Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 22, 2020	2019_797740_0022 (A1)	016172-19, 017523-19, 017524-19, 017554-19, 018417-19	Critical Incident System

Licensee/Titulaire de permis

Craigwiel Gardens
221 Main Street R. R. #1 AILSA CRAIG ON N0M 1A0

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

Craigholme
221 Main Street, R.R. #1 AILSA CRAIG ON N0M 1A0

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

Amended by SAMANTHA PERRY (740) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

On January 15, 2020, a request for an extension of the compliance due date of February 10, 2020, for Compliance Order #002 issued in inspection #2019_797740_0022, was received from Wayne Williams, Chief Executive Officer for Craigholme Nursing Home. The new compliance due date requested was April 15, 2020. After a teleconference on January 21, 2020 with home management staff, LSAO Inspection Managers and Inspectors an extension was agreed upon with a new compliance due date of March 27, 2020.

Issued on this 22nd day of January, 2020 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by SAMANTHA PERRY (740) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 09, 10, 11, 12, 13, 16, 17, 18, 19, 20, 24, 26, 27, 30, October 01, 02, 03 & 07, 2019.

The following intakes were completed within the Critical Incident Systems inspection:

Log# 016172-19 / CI# 2622-000014-19 related to falls management; and

Log# 017554-19 / CI# 2622-000018-19 also related falls management;

Log# 017523-19 / CI# 2622-000016-19 related to responsive behaviours;

Log# 017524-19 / CI# 2622-000017-19 related to responsive behaviours; and

Log# 018417-19 / CI# 2622-000019-19 also related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, Director of Care, Assistant Director of Care, Director of Food Services, Director of Environmental Services, Human Resources Manager, Quality Manager, Maintenance Staff, Director of the Adult Day Program, Admission Coordinator of the Adult Day Program, Registered Nurses, Registered Practical Nurses and Personal Support Workers.

The inspector(s) also made observations and reviewed residents' clinical records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

7 WN(s)
1 VPC(s)
6 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every alleged, suspected, or witnessed incident of abuse of a resident by anyone that the licensee knows of was immediately investigated.

Three Critical Incident System (CIS) reports were received by the Ministry of Long-Term Care (MOLTC) related to verbal and physical aggressiveness.

Review of the policy “Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences”, policy #RC-02-01-03, last updated June 2019, stated the following:
- All reported incidents of abuse and/or neglect will be objectively, thoroughly and promptly investigated.
- The Administrator/Delegate will “a. Promptly initiating an investigation (immediately if there is harm or risk of harm to a resident);” and “h. Ensuring that a copy of the documentation and all other evidence collected is stored within a secure area of the home”.
- Manager/Designate during the investigation will “a. Maintain the security and integrity of the physical evidence at the site of incident, fully investigate the incident, and complete the documentation of all known details in keeping with the steps outlined in the Workplace Investigation Toolkit available from People and Culture”.

A review of the identified resident’s clinical records documented five incidents of physical aggression on specified dates.

In an interview with the ADOC they said they were aware of the documented incidents of abuse related to the identified resident and that they didn’t have documented records of an investigation into the identified incidents of abuse.

The licensee failed to ensure that when they became aware of incidents of abuse by the identified resident towards other residents, that these incidents were immediately investigated.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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 resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident had occurred that the information upon which it was based was immediately reported to the Director.

Three Critical Incident System (CIS) reports received by the Ministry of Long-Term Care (MOLTC) related to verbal and physical aggressiveness.

Review of the policy "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", RC-02-01-02, last updated April 2017 documented the following:
- "Staff must complete an internal incident report and notify their supervisor (or during after-hours the Nurse on site). The Nurse would then call the Manager on-

call or General Manager/designate immediately upon suspecting or becoming aware of the abuse or neglect of a resident". "Management will promptly and objectively report all incidents to external regulatory authorities, including the police if there are reasons to believe a criminal code offence has been committed".
- "Note: The policy and procedures herein operate subject to applicable legislation and collective agreements".
- the Administrator/Designate, Director of Care/Designate or Supervisor/Designate will:
4. Follow province-specific reporting requirements. See Jurisdictional Reporting Requirements, Appendix 2.
5. Complete province-specific reporting form: c. Appendix 5 - Ontario LTC Critical Incident Reporting Form.
- All staff will:
A note states in part, Note: In Ontario, anyone who suspects or witnesses abuse that causes or may cause harm to a resident is required to contact the Ministry of Health and Long Term Care (Director) through the Action Line.
2. The person reporting the suspected abuse will follow the home's reporting/provincial reporting requirements to ensure the information is provided to the home Administrator/designate immediately.

Review of the MOLTC Critical Incident reporting system showed that the home did not contact the Service Ontario After-Hours Line or submit corresponding CIS reports related to the documented incidents where the identified resident was physically abusive towards other residents.

There were no documented records indicating the specific times the incidents of abuse, occurred on, with which the identified resident was involved.

Review of the identified resident’s clinical records showed the occurrence of two physically and verbally aggressive incidents for which the Assistant Director of Care (ADOC) was notified but did not report the incidents to the Director of the Ministry.

During an interview with the ADOC they stated their understanding of the reporting requirements for allegation of abuse were that they were to be reported to the MOLTC the next day. When asked if they were aware and considered the identified incidents to be abuse, the ADOC stated yes. When asked if the incidents of abuse were reported to the MOLTC and if they should have been

reported, the ADOC said they did not believe they were reported and expected that they should have been.

The licensee failed to ensure that when suspected abuse by the identified resident which resulted in risk of harm to other residents, and the information upon which it was based was immediately reported to the Director.

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: 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 :

The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin tears and pressure ulcers, received a skin assessment; immediate treatment to promote healing; was referred to the registered dietitian; and was reassessed at least weekly, if clinically indicated, by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

In accordance with Ontario Regulation 79/10 s. 48 (1) the licensee had failed to ensure that the following interdisciplinary programs were implemented in the home: A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

A) Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MOLTC) ActionLine and documented an incident that caused an injury to an identified resident.

The home's policy "Skin and Wound Program: Wound Care Management" #RC-23-01-02, last updated February 2017 stated the following:
-"Promptly assess all residents exhibiting altered skin integrity on initial discovery. Determine if wound is inherited or acquired, or worsening, and investigate root

causes. Use Bates Jensen Wound Assessment Tool, Appendix 2 for pressure ulcers/venous stasis or ulcers of any type; use Impaired Skin Integrity Assessment, Appendix 3 for all other skin impairments (i.e., skin tears, rashes, reddened areas, bruises)".
-“Monitor resident skin condition with each dressing change. Re-assess at minimum weekly. Re-evaluation and documentation of treatment with creams or other medicated preparations should occur at minimum weekly.”
-“Complete a referral to Registered Dietitian (RD) for all residents exhibiting altered skin integrity.”

The home’s “Skin and Wound Program: Prevention of Skin Breakdown” policy #RC-23-01-01, last updated February 2017 stated the following:
-“11. Assess effectiveness of interventions, document alternate approaches considered or applied, and ensure plan of care is up to date.”

While observing the identified resident, they stated to the inspector that they were in pain and specified to the inspector where they had pain.

Review of the resident’s Assessments showed:
- no documentation of a “Skin - Weekly Wound Assessment” completed when the identified resident’s skin integrity alterations were first identified on specified dates and no documentation of dietary referrals corresponding with the identified dates.

The clinical records for the identified resident were reviewed and showed various interventions related to altered skin integrity and pain management; however, no weekly monitoring and wound assessments were documented. The records also showed that, pain observations were documented on 38 out of 90 (42 per cent) shifts, skin observations were documented on 41 out of 90 (45 per cent) shifts, and turning and repositioning was documented on 24 out of 53 (45 per cent) shifts.

Progress notes were reviewed, and a skin note stated that the identified resident had several areas of altered skin integrity. Another skin note documented a new area of altered skin integrity in a different anatomical area.

During an interview with a Personal Support Worker (PSW) they stated they would look at the resident’s clinical records to determine the care they required. When asked how they would know if a resident had a wound, the PSW said they would know by doing their skin observations, during shift report, or directly from

the registered staff on the shift. The PSW said that the Registered Practical Nurse (RPN) would let the PSWs know what the direction of care would be. The PSW said that they would like to see more information provided regarding the type of wound and the direction to take. The PSW stated they were familiar with the identified resident and the resident's clinical record did not provide clear direction related to certain care areas and was not reflective of the resident's current status. When asked how they would monitor a resident's pain and skin condition the PSW said it would be documented in POC. The PSW said that the resident's pain and skin condition should be documented on each shift and turning and repositioning at least every two hours. The PSW said that documentation was not reflective of the care provided or not provided, as they did not always have time to document.

During an interview with a Registered Practical Nurse (RPN) they stated they would look at the resident's chart and the Care Plan to determine the care a resident required. The RPN said they were familiar with the identified resident and they exhibited pain and had areas of altered skin integrity. The RPN reviewed the resident's care plan and said that the interventions were not reflective of the resident's current status and was not clear. The RPN stated that rashes, reddened areas, and bruises were types of altered skin integrity that would require a clinically appropriate weekly skin and wound assessment completed by registered staff . The RPN said that if a resident was identified as having altered skin integrity, registered staff would complete the Treatment Administration Record (TAR) and complete the Bates Jensen skin assessment. The RPN confirmed that the resident's areas of altered skin integrity were not assessed on the day they were originally identified. The RPN stated they would expect an assessment to have been completed when the compromised areas of skin integrity were initially identified, and when the new wound was identified.

In an interview with the RPN they stated that altered areas of skin integrity included skin tears, pressure ulcers, bruises and rashes and would require a skin and wound assessment. The RPN said that they would document the assessment and expected that an assessment would be completed by the registered staff working on the shift when the wound was identified. When asked how referrals were completed, the RPN stated they were completed through the electronic clinical records and would involve a dietary referral as well. The clinical records for the identified resident were reviewed and showed that the RPN identified and documented that the identified resident had two areas of altered skin integrity and a new area of altered skin integrity on specified dates. The RPN said that skin and

wound assessments were not completed for the altered areas of skin integrity and should have been completed on the same date as identified. When asked if a referral was made to the registered dietitian (RD) and the skin and wound lead when the new areas were identified, the RPN said no, and they should have been.

During an interview, the RD said they would receive referrals for residents who exhibited altered areas of skin integrity through the electronic clinical records. When asked if they had received a referral for the identified resident, the RD reviewed their documentation and said no and expected to have received one. When asked if they had received a referral for a new area of altered skin integrity for the identified resident, they said no.

B) Review of the home's communication binder showed a note documenting there was a new area of altered skin integrity for the identified resident. The note stated, "with each new skin issue a skin-weekly impaired skin integrity assessment needs to be done at the time the issue is found."

The home's "Skin and Wound: Wound Care Management" policy #RC-23-01-02, last updated February 2017 stated the following:
-"Document altered skin integrity as per home's process. In homes with point of care (POC) tablets, the care staff will document by exception once a shift."
-"Record the treatment regimen on the MAR/eMAR and/or TAR/eTAR."
-"Document resolution of skin integrity issues in the interdisciplinary progress notes and update the resident care plan as needed."

The clinical records of the identified resident were reviewed and documented a new area of altered skin integrity on a specified date; however, no treatments or a referral to the RD were documented and the direction for registered and non-registered staff was unclear.

The Assistant Director of Care (ADOC) stated in an interview that interventions related to skin integrity should be documented in the resident's clinical care records and that more information should be provided so that the registered and non-registered staff providing direct care know the skin issues of the residents. The ADOC said that the direction to staff related to skin integrity was not clear and that they would expect that a skin integrity assessment had been completed for the identified resident.

C) A Personal Support Worker (PSW) informed inspectors that another identified resident had altered areas of skin integrity.

The clinical records for the identified resident were reviewed and documented that the resident had a potential for skin alteration and staff were to assess skin daily with care. Treatments and turning and repositioning were also identified as required interventions for the identified resident. Skin observations were documented on 47 out of 90 (52 per cent) shifts and turning and repositioning was documented on 34 out of 66 (52 per cent) shifts. The records also identified there was no direction for non-registered staff related to areas of altered skin integrity or the resident's treatments or interventions. Several skin notes were documented that identified new areas of altered skin integrity for which an initial skin assessment was completed; however, the initial assessments were not completed consistently and nor were the weekly wound reassessments completed consistently.

The treatment records were reviewed and documented several different types of treatments with various start and discontinue dates.

During an interview with the ADOC they said they would expect that a skin assessment should have been completed for each newly identified area of compromised skin integrity. The ADOC reviewed the resident's clinical records and said that they would expect that after the initial assessment identified any areas of altered skin integrity, that weekly assessments should have been completed. The ADOC said that if treatment was needed, registered staff should have been documenting those treatments or interventions for altered areas of skin integrity in the resident's clinical records. When asked what the direction to staff was for providing treatment to the identified resident's area of altered skin integrity, the ADOC said it was not clear.

The licensee failed to ensure that the skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions for the identified residents who exhibited altered skin integrity, including skin tears and pressure ulcers, received a skin assessment, immediate treatment to promote healing, a referral to the registered dietitian, and was reassessed at least weekly.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the Director was informed no later than one

business day after the occurrence of an incident where a resident was missing for less than three hours and returned to the home with no injury or adverse change in condition.

A) During the course of this inspection, it was identified that a resident had eloped from the home on a specified date.

The homes current policy "Critical Incident Reporting (ON)", policy #RC-09-01-06, last updated June 2019, stated in part that the Director of Care (DOC)/Designate will inform the Director no later than one business day after the occurrence of the incident of a resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

There were no Critical Incident System (CIS) reports submitted to the Ministry of Long-Term Care (MOLTC) for the identified resident's incidents of elopement.

A review of an identified resident's progress notes showed the following:
- the identified resident was returned to the home on a specified date by someone and another incident note stated that the identified resident was seen outside.

A review of the identified resident's clinical records documented other incidents of elopement for which the home did not report to the Director of the Ministry of Long-Term Care (MOLTC).

During an interview with the Assistant Director of Care (ADOC) they said that they were aware of the identified resident's incidents of elopement, said the incidents of elopement were required to be reported to the MOLTC, stated no, the incidents were not reported and should have been.

B) During the course of this inspection, it was identified that another resident had eloped from the home on a specified date.

A review of the identified resident's clinical records showed that the resident had eloped on a specified date.

In an interview with the ADOC they said they were aware of the documented incident of elopement on a specified date, that the incident was not reported to the Ministry and should have been.

The licensee failed to ensure that the Director was informed no later than one business day after a resident was missing for less than three hours and returned to the home with no injury or adverse change in condition when the identified residents eloped.

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including interdisciplinary assessments or on information provided to the licensee, that could potentially trigger such altercations; and the identification of and implementation of interventions.

The Ministry of Long-Term Care (MOLTC) received three Critical Incident System (CIS) reports related to an identified resident's responsive behaviours.

A review of the “Responsive Behaviours” policy RC-17-01-04, last updated February 2017 stated, in part: “Policy: Each resident will be assessed and observed for indicators of responsive behaviours on admission, quarterly, and as needed. All new or escalated instances of responsive behaviours will be reported, recorded and investigated on an ongoing basis. The home will implement and evaluate strategies and interventions to prevent, minimize and address responsive behaviours” and “Procedures: the interdisciplinary team will: 1- Observe and assess each resident using the provincially mandated and/or recommended assessment. The results of these assessments will be evaluated to plan appropriate interventions and update the care plan”.

A review of an identified resident’s Assessments showed that the resident was being monitored; however, no clinically appropriate assessments were completed to guide staff in determining the appropriate responsive behaviours interventions to be implemented.

A review of an identified resident’s care plan showed various interventions related to the identified resident’s responsive behaviours.

A review of an identified resident’s progress notes documented a history of exhibited responsive behaviours for which the Director of Care (DOC) and physician were aware.

During an interview with a Personal Support Worker (PSW) they stated that they were familiar with the identified resident and that they exhibited responsive behviours. The PSW said that interventions were in place to manage the identified resident’s responsive behaviours and that the resident’s care requirements would be indicated in a communication book.

The “Resident Observation Records” and “Dementia Observation System” records for the identified resident were reviewed and showed the following:
-Incomplete documentation of behaviour monitoring on 10 out of 18 (55 per cent) days.

The “Documentation Survey Report V2” for the identified resident was reviewed and showed the following:
-Monitoring was documented on 1106 out of 2496 (44 per cent) of the time for the indicated task.

In an interview with a Registered Practical Nurse (RPN) they said that the registered staff in charge on each unit would be responsible for assessing and documenting a residents' responsive behaviours through a “behaviour follow-up” assessment document. When asked if the identified resident exhibited responsive behaviours, the RPN said yes, the resident did exhibit responsive behaviours. When asked what interventions were in place to manage the resident’s responsive behaviours, the RPN stated they had specific monitoring in place. When asked if any behavioural assessments had been completed for the identified resident, the RPN stated they were not sure, but that they documented the resident’s behaviours daily. When asked if there had been evaluations to determine whether the interventions in place to manage the identified resident’s responsive behaviours were effective, the RPN stated they were not sure.

During an interview, a Behavioural Supports Ontario Personal Support Worker (BSO PSW) stated that they were familiar with the identified resident and that the resident had a history of responsive behaviours. The BSO PSW said that they were aware of altercations between the identified resident and co-residents of the home and that interventions were documented in the resident's plan of care. The BSO PSW stated that the resident’s health status and their responsive behaviours had changed and that the resident’s assessments and reassessments were based on staff communication and progress notes. When asked if any behavioural assessments had been completed for the identified resident, the PSW stated that the physician asked them to complete a Montreal Cognitive Assessment (MOCA) with the resident but the resident refused. When asked how it was determined what interventions were implemented to manage residents’ responsive behaviours, the PSW stated that it was based on trial and error and that the effectiveness of the interventions implemented by staff were not evaluated consistently.

The Assistant Director of Care (ADOC) reviewed the clinical records for the identified resident, which documented multiple resident to resident altercations. When asked what actions the home took following the altercations, they stated that monitoring and additional interventions were implemented, as well, the homes BSO team spent a lot of time with the resident to determine interventions. When asked if the interventions were evaluated and assessed to determine effectiveness, the ADOC stated they would think so, but that the home’s BSO team would be responsible for assessing and determining which interventions should be implemented related to responsive behaviours. The ADOC said that they were unsure of the assessment process or how the home was evaluating the

effectiveness of behavioural interventions. The ADOC said that no behavioural assessments had been completed for the identified resident and expected that they would have been.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between the identified resident and other residents. Staff and management in the home were aware of the potential risks, through staff observation and communication, but identifying factors and interventions were not based on assessments or reassessments of the resident.

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Findings/Faits saillants :

The licensee has failed to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring of residents, and the implementation of restorative care approaches, including that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

In accordance with Ontario Regulation 79/10 s. 48 (1) the licensee has failed to ensure that the following interdisciplinary programs were implemented in the home: A falls prevention and management program to reduce the incidence of

falls and the risk of injury.

In accordance with Ontario Regulation 79/10 s. 30 (1) 1. The licensee was required to ensure that staff in the home complied with the falls prevention and management program policies, procedures and protocols that were in place to reduce risk; 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and 4. The licensee should have kept a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Specifically, the home did not implement the “Falls Prevention and Management Program” which included the “Falls Prevention and Management Program” policy and procedures, #RC-15-01-01, last updated February 2017.

A. 1) The Ministry of Long-Term Care (MOLTC) received a critical incident system (CIS) report, regarding a fall causing an injury..

The home’s “Falls Prevention and Management Program” policy, # RC-05-01-01, last updated February 2017, included the following procedures under the title “Prevention of Falls”:
- “5. Screen all resident’s on admission, annually, with a change in condition that could potentially increase the resident’s risk of falls/fall injury, or after a serious fall injury or multiple falls (if not already at high risk). See Scott Fall Risk Screen for Residential Long-Term Care, Appendix 4.”
- “7. Flag residents at high risk of fall injury (e.g., new admissions, Scott Fall Risk Score >7, Fracture Risk >1) for additional monitoring, precautionary measures, and protective equipment (e.g., hip protectors, wrist guards, etc.) on admission and re-assessment. Clearly communicate responsibilities of all parties in prevention of falls and injury. See Falling Star/Leaf Flagging Guide, Appendix 7.”

The home’s “Falling Star/Leaf Flagging Guide – Appendix 7”, last updated February 2017 stated the following:
-“Residents in the program will be identified in one or more of the following ways:
• Wrist band or visible clothing item designated by the home;
• Icon on bedroom door and near bed; and/or
• Flag on chart”

Review of the Falls Committee meeting minutes identified the following documentation:
-“Scott’s Fall-to be documented on admission and after every fall”.
-“After fall process discussed: post falls assessment, Scott’s fall documentation, staff huddle, HIR [head injury routine] documentation is now available on-line, for now double chart on paper as well”.
-“possibly create a tick sheet reminder of what is necessary to chart with every fall”.

Assessments were reviewed and showed that the identified resident was at a high risk of falls.

There was no post-fall assessments or post-fall huddles documented for the identified.

The Care Plan for the identified resident documented various interventions related to the resident’s high risk for falls status.

The identified resident was observed lying in their bed, call bell within reach. Resident’s interventions were identified above the resident’s bed. There was no falling star or leaf identifier present in the resident’s bedroom area.

The Physiotherapist (PT) stated that they were familiar with the identified resident and were aware of the resident's fall. The PT stated that they assessed the resident upon return from hospital and that they were a high risk for falls. The PT said that falls risk was based on the Scott Falls Risk Assessment completed by the registered staff as well as their own resident assessment.

The Registered Nurse (RN) said that they were familiar with the identified resident and were aware of the resident's fall. The RN said that the resident has had a history of falls and stated that the resident was determined to be moderate to high risk for falls. The RN said that the resident’s status changed after the fall and was now in a wheelchair, used a mechanical sit to stand lift for transfers, and was involved with physiotherapy. The RN said that they would complete a Scott Fall Risk Assessment to determine whether a resident was at a high risk for falls. When asked who completed post-fall assessments, the RN said that it should be completed immediately after a fall by the registered staff. The RN said that falls interventions would be identified for staff in the care plan or on signage above the

bed. When asked if the home implemented the falling star or leaf logo for high fall risk residents, the RN said no. The RN stated that the home did not have an official falls prevention program and was unaware of the process for determining if a resident was part of the program.

2) The clinical records for an identified resident showed the resident had a previous fall and was identified as a high risk for falls.

An identified resident was observed in their bedroom sitting in their wheelchair, all falls interventions as identified by the signage at the head of the bed were in place. There was no falling star or leaf identifier present in the resident's bedroom area.

There was no post-fall assessments or post-fall huddles documented for the identified resident.

The written plan of care for the identified resident included various interventions related to the prevention of the resident's risk for falls.

3) The clinical records for an identified resident showed the resident had a documented fall.

A "Falls Management - Post-Fall Assessment" was initiated for the identified resident but was not completed and there was no post-fall huddle documentation included as part of the assessment.

The care plan for the identified resident documented that the resident was a high risk for falls and listed various interventions related to the prevention of the resident's risk for falls.

The resident was observed sleeping in bed with call bell within reach and the signage at the head of bed was current to the interventions observed in resident's room. However, there was no falling star or leaf identifier present in the resident's bedroom area.

During an interview the RN stated that they were newly appointed as the falls lead and were recently provided with the fall's prevention binder. The RN said that they were unsure of the falls lead responsibilities and that there was no falls prevention program in the home that set out clear direction to staff when a resident had

fallen.

In an interview the Director of Care (DOC) stated that post-fall assessments were to be completed post fall and that the home was not completing assessments and post-fall huddles consistently. The DOC said that it was not clear to staff what assessments were to be completed post fall. The DOC said that the falls management policy appendices were not fully implemented by staff and that the home was not doing the falling star/leaf flagging guide like the policy stated and that the home was not implementing all parts of the falls management policy.

B. The Ministry of Long-Term Care (MOLTC) received a Critical Incident System (CIS) report, which documented a fall, causing an injury.

The home's most current "Falls Prevention and Management" policy, #RC-15-01-01, last updated February 2017, included the following procedures under the title "Post-Fall Management":
2. Hold a Post-Fall Huddle, ideally within the hour and complete a post-fall assessment as soon as possible. See Post-Fall Assessment Tool, Appendix 11 and Post-Fall Team Huddle Process, Appendix 12.
The home's "Post Fall Team Huddle Process– Appendix 12", last updated February 2017 stated the following:
- "5. Complete Post Fall Assessment, which includes an area to summarize the Post Fall Team Huddle."

Assessments were reviewed for the identified resident that the resident was at a high risk for falls.

The Care Plan for the identified resident showed that the was identified as being a high risk for falls and documented several interventions related to the prevention of the resident's falls risk.

The clinical records for an identified resident showed the following:
-A "Fall Management" describing the identified resident's fall and location and the resident's status.
-There was no post-fall assessment or post-fall huddle documented for the identified resident.

A Registered Nurse (RN) during an interview stated that when a resident has a fall, they would assess the resident and make sure they were comfortable and

safe. The RN said that they would take the resident's vital signs, complete a head to toe assessment, assess surroundings, range of motion, whether the fall was witnessed or unwitnessed and determined if a head injury routine (HIR) needed to be started. The RN said that they would establish the resident's level of consciousness and if they had any injuries. When asked if the information documented for the identified resident was sufficient information to satisfy that a post-fall assessment was completed, the RN said no.

During an interview the Assistant Director of Care (ADOC) stated that staff were to complete post-fall assessments as per the home's Fall Prevention and Management policy. The ADOC said that a post-fall assessment should have been completed for the identified resident and any other resident who has fallen.

C) The home's "Quality Program Evaluation – Falls", with Annual Schedule: August, was reviewed. The evaluation was blank, and did not document the following:
-people who participated in the evaluation
-trends observed
-actions required by Falls Committee based on the analysis
-dates of the Quarterly Falls Control meetings held in the home
-objectives
-if policy changes were required
-signatures of those involved, or
-the summary of falls reported

The home's "Falls Prevention and Management Program" policy, # RC-05-01-01, last updated February 2017, included the following procedures under the title "Continuous Quality Improvement":
-"8. Evaluate program annually. Forward suggestions for policy or process improvement to Quality Department."

The DOC stated during an interview that no falls program evaluations were completed since 2016.

The licensee has failed to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring and the implementation of restorative care approaches, including that when the identified residents and any other residents in the home have fallen, they were assessed and post-fall assessments were conducted using a clinically

appropriate assessment instrument specifically designed for falls.

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, the home was equipped with a resident–staff communication and response system that:
- could be easily seen, accessed and used by residents at all times and is on at all times.

During the course of this inspection a resident identified through a Critical Incident System (CIS) report received by the Ministry of Long-Term Care (MOLTC) was observed by the inspectors.

Review of the identified resident's electronic clinical records documented several interventions regarding the resident's access and use of the communication and response systems.

In an interview with two Personal Support Workers (PSW) they identified the documented communication and response systems interventions as listed in the identified resident's electronic clinical records. However, they were unable to tell inspectors the manufacturers guidelines to set up a specified wireless communication and response system.

The Director of Care (DOC) said in an interview that, it was their understanding that all wireless communication and response systems were to be attached to the call communication systems as the wireless communication and response system's auditory signal would not be loud enough to alert staff.

The identified resident was observed by the inspector and when asked how they would call for assistance, the resident stated they would use the call communication system and when pressed, it should light up in the hallway. The identified resident then pressed their call communication system and the inspectors observed no auditory or visual signals. The Inspector asked the PSW, why the resident’s call bell was not plugged in and they stated they were not sure and that it may have been pulled out of the wall the resident's bed was moved. The PSW was observed reconnecting the call communication system back into the wall outlet, pressing the call communication system, which then activated an auditory and visual signal. When asked, the PSW stated that they expected that the call bell would be plugged in.

Review of the home's "Care Plan Item/Task listing Report", referencing "Standard Intervention: Bed alarm to be activated when resident is in bed, respond to alarm promptly" record was completed for residents who were identified as having a bed alarm.

The clinical records for an identified resident were reviewed and showed interventions related to bed safety.

The identified resident's bed area was observed to have a wireless communication and response system in place that was not attached to the call communication system. Inspectors activated the response system, which sounded at the source, but no visual or auditory signal was observed in the hallway. Later that day the identified resident was observed in their bedroom area and their call communication system was not within reach.

Clinical record review for an identified resident was reviewed and showed no interventions related to the use of the call communication systems.

The inspectors attempted to activate the call communication system for the identified resident and no visual or auditory signal was observed in the hallway. Later that day the inspectors activated the identified resident's call communication system for a second time; no visual or audible signal was observed in the hall.

During an interview with the Registered Nurse (RN) they said they would expect that the call communication system be within reach and available for all residents in the home. The RN said that the alarms should be connected to the call communication system and should signal in the hallway. When asked how registered staff are made aware of call communication systems requiring maintenance, the RN said the PSWs would report any malfunctioning call communication systems to the registered staff first and then the registered staff would notify maintenance.

The Maintenance Staff (MS) said in an interview that they would complete the “Resident Bed Inspection Alarm Audit” each month which included checking the call communication and response systems. The MS stated that when call communication systems were activated, they should be audible and visible in the hallway above the residents' doorway. When asked as part of the audit if they would check to see that the call communication system was audible, the MS said yes. When asked as part of the audit if they would check to see if the call communication system visually indicated where the alarm was coming from, they said no, they did not check the digital displays in the hallways or lights above the residents' doorways when they activated the call bell system.

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that was easily seen, accessed and on at all times for the identified residents and all other residents in the home. [s. 17. (1)]

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 by ensuring that the resident-staff communication and response system is easily seen, accessed and used by residents, staff and visitors at all times, and that it is on at all times, to be implemented voluntarily.

Issued on this 22nd day of January, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SAMANTHA PERRY (740) - (A1)
Inspection No. / No de l'inspection :	2019_797740_0022 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	016172-19, 017523-19, 017524-19, 017554-19, 018417-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 22, 2020(A1)
Licensee / Titulaire de permis :	Craigwiel Gardens 221 Main Street, R. R. #1, AILSA CRAIG, ON, N0M-1A0
LTC Home / Foyer de SLD :	Craigholme 221 Main Street, R.R. #1, AILSA CRAIG, ON, N0M-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Wayne Williams

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Craigwiel Gardens, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

Specifically, the licensee must:

A) Ensure that every alleged, suspected, or witnessed incidents of abuse for the identified residents, or any other residents by anyone that the licensee knows of, or is reported to the licensee, must be immediately investigated. The home must keep a documented record of this investigation.

B) Ensure all management, registered and non-registered staff working in the home, specific to their roles and responsibilities, receive training related to the home's policies and processes of completing an investigation related to Critical Incidents as per O.Reg. 104.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected, or witnessed incident of abuse of a resident by anyone that the licensee knows of was immediately investigated.

Three Critical Incident System (CIS) reports were received by the Ministry of Long-Term Care (MOLTC) related to verbal and physical aggressiveness.

Review of the policy "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences", policy #RC-02-01-03, last updated June 2019, stated the following:
- All reported incidents of abuse and/or neglect will be objectively, thoroughly and promptly investigated.
- The Administrator/Delegate will "a. Promptly initiating an investigation (immediately if there is harm or risk of harm to a resident);" and "h. Ensuring that a copy of the documentation and all other evidence collected is stored within a secure area of the home".
- Manager/Designate during the investigation will "a. Maintain the security and integrity of the physical evidence at the site of incident, fully investigate the incident, and complete the documentation of all known details in keeping with the steps outlined in the Workplace Investigation Toolkit available from People and Culture".

A review of the identified resident's clinical records documented five incidents of physical aggression on specified dates.

In an interview with the ADOC they said they were aware of the documented incidents of abuse related to the identified resident and that they didn't have documented records of an investigation into the identified incidents of abuse.

The licensee failed to ensure that when they became aware of incidents of abuse by the identified resident towards other residents, that these incidents were immediately investigated.

During this inspection, this non-compliance was found to have a severity of minimal risk to the residents. The scope was widespread, and the home had no previous history of non-compliance in this area. (721)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 10, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

Specifically, the licensee must:

A) Ensure that a person who has reasonable grounds to suspect that abuse or neglect involving the identified resident or any other resident that results in harm or a risk of harm shall immediately report the suspicion and the information upon which it is based to the Director.

B) Ensure the home's "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" policies, including procedures and protocols are reviewed and revised to ensure they provide clear home-specific directions for all staff regarding the processes for reporting suspected abuse or neglect of any resident in the home.

C) Ensure the Chief Executive Director (CEO), Director of Care (DOC), Assistant Director of Care (ADOC), Quality Manager, any applicable management staff, are trained on the revised zero tolerance of resident abuse and neglect.

D) Ensure all registered and non-registered staff (RPNs, RNs and PSWs) are trained on the revised zero tolerance of resident abuse and neglect: responses and reporting policies, specific to their roles and responsibilities.

Grounds / Motifs :

1. The licensee has failed to ensure that when a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident had occurred that the information upon which it was based was immediately reported to the Director.

Three Critical Incident System (CIS) reports received by the Ministry of Long-Term Care (MOLTC) related to verbal and physical aggressiveness.

Review of the policy "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", RC-02-01-02, last updated April 2017 documented the following:
- "Staff must complete an internal incident report and notify their supervisor (or during after-hours the Nurse on site). The Nurse would then call the Manager on-call or General Manager/designate immediately upon suspecting or becoming aware of the abuse or neglect of a resident". "Management will promptly and objectively report all

incidents to external regulatory authorities, including the police if there are reasons to believe a criminal code offence has been committed".
- "Note: The policy and procedures herein operate subject to applicable legislation and collective agreements".
- the Administrator/Designate, Director of Care/Designate or Supervisor/Designate will:
4. Follow province-specific reporting requirements. See Jurisdictional Reporting Requirements, Appendix 2.
5. Complete province-specific reporting form: c. Appendix 5 - Ontario LTC Critical Incident Reporting Form.
- All staff will:
A note states in part, Note: In Ontario, anyone who suspects or witnesses abuse that causes or may cause harm to a resident is required to contact the Ministry of Health and Long Term Care (Director) through the Action Line.
2. The person reporting the suspected abuse will follow the home's reporting/provincial reporting requirements to ensure the information is provided to the home Administrator/designate immediately.

Review of the MOLTC Critical Incident reporting system showed that the home did not contact the Service Ontario After-Hours Line or submit corresponding CIS reports related to the documented incidents where the identified resident was physically abusive towards other residents.

There were no documented records indicating the specific times the incidents of abuse, occurred on, with which the identified resident was involved.

Review of the identified resident's clinical records showed the occurrence of two physically and verbally aggressive incidents for which the Assistant Director of Care (ADOC) was notified but did not report the incidents to the Director of the Ministry.

During an interview with the ADOC they stated their understanding of the reporting requirements for allegation of abuse were that they were to be reported to the MOLTC the next day. When asked if they were aware and considered the identified incidents to be abuse, the ADOC stated yes. When asked if the incidents of abuse were reported to the MOLTC and if they should have been reported, the ADOC said they did not believe they were reported and expected that they should have been.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

The licensee failed to ensure that when suspected abuse by the identified resident which resulted in risk of harm to other residents, and the information upon which it was based was immediately reported to the Director.

During this inspection, this non-compliance was found to have a severity of minimal risk to the residents. The scope was patterned, and the home has a previous history of non-compliance in this area including:
-Written Notification (WN) issued January 23, 2017, during inspection 2017_263524_0003
-WN and Voluntary Plan of Corrective (VPC), issued January 11, 2018 during inspection 2018_533115_0005. (721)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 27, 2020(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

Specifically, the licensee must:

A) Ensure the home's "Skin and Wound Program: Wound Care Management" policies, including procedures and protocols are reviewed and revised to ensure they provide clear home-specific directions for all staff regarding the processes for residents who exhibit compromised skin integrity.

B) Ensure the Chief Executive Director (CEO), Director of Care (DOC), Assistant Director of Care (ADOC), Quality Manager, any applicable management staff, are trained on the revised skin and wound management policies.

C) Ensure all registered and non-registered staff (RPNs, RNs and PSWs) are trained on the revised skin and wound management policies, specific to their roles and responsibilities.

D) Ensure that there is a written plan of care for the identified residents and all other residents who have compromised skin integrity, that sets out clear directions to staff (registered and non-registered) and others who provide care to the resident including treatments or interventions and is reflective of the residents' current care needs.

E) Ensure the revised policies and procedures are fully implemented for the identified residents and any other resident in the home who has compromised skin integrity.

F) The home must develop and implement monthly monitoring to ensure that D) and E) of the orders are reviewed for accuracy.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin tears and pressure ulcers, received a skin assessment; immediate treatment to promote healing; was referred to the registered dietitian; and was reassessed at least weekly, if clinically indicated, by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

In accordance with Ontario Regulation 79/10 s. 48 (1) the licensee had failed to ensure that the following interdisciplinary programs were implemented in the home: A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

A) Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MOLTC) ActionLine and documented an incident that caused an injury to an identified resident.

The home's policy "Skin and Wound Program: Wound Care Management" #RC-23-01-02, last updated February 2017 stated the following:
-"Promptly assess all residents exhibiting altered skin integrity on initial discovery. Determine if wound is inherited or acquired, or worsening, and investigate root causes. Use Bates Jensen Wound Assessment Tool, Appendix 2 for pressure ulcers/venous stasis or ulcers of any type; use Impaired Skin Integrity Assessment, Appendix 3 for all other skin impairments (i.e., skin tears, rashes, reddened areas, bruises)".
-"Monitor resident skin condition with each dressing change. Re-assess at minimum weekly. Re-evaluation and documentation of treatment with creams or other medicated preparations should occur at minimum weekly."
-"Complete a referral to Registered Dietitian (RD) for all residents exhibiting altered skin integrity."

The home's "Skin and Wound Program: Prevention of Skin Breakdown" policy #RC-23-01-01, last updated February 2017 stated the following:
-"11. Assess effectiveness of interventions, document alternate approaches considered or applied, and ensure plan of care is up to date."

While observing the identified resident, they stated to the inspector that they were in pain and specified to the inspector where they had pain.

Review of the resident's Assessments showed:
- no documentation of a "Skin - Weekly Wound Assessment" completed when the identified resident's skin integrity alterations were first identified on specified dates and no documentation of dietary referrals corresponding with the identified dates.

The clinical records for the identified resident were reviewed and showed various interventions related to altered skin integrity and pain management; however, no weekly monitoring and wound assessments were documented. The records also showed that, pain observations were documented on 38 out of 90 (42 per cent) shifts, skin observations were documented on 41 out of 90 (45 per cent) shifts, and turning and repositioning was documented on 24 out of 53 (45 per cent) shifts.

Progress notes were reviewed, and a skin note stated that the identified resident had several areas of altered skin integrity. Another skin note documented a new area of altered skin integrity in a different anatomical area.

During an interview with a Personal Support Worker (PSW) they stated they would look at the resident's clinical records to determine the care they required. When asked how they would know if a resident had a wound, the PSW said they would know by doing their skin observations, during shift report, or directly from the registered staff on the shift. The PSW said that the Registered Practical Nurse (RPN) would let the PSWs know what the direction of care would be. The PSW said that they would like to see more information provided regarding the type of wound and the direction to take. The PSW stated they were familiar with the identified resident and the resident's clinical record did not provide clear direction related to certain care areas and was not reflective of the resident's current status. When asked how they would monitor a resident's pain and skin condition the PSW said it would be documented in POC. The PSW said that the resident's pain and skin condition should be documented on each shift and turning and repositioning at least every two hours. The PSW said that documentation was not reflective of the care provided or not provided, as they did not always have time to document.

During an interview with a Registered Practical Nurse (RPN) they stated they would look at the resident's chart and the Care Plan to determine the care a resident required. The RPN said they were familiar with the identified resident and they exhibited pain and had areas of altered skin integrity. The RPN reviewed the resident's care plan and said that the interventions were not reflective of the resident's current status and was not clear. The RPN stated that rashes, reddened areas, and bruises were types of altered skin integrity that would require a clinically appropriate weekly skin and wound assessment completed by registered staff . The RPN said that if a resident was identified as having altered skin integrity, registered

staff would complete the Treatment Administration Record (TAR) and complete the Bates Jensen skin assessment. The RPN confirmed that the resident's areas of altered skin integrity were not assessed on the day they were originally identified. The RPN stated they would expect an assessment to have been completed when the compromised areas of skin integrity were initially identified, and when the new wound was identified.

In an interview with the RPN they stated that altered areas of skin integrity included skin tears, pressure ulcers, bruises and rashes and would require a skin and wound assessment. The RPN said that they would document the assessment and expected that an assessment would be completed by the registered staff working on the shift when the wound was identified. When asked how referrals were completed, the RPN stated they were completed through the electronic clinical records and would involve a dietary referral as well. The clinical records for the identified resident were reviewed and showed that the RPN identified and documented that the identified resident had two areas of altered skin integrity and a new area of altered skin integrity on specified dates. The RPN said that skin and wound assessments were not completed for the altered areas of skin integrity and should have been completed on the same date as identified. When asked if a referral was made to the registered dietitian (RD) and the skin and wound lead when the new areas were identified, the RPN said no, and they should have been.

During an interview, the RD said they would receive referrals for residents who exhibited altered areas of skin integrity through the electronic clinical records. When asked if they had received a referral for the identified resident, the RD reviewed their documentation and said no and expected to have received one. When asked if they had received a referral for a new area of altered skin integrity for the identified resident, they said no.

B) Review of the home's communication binder showed a note documenting there was a new area of altered skin integrity for the identified resident. The note stated, "with each new skin issue a skin-weekly impaired skin integrity assessment needs to be done at the time the issue is found."

The home's "Skin and Wound: Wound Care Management" policy #RC-23-01-02, last updated February 2017 stated the following:
-"Document altered skin integrity as per home's process. In homes with point of care

(POC) tablets, the care staff will document by exception once a shift."
-"Record the treatment regimen on the MAR/eMAR and/or TAR/eTAR."
-"Document resolution of skin integrity issues in the interdisciplinary progress notes and update the resident care plan as needed."

The clinical records of the identified resident were reviewed and documented a new area of altered skin integrity on a specified date; however, no treatments or a referral to the RD were documented and the direction for registered and non-registered staff was unclear.

The Assistant Director of Care (ADOC) stated in an interview that interventions related to skin integrity should be documented in the resident's clinical care records and that more information should be provided so that the registered and non-registered staff providing direct care know the skin issues of the residents. The ADOC said that the direction to staff related to skin integrity was not clear and that they would expect that a skin integrity assessment had been completed for the identified resident.

C) A Personal Support Worker (PSW) informed inspectors that another identified resident had altered areas of skin integrity.

The clinical records for the identified resident were reviewed and documented that the resident had a potential for skin alteration and staff were to assess skin daily with care. Treatments and turning and repositioning were also identified as required interventions for the identified resident. Skin observations were documented on 47 out of 90 (52 per cent) shifts and turning and repositioning was documented on 34 out of 66 (52 per cent) shifts. The records also identified there was no direction for non-registered staff related to areas of altered skin integrity or the resident's treatments or interventions. Several skin notes were documented that identified new areas of altered skin integrity for which an initial skin assessment was completed; however, the initial assessments were not completed consistently and nor were the weekly wound reassessments completed consistently.

The treatment records were reviewed and documented several different types of treatments with various start and discontinue dates.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

During an interview with the ADOC they said they would expect that a skin assessment should have been completed for each newly identified area of compromised skin integrity. The ADOC reviewed the resident's clinical records and said that they would expect that after the initial assessment identified any areas of altered skin integrity, that weekly assessments should have been completed. The ADOC said that if treatment was needed, registered staff should have been documenting those treatments or interventions for altered areas of skin integrity in the resident's clinical records. When asked what the direction to staff was for providing treatment to the identified resident's area of altered skin integrity, the ADOC said it was not clear.

The licensee failed to ensure that the skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions for the identified residents who exhibited altered skin integrity, including skin tears and pressure ulcers, received a skin assessment, immediate treatment to promote healing, a referral to the registered dietitian, and was reassessed at least weekly.

During this inspection, this non-compliance was found to have a severity of minimal risk to the residents. The scope was widespread, and the home had no previous history of non-compliance in this area. (689)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 10, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
   i. a breakdown or failure of the security system,
   ii. a breakdown of major equipment or a system in the home,
   iii. a loss of essential services, or
   iv. flooding.
3. A missing or unaccounted for controlled substance.
4. Subject to subsection (3.1), 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.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Order / Ordre :

Specifically, the licensee must:

A) Ensure that the Director is informed of any incident where the identified residents or any other resident, is missing for less than three hours and was returned to the home with no injury or adverse change in condition, no later than one business day after the occurrence of the incident.

B) Ensure all management, registered and non-registered staff working in the home receive training, specific to their roles and responsibilities, related to the process of reporting Critical Incidents as per O.Reg. 107.

Grounds / Motifs :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident where a resident was missing for less than three hours and returned to the home with no injury or adverse change in condition.

A) During the course of this inspection, it was identified that a resident had eloped from the home on a specified date.

The homes current policy "Critical Incident Reporting (ON)", policy #RC-09-01-06, last updated June 2019, stated in part that the Director of Care (DOC)/Designate will inform the Director no later than one business day after the occurrence of the incident of a resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

There were no Critical Incident System (CIS) reports submitted to the Ministry of Long-Term Care (MOLTC) for the identified resident's incidents of elopement.

A review of an identified resident's progress notes showed the following:
- the identified resident was returned to the home on a specified date by someone and another incident note stated that the identified resident was seen outside.

A review of the identified resident's clinical records documented other incidents of elopement for which the home did not report to the Director of the Ministry of Long-Term Care (MOLTC).

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

During an interview with the Assistant Director of Care (ADOC) they said that they were aware of the identified resident's incidents of elopement, said the incidents of elopement were required to be reported to the MOLTC, stated no, the incidents were not reported and should have been.

B) A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MOLTC) for an identified resident related to an incident of elopement.

A review of the identified resident's clinical records showed that the resident had eloped on a specified date.

In an interview with the ADOC they said they were aware of the documented incident of elopement on a specified date, that the incident was not reported to the Ministry and should have been.

The licensee failed to ensure that the Director was informed no later than one business day after a resident was missing for less than three hours and returned to the home with no injury or adverse change in condition when the identified residents eloped.

During this inspection, this non-compliance was found to have a severity of no risk to the residents. The scope was widespread, and the home has a previous history of non-compliance in this area including:
-Written Notification (WN) issued July 7, 2017 during inspection 2017_660218_0003. (721)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 10, 2020

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

Specifically the licensee must:

A) Ensure the home's Responsive Behaviour policies, including procedures and protocols are reviewed and revised to ensure they provide clear home-specific directions for all staff regarding the processes for residents who exhibit responsive behaviours.

B) Ensure the Chief Executive Director (CEO), Director of Care (DOC), Assistant Director of Care (ADOC), Quality Manager, and any applicable management staff are trained on the revised responsive behaviours policy.

C) Ensure all registered and non-registered staff (RPNs, RNs and PSWs) are trained on the revised responsive behaviours policy, specific to their roles and responsibilities.

D) Ensure the revised policies and procedures are fully implemented for all identified residents and any other residents in the home who exhibit responsive behaviours.

Grounds / Motifs :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including interdisciplinary assessments or on information provided to the licensee, that could potentially trigger such altercations; and the identification of and implementation of interventions.

The Ministry of Long-Term Care (MOLTC) received three Critical Incident System (CIS) reports related to an identified resident's responsive behaviours.

A review of the "Responsive Behaviours" policy RC-17-01-04, last updated February 2017 stated, in part: "Policy: Each resident will be assessed and observed for indicators of responsive behaviours on admission, quarterly, and as needed. All new or escalated instances of responsive behaviours will be reported, recorded and investigated on an ongoing basis. The home will implement and evaluate strategies and interventions to prevent, minimize and address responsive behaviours" and "Procedures: the interdisciplinary team will: 1-Observe and assess each resident using the provincially mandated and/or recommended assessment. The results of these assessments will be evaluated to plan appropriate interventions and update the care plan".

A review of an identified resident's Assessments showed that the resident was being monitored; however, no clinically appropriate assessments were completed to guide staff in determining the appropriate responsive behaviours interventions to be implemented.

A review of an identified resident's care plan showed various interventions related to the identified resident's responsive behaviours.

A review of an identified resident's progress notes documented a history of exhibited responsive behaviours for which the Director of Care (DOC) and physician were aware.

During an interview with a Personal Support Worker (PSW) they stated that they were familiar with the identified resident and that they exhibited responsive behviours. The PSW said that interventions were in place to manage the identified resident's responsive behaviours and that the resident's care requirements would be indicated in a communication book.

The "Resident Observation Records" and "Dementia Observation System" records for the identified resident were reviewed and showed the following:
-Incomplete documentation of behaviour monitoring on 10 out of 18 (55 per cent) days.

The "Documentation Survey Report V2" for the identified resident was reviewed and showed the following:
-Monitoring was documented on 1106 out of 2496 (44 per cent) of the time for the indicated task.

In an interview with a Registered Practical Nurse (RPN) they said that the registered staff in charge on each unit would be responsible for assessing and documenting a residents' responsive behaviours through a "behaviour follow-up" assessment document. When asked if the identified resident exhibited responsive behaviours, the RPN said yes, the resident did exhibit responsive behaviours. When asked what interventions were in place to manage the resident's responsive behaviours, the RPN stated they had specific monitoring in place. When asked if any behavioural assessments had been completed for the identified resident, the RPN stated they were not sure, but that they documented the resident's behaviours daily. When asked if there had been evaluations to determine whether the interventions in place to manage the identified resident's responsive behaviours were effective, the RPN stated they were not sure.

During an interview, a Behavioural Supports Ontario Personal Support Worker (BSO PSW) stated that they were familiar with the identified resident and that the resident had a history of responsive behaviours. The BSO PSW said that they were aware of altercations between the identified resident and co-residents of the home and that interventions were documented in the resident's plan of care. The BSO PSW stated that the resident's health status and their responsive behaviours had changed and that the resident's assessments and reassessments were based on staff communication and progress notes. When asked if any behavioural assessments had been completed for the identified resident, the PSW stated that the physician asked them to complete a Montreal Cognitive Assessment (MOCA) with the resident but the resident refused. When asked how it was determined what interventions were implemented to manage residents' responsive behaviours, the PSW stated that it was based on trial and error and that the effectiveness of the interventions

implemented by staff were not evaluated consistently.

The Assistant Director of Care (ADOC) reviewed the clinical records for the identified resident, which documented multiple resident to resident altercations. When asked what actions the home took following the altercations, they stated that monitoring and additional interventions were implemented, as well, the homes BSO team spent a lot of time with the resident to determine interventions. When asked if the interventions were evaluated and assessed to determine effectiveness, the ADOC stated they would think so, but that the home's BSO team would be responsible for assessing and determining which interventions should be implemented related to responsive behaviours. The ADOC said that they were unsure of the assessment process or how the home was evaluating the effectiveness of behavioural interventions. The ADOC said that no behavioural assessments had been completed for the identified resident and expected that they would have been.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between the identified resident and other residents. Staff and management in the home were aware of the potential risks, through staff observation and communication, but identifying factors and interventions were not based on assessments or reassessments of the resident.

During this inspection, this non-compliance was found to have a severity of minimal risk to the residents. The scope was isolated, and the home has a previous history of non-compliance in this area including
- Voluntary plan of correction (VPC) issued July 07, 2017 during inspection 2017_660218_0003.
(740)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 10, 2020

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. Falls prevention and management

Order / Ordre :

Specifically, the licensee must:

A) Ensure the home's "Falls Prevention and Management Program" policy, # RC-05-01-01, including procedures and protocols are reviewed and revised to ensure they provide clear home-specific directions for all staff regarding the processes for residents who fall in the home.

B) Ensure that the management of the home provides support and coaching to the falls prevention team lead related to their roles and responsibilities.

C) Ensure the Chief Executive Director (CEO), Director of Care (DOC), Assistant Director of Care (ADOC), Quality Manager, any applicable management staff, are trained on the revised fall prevention policy. The home must keep a documented record of the training provided.

D) Ensure all registered, non-registered staff (RPNs, RNs and PSWs), and Physiotherapists are trained on the revised fall prevention policy, specific to their roles and responsibilities.

E) Ensure the revised policy and procedures are fully implemented for those residents identified and any other resident in the home who has a fall.

G) Ensure the Falls Prevention and Management Program is evaluated monthly, until complied with, and the home must maintain a written record of the evaluations.

Grounds / Motifs :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

1. The licensee has failed to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring of residents, and the implementation of restorative care approaches, including that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

In accordance with Ontario Regulation 79/10 s. 48 (1) the licensee has failed to ensure that the following interdisciplinary programs were implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury.

In accordance with Ontario Regulation 79/10 s. 30 (1) 1. The licensee was required to ensure that staff in the home complied with the falls prevention and management program policies, procedures and protocols that were in place to reduce risk; 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and 4. The licensee should have kept a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Specifically, the home did not implement the "Falls Prevention and Management Program" which included the "Falls Prevention and Management Program" policy and procedures, #RC-15-01-01, last updated February 2017.

A. 1) The Ministry of Long-Term Care (MOLTC) received a critical incident system (CIS) report, regarding a fall causing an injury..

The home's "Falls Prevention and Management Program" policy, # RC-05-01-01, last updated February 2017, included the following procedures under the title "Prevention of Falls":
- "5. Screen all resident's on admission, annually, with a change in condition that could potentially increase the resident's risk of falls/fall injury, or after a serious fall injury or multiple falls (if not already at high risk). See Scott Fall Risk Screen for Residential Long-Term Care, Appendix 4."

- "7. Flag residents at high risk of fall injury (e.g., new admissions, Scott Fall Risk Score >7, Fracture Risk >1) for additional monitoring, precautionary measures, and protective equipment (e.g., hip protectors, wrist guards, etc.) on admission and re-assessment. Clearly communicate responsibilities of all parties in prevention of falls and injury. See Falling Star/Leaf Flagging Guide, Appendix 7."

The home's "Falling Star/Leaf Flagging Guide – Appendix 7", last updated February 2017 stated the following:
-"Residents in the program will be identified in one or more of the following ways:
• Wrist band or visible clothing item designated by the home;
• Icon on bedroom door and near bed; and/or
• Flag on chart"

Review of the Falls Committee meeting minutes identified the following documentation:
-"Scott's Fall-to be documented on admission and after every fall".
-"After fall process discussed: post falls assessment, Scott's fall documentation, staff huddle, HIR [head injury routine] documentation is now available on-line, for now double chart on paper as well".
-"possibly create a tick sheet reminder of what is necessary to chart with every fall".

Assessments were reviewed and showed that the identified resident was at a high risk of falls.

There was no post-fall assessments or post-fall huddles documented for the identified.

The Care Plan for the identified resident documented various interventions related to the resident's high risk for falls status.

The identified resident was observed lying in their bed, call bell within reach. Resident's interventions were identified above the resident's bed. There was no falling star or leaf identifier present in the resident's bedroom area.

The Physiotherapist (PT) stated that they were familiar with the identified resident and were aware of the resident's fall. The PT stated that they assessed the resident upon return from hospital and that they were a high risk for falls. The PT said that

falls risk was based on the Scott Falls Risk Assessment completed by the registered staff as well as their own resident assessment.

The Registered Nurse (RN) said that they were familiar with the identified resident and were aware of the resident's fall. The RN said that the resident has had a history of falls and stated that the resident was determined to be moderate to high risk for falls. The RN said that the resident's status changed after the fall and was now in a wheelchair, used a mechanical sit to stand lift for transfers, and was involved with physiotherapy. The RN said that they would complete a Scott Fall Risk Assessment to determine whether a resident was at a high risk for falls. When asked who completed post-fall assessments, the RN said that it should be completed immediately after a fall by the registered staff. The RN said that falls interventions would be identified for staff in the care plan or on signage above the bed. When asked if the home implemented the falling star or leaf logo for high fall risk residents, the RN said no. The RN stated that the home did not have an official falls prevention program and was unaware of the process for determining if a resident was part of the program.

2) The clinical records for an identified resident showed the resident had a previous fall and was identified as a high risk for falls.

An identified resident was observed in their bedroom sitting in their wheelchair, all falls interventions as identified by the signage at the head of the bed were in place. There was no falling star or leaf identifier present in the resident's bedroom area.

There was no post-fall assessments or post-fall huddles documented for the identified resident.

The written plan of care for the identified resident included various interventions related to the prevention of the resident's risk for falls.

3) The clinical records for an identified resident showed the resident had a documented fall.

A "Falls Management - Post-Fall Assessment" was initiated for the identified resident but was not completed and there was no post-fall huddle documentation included as part of the assessment.

The care plan for the identified resident documented that the resident was a high risk for falls and listed various interventions related to the prevention of the resident's risk for falls.

The resident was observed sleeping in bed with call bell within reach and the signage at the head of bed was current to the interventions observed in resident's room. However, there was no falling star or leaf identifier present in the resident's bedroom area.

During an interview the RN stated that they were newly appointed as the falls lead and were recently provided with the fall's prevention binder. The RN said that they were unsure of the falls lead responsibilities and that there was no falls prevention program in the home that set out clear direction to staff when a resident had fallen.

In an interview the Director of Care (DOC) stated that post-fall assessments were to be completed post fall and that the home was not completing assessments and post-fall huddles consistently. The DOC said that it was not clear to staff what assessments were to be completed post fall. The DOC said that the falls management policy appendices were not fully implemented by staff and that the home was not doing the falling star/leaf flagging guide like the policy stated and that the home was not implementing all parts of the falls management policy.

B. The Ministry of Long-Term Care (MOLTC) received a Critical Incident System (CIS) report, which documented a fall, causing an injury.

The home's most current "Falls Prevention and Management" policy, #RC-15-01-01, last updated February 2017, included the following procedures under the title "Post-Fall Management":
2. Hold a Post-Fall Huddle, ideally within the hour and complete a post-fall assessment as soon as possible. See Post-Fall Assessment Tool, Appendix 11 and Post-Fall Team Huddle Process, Appendix 12.
The home's "Post Fall Team Huddle Process– Appendix 12", last updated February 2017 stated the following:
- "5. Complete Post Fall Assessment, which includes an area to summarize the Post Fall Team Huddle."

Assessments were reviewed for the identified resident that the resident was at a high risk for falls.

The Care Plan for the identified resident showed that the was identified as being a high risk for falls and documented several interventions related to the prevention of the resident's falls risk.

The clinical records for an identified resident showed the following:
-A "Fall Management" describing the identified resident's fall and location and the resident's status.
-There was no post-fall assessment or post-fall huddle documented for the identified resident.

A Registered Nurse (RN) during an interview stated that when a resident has a fall, they would assess the resident and make sure they were comfortable and safe. The RN said that they would take the resident's vital signs, complete a head to toe assessment, assess surroundings, range of motion, whether the fall was witnessed or unwitnessed and determined if a head injury routine (HIR) needed to be started. The RN said that they would establish the resident's level of consciousness and if they had any injuries. When asked if the information documented for the identified resident was sufficient information to satisfy that a post-fall assessment was completed, the RN said no.

During an interview the Assistant Director of Care (ADOC) stated that staff were to complete post-fall assessments as per the home's Fall Prevention and Management policy. The ADOC said that a post-fall assessment should have been completed for the identified resident and any other resident who has fallen.

C) The home's "Quality Program Evaluation – Falls", with Annual Schedule: August, was reviewed. The evaluation was blank, and did not document the following:
-people who participated in the evaluation
-trends observed
-actions required by Falls Committee based on the analysis
-dates of the Quarterly Falls Control meetings held in the home
-objectives
-if policy changes were required
-signatures of those involved, or

-the summary of falls reported

The home's "Falls Prevention and Management Program" policy, # RC-05-01-01, last updated February 2017, included the following procedures under the title "Continuous Quality Improvement":
-"8. Evaluate program annually. Forward suggestions for policy or process improvement to Quality Department."

The DOC stated during an interview that no falls program evaluations were completed since 2016.

The licensee has failed to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring and the implementation of restorative care approaches, including that when the identified residents and any other residents in the home have fallen, they were assessed and post-fall assessments were conducted using a clinically appropriate assessment instrument specifically designed for falls.

During this inspection, this non-compliance was found to have a severity of minimal risk to the residents. The scope was widespread, and the home has no previous history of non-compliance in this area.
(740)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 10, 2020

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of January, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by SAMANTHA PERRY (740) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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