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
Jul 13, 2018	2018_722630_0011	012816-18	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Healthcare (CT) GPCO Ltd. as General Partner of Omni Healthcare (Country Terrace) Limited Partnership
161 Bay Street, Suite 2430 TD Canada Trust Tower TORONTO ON M5J 2S1

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

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

AMIE GIBBS-WARD (630), MELANIE NORTHEY (563), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): June 18, 19, 20, 21, 22, 25, 26, 27 and 28, 2018.

The following Critical Incident intakes were completed within this inspection:

Related to the prevention of abuse and neglect:
Critical Incident Log #028642-16 / CI 0907-000021-16
Critical Incident Log #029980-16 / CI 0907-000022-16

Critical Incident Log #033230-16 / CI 0907-000026-16
Critical Incident Log #021350-17 / CI 0907-000016-17
Critical Incident Log #022698-17 / CI 0907-000020-17
Critical Incident Log #024383-17 / CI 0907-000023-17
Critical Incident Log #023597-17 / CI 0907-000025-17
Critical Incident Log #027257-17 / CI 0907-000031-17
Critical Incident Log #006825-18 / CI 0907-000011-18
Critical Incident Log #009534-18 / CI 0907-000017-18

Related to medication administration:
Critical Incident Log #022948-17 / CI 0907-000019-17
Critical Incident Log #024573-17 / CI 0907-000027-17
Critical Incident Log #025486-17 / CI 0907-000029-17
Critical Incident Log #003413-18 / CI 0907-000004-18
Critical Incident Log #005342-18 / CI 0907-000009-18

Related to falls prevention
Critical Incident Log #006720-18 / CI 0907-000014-18
Critical Incident Log #013408-18 / CI 0907-000019-18

The following Complaint intake was completed within this inspection:
Complaint Log #004011-17 related to the nutrition and hydration care program, related to nursing and personal support services and the infection prevention and control program.

During the course of the inspection, the inspector(s) spoke with the OMNI Director of Operations, the Director of Care (DOC), the Clinical Care Co-ordinator (CCC), the Nutritional Care Manager, the Office Manager, the Quality Assurance Registered Practical Nurse (RPN) Lead, the Ontario Nurses Association (ONA) Representative, the Unifor Representative, the Behavioural Supports Ontario (BSO) Lead, the BSO RPN, Registered Nurses (RNs), RPNs, Personal Support Workers (PSWs), a Housekeeper, a Dietary Aide, a TNT Security Guard, a Life Enrichment staff member, the residents' council co-presidents, family members and over twenty identified residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed meal and snack service, observed residents and the care provided to them, reviewed health

care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed various meeting minutes and written records of program evaluations.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 VPC(s)**
- **2 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. 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 protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC) which documented suspected staff to resident abuse for eight identified residents. The report stated that the allegations were confirmed during the course of the investigation.

The home's investigation documentation was reviewed by an inspector and included a summary report in which the Director of Care (DOC) and Administrator summarized the results of the investigation and that they had determined that specific types of staff to resident abuse by a specific staff member had occurred. This report documented that the DOC and Administrator thought the actions of this staff member placed residents' safety at risk. The documentation also included a disciplinary report for a specific staff member and documentation of staff interviews.

During an interview the DOC told an inspector that the interviews completed for their investigation suggested suspected abuse happened more than once and prior to the date of the CIS report. The DOC acknowledged that there were residents who had been identified during their investigation as having been allegedly neglected or abused by this specific staff member who were not included in the CIS report. The DOC also verified that the residents absent from the CIS report were not investigated, were not provided support or counselling, and their families were not notified. The DOC stated all allegations were confirmed related to two types of abuse and neglect by this specific staff member. The DOC was asked, "What measures and strategies were put in place to prevent abuse and neglect of residents by this staff member?" The DOC responded that the staff member was supervised by the other staff members, staff were made more aware to report allegations immediately, and the staff member was moved to another care area.

During the inspection identified staff members were interviewed by an inspector regarding the allegations and the home's investigation. During these interviews the staff members reported having witnessed this identified staff member treating residents in specific ways. One of the staff members verified that they did not report the neglect or abuse prior to a specific date and that they were not comfortable reporting incidents of suspected abuse and/or neglect to their manager, but were required to report right away.

During a follow-up interview the DOC acknowledged to an inspector that the staff who worked with this identified staff member only reported what they witnessed once asked

as part of the investigation. The DOC verified that the incidents that were discussed during the staff interviewed happened prior and with no specific date referenced.

During an interview an identified resident told an inspector that a staff member had treated them in a specific way which upset them.

The OMNI Reporting Incidents of Abuse Policy #AM-6.7 effective June 2015, stated the following:
- All matters required to be reported to the Ministry of Health are investigated and reported within the designated time frames.
- "Upon becoming aware of any of the following alleged, suspected or witnessed incidents, the home shall contact the Ministry of Health immediately: improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; abuse of a resident by anyone or neglect of a resident that resulted in harm or risk of harm to the resident."
- "The home shall thoroughly investigate each incident of abuse."
- "A resident's family or substitute decision maker shall be contacted to inform them of any alleged, suspected or witnessed incident of abuse or neglect immediately after it is reported and subsequently contacted to notify them of the results of any investigation conducted."

The OMNI Zero Tolerance of Abuse and Neglect of Residents Policy #AM-6.9 effective June 2015, included the following:
- "Every resident is treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and is free from mental and physical abuse, always."
- "All employees are aware of the expected behaviour and aware of the procedures when they witness, suspect or hear of a resident being abused or neglected."
- "Zero tolerance means within the policy OMNI Healthcare shall: uphold the right of each resident to live free from abuse and neglect and to be treated with courtesy and respect."
- "The responsibility of every OMNI staff member to report any suspected or witnessed neglect or abuse of a resident as indicated in this policy. The policy documented employee training and retraining requirements that included mandatory reporting procedures, review of the policy of Zero Tolerance of Abuse and Neglect, and behavioural support procedures."

The licensee has failed to protect multiple residents from abuse and neglect by a specific staff member. Staff did not report the suspected abuse and neglect at the time it

occurred and the report to the Director was missing the names of other residents named in the witness statement of these staff. For those residents absent from the report, families were not notified of the suspicions. (563)

B) The home submitted a Critical Incident System (CIS) report on a specific date for a mandatory report of an incident of staff to resident abuse. The CIS report did not include the name of the staff member.

The home's internal investigation records were reviewed and included an interview with an identified resident by the Administrator and a staff member on a specific date. This interview documentation stated that the resident was upset related to a way they had been treated by a staff member.

During an interview a staff member told an inspector that there was an identified resident who was upset on a specific date and they had asked another staff member to speak with the resident.

During an interview with another staff member they told an inspector that they went to speak with an identified resident as that resident was upset.

During an interview with the Director of Care (DOC) they acknowledged to an inspector that the CI report did not indicate the name of the staff member and it should have. The DOC also said that after previous incidents of staff to resident abuse involving this identified staff member the staff member had been moved to a different care area.

The licensee has failed to protect this identified resident from abuse by an identified staff member. (213) [s. 19. (1)]

2. The licensee has failed to ensure that residents were protected from abuse by anyone. The home submitted a Critical Incident System (CIS) report on a specific date regarding an incident between two residents. The CIS report also indicated that upon review of the documentation, it was found that there was documentation that similar incidents had occurred on two prior dates, but the police and the management of the home were not notified of these two incidents.

A record review of documentation in Med-e Care was completed for the residents and included the following:
- On a specific date a "Socially Inappropriate or Disruptive" titled progress note which

stated that one identified resident was seen touching another identified resident in a specific way. It stated that the one resident was redirected and was told this behaviour was inappropriate.
- On another specific date a "Socially Inappropriate or Disruptive" titled progress note which stated that the identified resident seen touching another identified resident in a specific way. It stated that this resident was removed from the area and asked not to do that again.
- On another specific date a "Socially Inappropriate or Disruptive" titled progress note which stated that one identified resident attempted to touch another identified resident. The resident was told this is not appropriate and they stopped.

During an interview a staff member told an inspector that they recalled the incidents of this resident being inappropriate with another resident. The staff member said that this was reported to the Registered Nurse (RN) on duty. The staff member said that at the time, they felt that the behaviour was inappropriate, but that they did not make the connection that it was abuse. They said that they were provided with re-training after the last incident and they then understood that this was abuse.

In an interview with Director of Care (DOC) said that the first two incidents of inappropriate behaviour were not reported to management. They said that the registered staff who did not report the first two incidents were spoken to after the third incident was reported, and that they apparently did not recognize or identify the incidents as abuse. The DOC shared that they were unaware of the first two incidents of inappropriate behaviour from the one identified resident to the other identified resident. As the management of the home was unaware, they did not report the first two incidents to the MOHLTC and were not able to take appropriate actions to prevent reoccurrence. The DOC also said that this resident had not displayed this behaviour toward any other residents.

The licensee has failed to ensure that an identified resident was protected from abuse by another identified resident. (213) [s. 19. (1)]

3. The licensee has failed to ensure that all resident were protected from physical abuse by anyone.

On a specific date the home submitted a CIS report to the Ministry of Health and Long-Term Care (MOHLTC) which was identified as an allegation of resident to resident abuse.

On another specific date the home submitted a CIS report to the Ministry of Health and Long-Term Care (MOHLTC) which was identified as an allegation of resident to resident abuse related to the same two identified residents.

During an interview an identified resident told an inspector that there had been two incidents with another resident in the home which had resulted in specific injuries.

During interviews the Behavioural Supports Ontario (BSO) staff members said that these two residents both had responsive behaviours. The BSO staff member reported there had been altercations between these two residents related to a specific trigger.

During an interview the DOC told an inspector that the two altercations between these two identified resident were considered to be a specific type of abuse.

The licensee failed to protect an identified resident from abuse from another identified resident. Staff and management in the home reported that the one resident was a known

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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A) During stage 1 of the Resident Quality Inspection (RQI) a staff member reported that an identified resident had an unwitnessed fall on a specific date.

During an interview a staff member said that after a fall the registered nursing staff were to assess the resident, including checking their vital signs, and then document the assessment using the skin assessment, the pain assessment and the post fall assessment form in Med-e Care.

During an interview another staff member said that it was the expectation in the home that after a resident had fallen a post fall assessment would be completed and documented by the registered staff who responded to the fall. This staff member said that these assessments were to be documented in Med-e Care using the "Post Fall Assessment" form as well as the pain assessment form and the skin assessment form. This staff member also said there was a paper version of a head injury routine form that staff were to complete if the fall was unwitnessed or the resident was known to have hit their head.

The clinical record for this resident included the following documentation:
- A progress note for a specific date which stated that a staff member had found the resident on the floor. There was no "Post Fall Assessment" form documented for this fall.

- A progress note for another specific date which stated that this resident was found on the floor. There were no vital signs documented and there was no "Post Fall Assessment" form documented for this fall.
- A progress note for another specific date which stated that this resident was found on the floor by a staff member. There was no "Post Fall Assessment" form documented for this fall.

The home's policy titled "Resident Falls CS-12.1" with effective date January 2013 included the following procedures:
-"The post-fall assessment shall be initiated as soon as possible after the resident has been assessed and is safe and comfortable."
-"The post-fall assessment shall be completed within 24 hours of the fall and provided to the Director of Care for review. The completed post-fall assessment shall be filed in the resident's clinical record."

During an interview, an inspector and a staff member reviewed the clinical record in Med-

e Care for this resident. This staff member acknowledged that this resident had falls documented by staff in the progress notes and that these falls did not have "Post Fall Assessment" forms documented in the electronic record. This staff member said it was the expectation in the home that a "Post Fall Assessment" form would be completed for each fall.

During an interview an inspector and the Director of Care (DOC) reviewed the clinical record for this resident. The DOC acknowledged that this resident had falls documented by staff in the progress notes on specific dates and that these falls did not have "Post Fall Assessment" forms documented. The DOC said it was the expectation in the home that a "Post Fall Assessment" form would be completed for each fall and any time a resident was found on the floor it was considered to be a fall. When asked if there was a process in place to identify if assessments were being done for the falls, the DOC said that they were working on an auditing process but it had not been implemented yet. The DOC said that they thought that they were aware of the falls for residents in the home, but the missing piece was the completion of the post fall assessments.

B) The home submitted a Critical Incident System (CIS) report to the MOHLTC which identified that on a specific date an identified resident was found on the floor in their room. This report stated that the resident sustained a specific injury from the fall.

The clinical record for this resident included the following documentation:
- A progress note on a specific date which stated that the resident was found on the floor.
- A progress note at later time on that specific date which stated that the resident was showing signs of pain and was unable to stand.
- There was no documented pain assessment or "Post Fall Assessment" forms documented for this fall.

During an interview a staff member reviewed the clinical record for this resident and said that the resident had been found on the floor and had been assessed by identified staff members. This staff member said that there was a progress note but there was no pain assessment and no "Post Fall Assessment" documented.

During an interview the DOC said that this resident had experienced a fall from which the resident sustained a specific injury. An inspector and the DOC reviewed the clinical record for this resident and the DOC acknowledged that a post fall assessment or pain assessment were not documented after this fall. The DOC said that the registered staff were supposed to complete these assessments in the electronic documentation system

for each fall. When asked what was considered to be a fall, the DOC said that any time a resident was found on the floor it was to be considered to be a fall and that in this case the staff did not complete the assessment that they were supposed to document as per the process in the home.

Based on these interviews and record reviews the licensee failed to ensure that each time these two residents had fallen a post-fall assessment was conducted using the home's designated clinically appropriate assessment instrument. (630) [s. 49. (2)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

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

Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A skin and wound care program to promote skin integrity, prevent development of wounds and pressure ulcers, and provide effective skin and wound care interventions."

the skin and wound care program, at a minimum, provided for "treatments and interventions, including physiotherapy and nutritional care."

Specifically, staff did not comply with the licensee's "Wound Assessment and Documentation HLHS-TP-4.7" policy with effective date April 2017, which was part of the licensee's skin and wound care program. This policy included the following procedures:
- "Treatment of a wound shall be recorded in the electronic Treatment Administration Record."
- "In the event that a treatment is not required, any follow up assessment or observation shall be documented in the electronic Treatment Administration Record and Wound tracker software section of Med-e Care and the appropriate sections in Point Click Care."

A) During stage 1 of the Resident Quality Inspection (RQI) an inspector observed that an identified resident had a dressing on a specific part of their body.

During an interview a staff member looked in Wound Tracker and said that this resident had an area of compromised skin integrity that was of unknown origin. This staff member said this resident's treatments and dressing were recorded in Wound Tracker and not the electronic Treatment Administration Record (eTAR). This staff member said that for pressure ulcers they used the eTAR to document treatments but for other types of skin issues they used Wound Tracker.

The clinical record for this identified resident included no documentation of treatments for this wound in the eTAR.

B) During stage 1 of the Resident Quality Inspection (RQI) an inspector identified, through a clinical record review, that another identified resident had multiple areas of altered skin integrity documented since their admission to the home.

During an interview a staff member told an inspector that they would know what treatments or dressings a resident required related to any skin concerns in the Wound Tracker and that would be passed on at report. When asked if the treatments were part of the eTAR, this staff member said that they did not all show up and it depended on who did the assessment. This staff member said that they thought that all treatments should be in the eTAR. When asked about this wound the staff member said that they were not sure about the stage of the wound or the dressing it required and that when they had just assessed the wound there was a dressing on it.

The clinical record for this resident included no documentation of treatments for any of these wounds for a specific time period in the eTAR.

During an interview the Director of Care (DOC) and an inspector reviewed the eTAR for this resident and it was identified that this record did not include any documentation of treatments or assessments. The DOC said that they thought that treatments for skin tears and smaller wounds were being documented in Wound Tracker and not in the eTAR. The inspector and the DOC reviewed the "Wound Assessment and Documentation HLHS-TP-4.7" policy regarding the documentation of treatments for wounds. The DOC said that they had spoken with staff and there were different practices in different areas of the home related to documentation of treatments for wounds. The DOC said that the expectation was that dressings and treatments for wounds would be documented in the eTAR, in accordance with the policy, and that the staff would be adding the treatments back into the eTARs for all residents.

The licensee has failed to ensure that staff complied with the "Wound Assessment and Documentation HLHS-TP-4.7" policy which was part of the licensee's skin and wound care program. (630) [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, or system, the plan, policy or system is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

During stage 1 of the Resident Quality Inspection (RQI) an inspector observed that an identified resident had an area of altered skin integrity.

During an interview the inspector asked a staff member if this resident had any skin concerns and the staff looked in the clinical record and said that they were not aware of any skin integrity concerns. The inspector asked the staff member to look at the resident and the staff member said that there was an area of altered skin integrity and that there were no assessments or treatments documented for this area.

The clinical record for this resident included no documentation of assessments or treatments for any areas of altered skin integrity apart from a progress note dated the day that the inspector spoke with the identified resident.

During an interview the Director of Care (DOC) said it was the expectation in the home that all areas of altered skin integrity would be assessed by a registered staff member

using the Wound Tracker in electronic charting system including a picture of the area. The inspector and DOC reviewed the assessment and progress notes completed in Wound Tracker for this resident. The DOC acknowledged that there was no assessment documented for this area. The DOC observed this area on the resident and told the inspector that it was a small scabbed area and it was the expectation that staff would have assessed and then monitor the area.

The licensee has failed to ensure that this resident's altered skin integrity was assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. (630) [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident who exhibited altered skin integrity, including skin tears, was reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

A) During stage 1 of the Resident Quality Inspection (RQI) an inspector observed that an identified resident had a dressing in a specific location.

During an interview a staff member said that when a resident had an area of altered skin integrity it was the process in the home that the registered staff would complete a weekly wound assessment in the Wound Tracker in the electronic documentation system. This staff member looked in Wound Tracker and said that this resident had an area of altered skin integrity and they were unsure when the wound was first identified but they had completed an assessment in Wound Tracker when the Personal Support Workers (PSWs) had reported the area to them.

The clinical record for this resident included the following documentation:
- A progress note on a specific date which stated that this resident had a new skin tear in an identified location and an initial wound assessment in Wound Tracker on this date.
- There was no weekly wound assessment documented in Wound Tracker for the following week.

During an interview the Director of Care (DOC) said the expectation in the home was that staff would complete a full assessment of skin tears in Wound Tracker on a weekly basis. The inspector and DOC reviewed the assessment completed in Wound Tracker for this resident and the acknowledged that there had not been a weekly assessment completed for this wound for a specific date.

B) During stage 1 of the Resident Quality Inspection (RQI) an inspector identified, through a clinical record review, that another identified resident had multiple areas of altered skin integrity documented since their admission to the home.

During an interview an identified staff member told the inspector that they had just completed an assessment of resident’s skin integrity and this resident had a specific area of altered skin integrity.

The clinical record for this resident included the following documentation:
- The Wound Tracker identified three wounds that had been assessed since the resident had been admitted.
- One of the identified areas had an initial documented wound assessment but no weekly documented assessments.
- Another of the identified areas was missing one weekly wound assessment between the initial documented wound assessment and the time of inspection.

During an interview the DOC said the expectation in the home was that staff would complete a full assessment of skin tears and wounds in Wound Tracker on a weekly basis. The inspector and DOC reviewed the assessment completed in Wound Tracker for this resident and the DOC acknowledged that there had not been a weekly assessment completed for these area of altered skin integrity and it was the expectation that staff would have completed the weekly assessments.

The licensee has failed to ensure that these residents' altered skin integrity were reassessed at least weekly by a member of the registered nursing staff. (630) [s. 50. (2) (b) (iv)]

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 a resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and is reassessed at least weekly by a member of the registered nursing staff if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) The Medication/Treatment Administration Record for an identified resident documented that a specific medication was to be given according to specific directions.

A medication incident from a specific date showed that a medication error had occurred in which a different medication was given to this resident instead of the one prescribed, but there was no harm to the resident.

An electronic progress note on an specific date stated a medication error had occurred as medications were to be administered to this resident and the registered staff member noticed that the medication that was to be given earlier in the day was still in the medication package.

During an interview the Director of Care (DOC) verified that this resident did not receive their prescribed medication in accordance with the directions for use specified by the prescriber.

The licensee has failed to ensure that drugs were administered to this identified resident in accordance with the directions for use specified by the prescriber.

B) The Medication/Treatment Administration Record for another identified resident documented that a specific medication was to be given according to specific instructions.

A medication incident with a specific dated showed there was a dose omission of this medication. The report stated that during a narcotic count with the evening shift a Registered Nurse noted that the resident's medication had not been given as prescribed.

During an interview the DOC verified there was a dose omission of a specific medication on this specific date.

The licensee has failed to ensure that this medication was administered to the identified resident in accordance with the directions for use specified by the prescriber. (563) [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review were implemented, and a written record was kept of everything.

The Quarterly Professional Advisory Committee (PAC) Meeting Minutes for a specific date included a Medical Pharmacies Clinical Consultant Pharmacist Quarterly Report where it documented, "discussed audit findings and solutions, medication incidents, two checks on allergies on admission, and double checks on high alerts." There was no documentation that included the changes and improvements implemented.

During an interview the Director of Care (DOC) acknowledged to an inspector that the review of the medication incidents documented as part of the "Medication Error Summary Reports" for a specific time period, identified incidents that included a pharmacy error related to dispensing/delivery, a dose omission of a specific medication, an incorrect drug administration two specific medications, missing medication, and a documentation error where the allergies did not match the Best Possible Medication History (BPMH) and order sheet. The DOC stated that there were changes and improvements discussed at the meeting, but were not documented as part of the PAC quarterly review.

The licensee has failed to ensure that the quarterly review of the medication incidents for an identified time frame included any changes and improvements implemented as part of the written record. (563) [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review are implemented, and a written record was kept of everything, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the analysis undertaken under clause (a) were considered in the evaluation; and that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented was promptly prepared.

Section 99 of the Ontario Regulation 79/10 states in clause (a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it; (b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences; and (d) that the changes and improvements under clause (b) are promptly implemented.

The OMNI Health Care Policy/Program Evaluation was dated "January 2018" as the reporting period. Eight staff members were documented as "review participants". The

"Summary of Abuse and Neglect Incident in the Home since last Review" documented that the home had a specific number of Critical Incidents (CIS) related to abuse in 2017. These were all documented as resident to resident abuse and the result of dementia. In the evaluation there was nothing documented under "suggested changes to existing practices", but then under "change implementation date(s)" it was documented that "immediately for all new hires at General Orientation as well as annual education through SURGE" with no date when the change was implemented. In the evaluation under "results and/or observations related to changes" it is documented to "Complete Resident Care and Safety Survey annually/Resident Satisfaction Survey, Family information sessions 2 x a month" with no date related to when this improvement was implemented.

The Director of Care (DOC) told an inspector that they did not remember participating in the OMNI Health Care Policy/Program Evaluation for the reporting period of January 2018, but acknowledged that their name was listed as a review participant. The DOC stated the evaluation would likely be for the 2017 calendar year. The DOC stated that they did not remember being a participant in any meetings where the policy related to prevention of abuse and neglect or incidents of abuse and neglect were reviewed. The DOC also stated that the Administrator led the program review and acknowledged that the Administrator's name was absent from the document. Based on the documentation in the OMNI Health Care Policy/Program Evaluation, the DOC stated there were an identified number of CIS reports related to abuse and neglect in 2017, and were all resident to resident abuse. The DOC stated this documentation was inaccurate as there were other incidents related to staff to resident abuse in 2017. The DOC verified that the evaluation did not include all types of abuse and that according to this documented evaluation, it was not based on the analysis of each incident of abuse of a resident in 2017.

During an interviews with two identified staff members they reported that they did not remember participating in the OMNI Health Care Policy/Program Evaluation for the reporting period of January 2018, but acknowledged that their names were listed as a review participant.

The licensee failed to ensure that the results of the analysis undertaken were considered in the evaluation and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented were a part of the written record. Three participants in the evaluation of the abuse and neglect program were interviewed and they did not recall attending a meeting to review the abuse policy or incidents of abuse. (563) [s. 99.]

Issued on this 25th day of July, 2018

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) :	AMIE GIBBS-WARD (630), MELANIE NORTHEY (563), RHONDA KUKOLY (213)
Inspection No. / No de l'inspection :	2018_722630_0011
Log No. / No de registre :	012816-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 13, 2018
Licensee / Titulaire de permis :	Omni Healthcare (CT) GPCO Ltd. as General Partner of Omni Healthcare (Country Terrace) Limited Partnership 161 Bay Street, Suite 2430, TD Canada Trust Tower, TORONTO, ON, M5J-2S1
LTC Home / Foyer de SLD :	Country Terrace 10072 Oxbow Drive, R.R. #3, Komoka, ON, N0L-1R0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karen Dann

To Omni Healthcare (CT) GPCO Ltd. as General Partner of Omni Healthcare (Country Terrace) Limited Partnership, 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. 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 must be compliant with s. 19 (1) of the LTCHA.

Specifically the licensee must:

a) Develop and implement measures in the home to ensure that an identified staff member complies with the home's written policy on the prevention of abuse and neglect. The home must maintain a documented record of the measures that have been developed and implemented including any education provided to this staff member.

b) Ensure that the policy to promote zero tolerance of abuse and neglect of residents is complied with by all staff and management in the home, specific to but not limited to:
1) the immediate reporting of the allegation of abuse or neglect to the management in the home;
2) the documentation of the home's investigation;
3) the reporting of allegations of abuse or neglect to the Director;
4) the completion of the Critical Incident System (CIS) reports to the Ministry of Health and Long-Term Care (MOHLTC);
5) the notification of residents and/or family members of allegations of abuse or neglect
6) assistance and support for the abused/neglected residents.

c) Develop and implement measures in the home to ensure there is ongoing monitoring, assessments and implementation of documented interventions to protect an identified resident and every other resident from abuse by an identified resident.

d) Develop and implement measures in the home to ensure there is ongoing monitoring, assessments and implementation of documented interventions to protect an identified resident and every other resident from abuse by an identified resident.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC) which documented suspected staff to

resident abuse for eight identified residents. The report stated that the allegations were confirmed during the course of the investigation.

The home's investigation documentation was reviewed by an inspector and included a summary report in which the Director of Care (DOC) and Administrator summarized the results of the investigation and that they had determined that specific types of staff to resident abuse by a specific staff member had occurred. This report documented that the DOC and Administrator thought the actions of this staff member placed residents' safety at risk. The documentation also included a disciplinary report for a specific staff member and documentation of staff interviews.

During an interview the DOC told an inspector that the interviews completed for their investigation suggested suspected abuse happened more than once and prior to the date of the CIS report. The DOC acknowledged that there were residents who had been identified during their investigation as having been allegedly neglected or abused by this specific staff member who were not included in the CIS report. The DOC also verified that the residents absent from the CIS report were not investigated, were not provided support or counselling, and their families were not notified. The DOC stated all allegations were confirmed related to two types of abuse and neglect by this specific staff member. The DOC was asked, "What measures and strategies were put in place to prevent abuse and neglect of residents by this staff member?" The DOC responded that the staff member was supervised by the other staff members, staff were made more aware to report allegations immediately, and the staff member was moved to another care area.

During the inspection identified staff members were interviewed by an inspector regarding the allegations and the home's investigation. During these interviews the staff members reported having witnessed this identified staff member treating residents in specific ways. One of the staff members verified that they did not report the neglect or abuse prior to a specific date and that they were not comfortable reporting incidents of suspected abuse and/or neglect to their manager, but were required to report right away.

During a follow-up interview the DOC acknowledged to an inspector that the staff who worked with this identified staff member only reported what they witnessed once asked as part of the investigation. The DOC verified that the incidents that were discussed during the staff interviewed happened prior and

with no specific date referenced.

During an interview an identified resident told an inspector that a staff member had treated them in a specific way which upset them.

The OMNI Reporting Incidents of Abuse Policy #AM-6.7 effective June 2015, stated the following:
- All matters required to be reported to the Ministry of Health are investigated and reported within the designated time frames.
- "Upon becoming aware of any of the following alleged, suspected or witnessed incidents, the home shall contact the Ministry of Health immediately: improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; abuse of a resident by anyone or neglect of a resident that resulted in harm or risk of harm to the resident."
- "The home shall thoroughly investigate each incident of abuse."
- "A resident's family or substitute decision maker shall be contacted to inform them of any alleged, suspected or witnessed incident of abuse or neglect immediately after it is reported and subsequently contacted to notify them of the results of any investigation conducted."

The OMNI Zero Tolerance of Abuse and Neglect of Residents Policy #AM-6.9 effective June 2015, included the following:
- "Every resident is treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and is free from mental and physical abuse, always."
- "All employees are aware of the expected behaviour and aware of the procedures when they witness, suspect or hear of a resident being abused or neglected."
- "Zero tolerance means within the policy OMNI Healthcare shall: uphold the right of each resident to live free from abuse and neglect and to be treated with courtesy and respect."
- "The responsibility of every OMNI staff member to report any suspected or witnessed neglect or abuse of a resident as indicated in this policy. The policy documented employee training and retraining requirements that included mandatory reporting procedures, review of the policy of Zero Tolerance of Abuse and Neglect, and behavioural support procedures."

The licensee has failed to protect multiple residents from abuse and neglect by a specific staff member. Staff did not report the suspected abuse and neglect at

the time it occurred and the report to the Director was missing the names of other residents named in the witness statement of these staff. For those residents absent from the report, families were not notified of the suspicions. (563)

B) The home submitted a Critical Incident System (CIS) report on a specific date for a mandatory report of an incident of staff to resident abuse. The CIS report did not include the name of the staff member.

The home's internal investigation records were reviewed and included an interview with an identified resident by the Administrator and a staff member on a specific date. This interview documentation stated that the resident was upset related to a way they had been treated by a staff member.

During an interview a staff member told an inspector that there was an identified resident who was upset on a specific date and they had asked another staff member to speak with the resident.

During an interview with another staff member they told an inspector that they went to speak with an identified resident as that resident was upset.

During an interview with the Director of Care (DOC) they acknowledged to an inspector that the CI report did not indicate the name of the staff member and it should have. The DOC also said that after previous incidents of staff to resident abuse involving this identified staff member the staff member had been moved to a different care area.

The licensee has failed to protect this identified resident from abuse by an identified staff member. (213) [s. 19. (1)]

2. The licensee has failed to ensure that residents were protected from abuse by anyone.
The home submitted a Critical Incident System (CIS) report on a specific date regarding an incident between two residents. The CIS report also indicated that upon review of the documentation, it was found that there was documentation that similar incidents had occurred on two prior dates, but the police and the management of the home were not notified of these two incidents.

A record review of documentation in Med-e Care was completed for the

residents and included the following:
- On a specific date a "Socially Inappropriate or Disruptive" titled progress note which stated that one identified resident was seen touching another identified resident in a specific way. It stated that the one resident was redirected and was told this behaviour was inappropriate.
- On another specific date a "Socially Inappropriate or Disruptive" titled progress note which stated that the identified resident seen touching another identified resident in a specific way. It stated that this resident was removed from the area and asked not to do that again.
- On another specific date a "Socially Inappropriate or Disruptive" titled progress note which stated that one identified resident attempted to touch another identified resident. The resident was told this is not appropriate and they stopped.

During an interview a staff member told an inspector that they recalled the incidents of this resident being inappropriate with another resident. The staff member said that this was reported to the Registered Nurse (RN) on duty. The staff member said that at the time, they felt that the behaviour was inappropriate, but that they did not make the connection that it was abuse. They said that they were provided with re-training after the last incident and they then understood that this was abuse.

In an interview with Director of Care (DOC) said that the first two incidents of inappropriate behaviour were not reported to management. They said that the registered staff who did not report the first two incidents were spoken to after the third incident was reported, and that they apparently did not recognize or identify the incidents as abuse. The DOC shared that they were unaware of the first two incidents of inappropriate behaviour from the one identified resident to the other identified resident. As the management of the home was unaware, they did not report the first two incidents to the MOHLTC and were not able to take appropriate actions to prevent reoccurrence. The DOC also said that this resident had not displayed this behaviour toward any other residents.

The licensee has failed to ensure that an identified resident was protected from abuse by another identified resident. (213) [s. 19. (1)]

3. The licensee has failed to ensure that all resident were protected from physical abuse by anyone.

On a specific date the home submitted a CIS report to the Ministry of Health and Long-Term Care (MOHLTC) which was identified as an allegation of resident to resident abuse.

On another specific date the home submitted a CIS report to the Ministry of Health and Long-Term Care (MOHLTC) which was identified as an allegation of resident to resident abuse related to the same two identified residents.

During an interview an identified resident told an inspector that there had been two incidents with another resident in the home which had resulted in specific injuries.

During interviews the Behavioural Supports Ontario (BSO) staff members said that these two residents both had responsive behaviours. The BSO staff member reported there had been altercations between these two residents related to a specific trigger.

During an interview the DOC told an inspector that the two altercations between these two identified resident were considered to be a specific type of abuse.

The licensee failed to protect an identified resident from abuse from another identified resident. Staff and management in the home reported that the one resident was a known trigger for responsive behaviours by the other resident and failed to implement effective strategies to minimize the risk of abuse. (630) [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual risk. The scope of the issue was a level 1 as it was isolated. The home had a level 3 history as they had on-going noncompliance with this section of the LTCHA that included:
- Written Notification (WN) and Compliance Order (CO) issued August 22, 2016 (2016_276537_0029) and complied October 5 2017. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 21, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 49. (2)

Specifically the licensee must:
a) Ensure that post fall assessments for two identified residents and any other resident are completed and documented whenever the resident has fallen.

b) Ensure that all Registered Nurses and Registered Practical Nurses working in the home are reeducated on the home's Falls Prevention and Management policies and procedures as related to completing and documenting post fall assessments. The home must keep a documented record of the education provided.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A) During stage 1 of the Resident Quality Inspection (RQI) a staff member reported that an identified resident had an unwitnessed fall on a specific date.

During an interview a staff member said that after a fall the registered nursing staff were to assess the resident, including checking their vital signs, and then document the assessment using the skin assessment, the pain assessment and the post fall assessment form in Med-e Care.

During an interview another staff member said that it was the expectation in the home that after a resident had fallen a post fall assessment would be completed and documented by the registered staff who responded to the fall. This staff member said that these assessments were to be documented in Med-e Care using the "Post Fall Assessment" form as well as the pain assessment form and the skin assessment form. This staff member also said there was a paper version of a head injury routine form that staff were to complete if the fall was unwitnessed or the resident was known to have hit their head.

The clinical record for this resident included the following documentation:
- A progress note for a specific date which stated that a staff member had found the resident on the floor. There was no "Post Fall Assessment" form documented for this fall.
- A progress note for another specific date which stated that this resident was found on the floor. There were no vital signs documented and there was no "Post Fall Assessment" form documented for this fall.
- A progress note for another specific date which stated that this resident was found on the floor by a staff member. There was no "Post Fall Assessment" form documented for this fall.

The home's policy titled "Resident Falls CS-12.1" with effective date January 2013 included the following procedures:
-"The post-fall assessment shall be initiated as soon as possible after the resident has been assessed and is safe and comfortable."
-"The post-fall assessment shall be completed within 24 hours of the fall and provided to the Director of Care for review. The completed post-fall assessment shall be filed in the resident's clinical record."

During an interview, an inspector and a staff member reviewed the clinical record in Med-e Care for this resident. This staff member acknowledged that this resident had falls documented by staff in the progress notes and that these falls did not have "Post Fall Assessment" forms documented in the electronic record. This staff member said it was the expectation in the home that a "Post Fall Assessment" form would be completed for each fall.

During an interview an inspector and the Director of Care (DOC) reviewed the clinical record for this resident. The DOC acknowledged that this resident had falls documented by staff in the progress notes on specific dates and that these falls did not have "Post Fall Assessment" forms documented. The DOC said it

was the expectation in the home that a "Post Fall Assessment" form would be completed for each fall and any time a resident was found on the floor it was considered to be a fall. When asked if there was a process in place to identify if assessments were being done for the falls, the DOC said that they were working on an auditing process but it had not been implemented yet. The DOC said that they thought that they were aware of the falls for residents in the home, but the missing piece was the completion of the post fall assessments.

B) The home submitted a Critical Incident System (CIS) report to the MOHLTC which identified that on a specific date an identified resident was found on the floor in their room. This report stated that the resident sustained a specific injury from the fall.

The clinical record for this resident included the following documentation:
- A progress note on a specific date which stated that the resident was found on the floor.
- A progress note at later time on that specific date which stated that the resident was showing signs of pain and was unable to stand.
- There was no documented pain assessment or "Post Fall Assessment" forms documented for this fall.

During an interview a staff member reviewed the clinical record for this resident and said that the resident had been found on the floor and had been assessed by identified staff members. This staff member said that there was a progress note but there was no pain assessment and no "Post Fall Assessment" documented.

During an interview the DOC said that this resident had experienced a fall from which the resident sustained a specific injury. An inspector and the DOC reviewed the clinical record for this resident and the DOC acknowledged that a post fall assessment or pain assessment were not documented after this fall. The DOC said that the registered staff were supposed to complete these assessments in the electronic documentation system for each fall. When asked what was considered to be a fall, the DOC said that any time a resident was found on the floor it was to be considered to be a fall and that in this case the staff did not complete the assessment that they were supposed to document as per the process in the home.

Based on these interviews and record reviews the licensee failed to ensure that

each time these two residents had fallen a post-fall assessment was conducted using the home's designated clinically appropriate assessment instrument. (630) [s. 49. (2)]

The severity of this issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 2 as it was a pattern. The home had a level 3 history as they had on-going noncompliance with this section of the LTCHA that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued August 22, 2016 (2016_276537_0029). (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 21, 2018

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 July, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Amie Gibbs-Ward

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