not notified of the fall and resulting injuries. Registered Practical Nurse #37 indicated he/she did not contact the physician as he/she was fearful of waking physician during the night and his/her direction from RN #38 was to monitor Resident #01. RPN #37 indicated he/she had communicated his/her concerns to RN #38.

Registered Nurse #38 indicated he/she had not communicated the incident with injury to the physician as he/she was not aware that Resident #01 had bruising

nor continued blood loss from the injuries; RN indicated, Resident #01 was stable and did not need to be transferred to the hospital for medical treatment.

Resident #01 was assessed by the oncoming Resident Care Area Manager (shift supervisor), at which time, the family of the resident was contacted (approximately seven hours later) and a decision was made to transfer Resident #01 to hospital for assessment and treatment.

The home's policy Resident Safety-Falls Prevention (#RSL-SAF-055), directs Registered Nursing Staff to do the following for a Fall resulting in injury, notify the physician immediately if the resident has suffered an injury; in the absence of the physician, the registered nursing staff will exercise clinical judgement in calling 911 to arrange for transportation to the hospital.

Resident #01 was transferred to the hospital on a specific date, approximately seven hours post fall and treated for injuries sustained.

During this Inspection, a Critical Incident Report (CIR) was inspected, the CIR details Resident #01 having had an unwitnessed fall, on a specific date and at a specific time. Resident #01 sustained substantial injuries. Registered Practical Nurse indicated the bandages covering resident's injuries required changing twice due to blood saturating the dressing. Registered Practical Nurse #37 and Registered Nurse #38 both indicated the physician had not been notified of the fall and resulting injury. Resident #01 was not transferred to the hospital for assessment and treatment until approximately seven hours later, at which time, resident was treated for his/her injuries. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 14, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 30th day of July, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Kelly Burns

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