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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 8, 2019	2019_414110_0003	001552-19	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Guildwood
60 Guildwood Parkway SCARBOROUGH ON M1E 1N9

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

DIANE BROWN (110)

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): February 4, 5, 8, 11, 2019.

During the course of this inspection the inspector completed a record review of resident health records, relevant home policies and other inspection observations.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Physiotherapist, Registered Nurses, Personal Support Workers and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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

- **5 WN(s)**
- **2 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

Two Critical Incident (CI) Reports were submitted to the Ministry of Health and Long Term Care (MOHLTC) on identified dates indicating an unexpected incident, fall and injury, related to resident #001.

On an identified date, the MOHLTC received an anonymous complaint related to the home not following proper procedures related to the unexpected incident, fall and injury of resident #001.

A record review of resident #001's medical records documented the resident had a fall in the home and a decline in health.

A review of the Risk Management Report of the unexpected incident, fall of resident #001 documented how PSW #111 described resident #001 at the time of the fall and the events leading up to the CI. An interview with PSW #111 revealed knowledge of how resident #001 required the use of a mobility device for safe ambulation and described the events leading up to the resident's fall.

A review of the resident's written plan of care identified resident #001's need for an identified mobility device to ambulate safely.

An interview with Physiotherapist (PT) #104 shared that resident #001 was at high risk for falls without the use of their mobility device.

An interview with PSW #112, resident #001's caregiver during the identified shift of the reported CIs, shared the events leading up to the CI which included observing the resident's mobility device in an identified location without the resident.

The inspection revealed additional findings whereby on the identified date and time leading up to the CI, resident #001 was observed ambulating without their mobility device and that a staff had knowledge that resident #001 was ambulating without their device. An interview with DOC #105 identified the staff as PSW #106 and identified other staff PSW #108 and RPN #114 who were also present at the same identified date and time.

During an interview with PSW #106 the Inspector shared additional findings of the identified shift leading to the CI involving resident #001. PSW #106 was unable to recall the events of that shift leading up to the resident's fall and the CI.

In an interview with the investigative Coroner the cause of resident #001's unexpected incident was related to a fall and identified risk factors.

An interview with DOC #113 confirmed that resident #001's care set out in the plan of care was not provided to the resident as specified in the plan as resident #001 was not provided their mobility device as set out in their plan of care. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect
Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

For the purposes of the Act and Regulations, O.Reg. 79/10, s. 5 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Two Critical Incident (CI) Reports were submitted to the Ministry of Health and Long Term Care (MOHLTC) on identified dates indicating an unexpected incident, fall and injury, related to resident #001.

On an identified date, the MOHLTC received an anonymous complaint related to the home not following proper procedures related to the unexpected incident, fall and injury of resident #001.

A review of the Risk Management Report of the unexpected incident, fall of resident #001, documented how PSW #111 described resident #001 at the time of the fall incident and the events leading up to the CI. The report identified the resident's pain level at a maximum level.

An interview with PSW #111 revealed knowledge of how resident #001 required the use of a mobility device to ambulate safely and described the events leading up the CIs and the resident's fall.

A review of the resident's written plan of care identified resident #001's need for an identified mobility device.

A record review of a progress note documented an assessment at an identified date, time and time period following the resident's fall that reported the resident had an identified decline in health.

A record review of resident #001's medical records documented the resident had a fall in the home and a decline in health.

The inspection revealed additional findings whereby on the identified date and time leading up to the CI resident #001 was observed ambulating without their mobility device and that a staff had knowledge of resident #001 ambulating without their device. An interview with DOC #105 identified the staff as PSW #106 and identified other staff PSW #108 and RPN #114 who were also present.

In separate interviews with PSW #106 and #108 the Inspector shared additional findings of resident #001 on the identified shift leading to the CI. PSW #106 and #108 were both unable to recall the events of that shift leading up to the resident's fall and the CI.

The licensee failed to take action when resident #001 was observed ambulating without their mobility device as specified in the resident's plan of care.

Post resident fall.

2. The home's policy entitled "Falls Prevention and Management Program"; policy number RC-15-01-01; Last updated: February 2017, directed staff in the management of a post fall to treat any injuries and manage pain.

A review of the Risk Management Report of the unexpected incident and fall of resident #001 documented how PSW #111 discovered and described resident #001 at the time of the fall incident and the events leading up to the CI. During an interview with PSW #111, they revealed knowledge that resident #001 required the use of a mobility device to ambulate safely and described the events leading up the CIs and the resident at the time of the fall. The report documented, approximately one hour after the resident’s fall, the resident’s pain at the maximum pain level. RN #109 documented the Risk Management Report.

An interview with RN #109 confirmed the documentation and revealed that the resident's facial and verbal gestures led them to their assessment that the resident had a maximum pain level. The RN further shared that the physician was not notified of the resident’s change in status and pain.

An interview with PSW #112 who provided care to the resident following their fall revealed that the identified sounds the resident was making when they tried to change the resident’s clothes led them to believe the resident was in pain.

A record review of four “Clinical Monitoring Record V-3 Q 1 hr Neuro Check” forms following the initial resident RN assessment were completed by RPN #110. The documentation failed to reassess the resident's pain level as prompted by and required by the clinical monitoring record. An interview with RPN #110 confirmed that they did not complete the pain level assessments but had documented observations related to the resident's pain.

A review of the four Clinical Monitoring Record’s identified documentation of resident complaints of pain in identified areas.

An interview with RPN #110 revealed that the resident stated they were in pain and that an identified area of the their body was painful. When the Inspector asked how the resident’s pain was managed RPN #110 stated they focused on another visually injured area of the resident’s by applying a treatment and confirmed that no medication was given for pain and stated they were still waiting to see if the resident was going to the hospital.

A record review of resident's historical pain levels in point click care and interviews with PSW #001 and #002 confirmed that resident #001 did not usually complain of pain prior

to this fall and both staff shared that the resident never really complained.

An interview with DOC #113 confirmed that the resident's pain level should have been assessed every hour as part of the clinical monitoring record and that the physician should have been informed of the resident's pain level.

The licensee failed to contact the physician to report the resident's fall, injury and pain level and therefore failed to take action to manage the resident's pain.

3. The home's policy entitled "Falls Prevention and Management Program"; policy number RC-15-01-01; Last updated: February 2017, directed staff in the management of a post fall to complete an initial physical and neurological assessment and If a resident hits their head or is suspected of hitting their head (e.g. unwitnessed fall) to complete the Clinical Monitoring Record.

A record review identified that the post fall injury routine, documented in the "Clinical Monitoring Record V-3 Q 1 hr Neuro Check" for the identified dates and times were all incomplete and that the neurological assessments, were blank. An interview with RPN #110 who was responsible for completing the Clinical Monitoring Records stated that they were unsure of how to complete the assessments and revealed that they did not have a proper instrument. The RPN #110 revealed that they had not shared their lack of knowledge with the RN in charge.

A record review of the Medication Administration Record (MARS) for the identified date of the CI revealed a regularly scheduled medication, identified as medication type A.

An interview with PSW #112 who provided care to the resident following their fall revealed that the described sounds the resident was making when they tried to change the resident's clothes led them to believe the resident was in pain. The PSW shared that they asked the resident where the pain was and the resident did not respond and just made sounds suggestive of being in pain.

A record review of a progress note documented an assessment at an identified date, time and time period following the resident's fall that reported the resident had an identified decline in health.

A record review of resident #001’s medical records documented the resident had a fall in the home and a decline in health.

In an interview with the investigative Coroner the cause of resident #001's unexpected incident was related to a fall and identified risk factors.

An interview with DOC #113 confirmed the identified blank assessments were part of the clinical monitoring tool and neurological assessment of a resident. The DOC stated it was an expectation that these assessments be completed every hour for the first 4 hours than every 8 hours for 72 hours. The DOC confirmed the clinical monitoring tool was not completed as required.

The licensee failed to take action by not completing a neurological assessment of the resident, following an unwitnessed fall and resulting in an identified injury .

An interview DOC #113 confirmed a pattern of inaction towards resident #001. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee has failed to comply with its Falls Prevention and Management Program

RC-15-01-01. According to Ontario Regulation (O. Reg.) 79/10, s. 8 (1) b, Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

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

O. Reg. 79/10, s 30 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Inspector #110 reviewed the home's policy entitled "Falls Prevention and Management Program" ; policy number RC-15-01-01; Last updated: February 2017, which indicated the following:
Post Fall Management
1. Implement Post-fall Clinical Pathway
a. Complete an initial physical and neurological assessment;
b. Determine if the resident can be safely monitored and treated within the home or if transfer to acute care is required;
c. Treat any injuries and manage pain;
d. If a resident hits head or is suspected of hitting head (e.g. unwitnessed fall) complete Clinical Monitoring Record, Appendix 10
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
3. Notify the POA/SDM/family, physician/NP and management as required.

Two Critical Incident (CI) Reports were submitted to the Ministry of Health and Long Term Care (MOHLTC) on identified dates indicating an unexpected incident, fall and injury, related to resident #001.

On an identified date, the MOHLTC received an anonymous complaint related to the home not following proper procedures related to the unexpected incident, fall and injury of resident #001.

A review of the Risk Management Report of the unexpected incident, fall of resident #001, documented how PSW #111 described resident #001 at the time of the fall incident and the events leading up to the CI. An interview with PSW #111 revealed knowledge of how resident #001 required the use of a mobility device to ambulate safely and then described the events leading up the CIs and the resident's fall.

A record review of resident #001’s medical records documented unexpected incident was related to a fall in the home.

A record review of a progress note documented an assessment at an identified date, time and time period following the resident’s fall that reported an identified decline in health.

An interview with RN #103 and DOC #105 confirmed that the clinical monitoring record is the neurological assessment of the resident and part of the home’s post fall policy when the resident hits their head or is suspected of hitting their head like in the case of an unwitnessed fall.

A record review identified that the post fall injury routine, documented in the “Clinical Monitoring Record V-3 Q 1 hr Neuro Check” for the identified dates and times were all incomplete and that the neurological assessments, were blank. An interview with RPN #110 who was responsible for completing the Clinical Monitoring Records stated that they were unsure of how to complete the assessment and revealed that they did not have a proper instrument. The RPN #110 revealed that they had not shared their lack of knowledge with the RN in charge.

A further record review revealed that the physician/NP was not notified of resident #001’s fall. An interview with RN #109 confirmed that the physician/NP had not been contacted.

A record review revealed the absence of the Post-Fall Assessment and Post-Fall Huddle. An interview with RN #109 confirmed a Post-Fall Assessment and Post-Fall Huddle had not been completed.

A review of the Risk Management Report of the unexpected incident and fall of resident #001 documented, approximately one hour after the resident's fall , the resident's pain at the maximum pain level. RN #109 documented the Risk Management Report.

An interview with RN #109 confirmed the documentation and revealed that the resident's facial and verbal gestures led them to their assessment that the resident had a maximum pain level. The RN further shared that the physician was not notified of the resident's change in status and pain level.

An interview with PSW #112 who provided care to the resident following their fall revealed that the identified sounds the resident was making when they tried to change the resident's clothes led them to believe the resident was in pain.

An interview with RPN #110 revealed that the resident stated they were in pain and that an identified area of the their body was sore. When the Inspector asked how the resident's pain was managed RPN #110 stated they focused on another visually injured area of the resident's by applying ice and confirmed that no medication was given for pain and stated they were still waiting to see if the resident was going to the hospital.

In an interview with the investigative Coroner the cause of resident #001's unexpected incident was related to a fall and identified risk factors.

The licensee failed to ensure the home's policy Falls Prevention and Management Program RC-15-01-01 by way of failing to complete a neurological assessment by completing the Clinical Monitoring Record, completing a Post-Fall Assessment including the Post-Fall Team Huddle, notifying the physician/NP and managing pain following resident #001's fall in the identified date of the CI. [s. 8. (1) (a),s. 8. (1) (b)]

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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. r. 107. (4)The licensee failed to inform the Director of an incident under subsection (1),

(3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. 2. A description of the individuals involved in the incident, including, i. names of any residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or are responding to the incident. 3. Actions taken in response to the incident, including, i. what care was given or action taken as a result of the incident, and by whom, ii. whether a physician or registered nurse in the extended class was contacted, iii. what other authorities were contacted about the incident, if any, iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and v. the outcome or current status of the individual or individuals who were involved in the incident. 4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence. 5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

Two Critical Incident (CI) Reports were submitted to the Ministry of Health and Long Term Care (MOHLTC) on identified dates indicating an unexpected incident, fall and injury, related to resident #001.

On an identified date, the MOHLTC received an anonymous complaint related to the home not following proper procedures related to the unexpected incident, fall and injury of resident #001.

Upon completion of an on-site inspection of the critical incident and a review of both CI reports submitted to the MOHLTC the following inaccuracies and omissions were reported:

1. One of the identified Critical Incident Reports stated that a named physician was informed around at an identified time when the resident had fallen and that no specific instructions were given.

A record review of resident #001's progress notes and the Risk Management Report

along with an interview with RN#109, who worked the identified shift, confirmed that a doctor including the named physician had not been informed of the resident's fall and therefore no specific instructions were given.

The licensee inaccurately reported that the physician was notified post resident fall and that no specific instructions were given.

2. One of the identified Critical Incident Reports reported that neurological monitoring started for resident #001 for the first identified hours and that the resident was stable and no concerns were noted by nurses.

A record review identified that the post fall injury routine, documented in the "Clinical Monitoring Record V-3 Q 1 hr Neuro Check" for the identified dates and times were all incomplete and that the neurological assessments, were blank. An interview with RPN #110 who was responsible for completing the Clinical Monitoring Records stated that they were unsure of how to complete the assessment and revealed that they did not have a proper instrument. The RPN #110 revealed that they had not shared their lack of knowledge with the RN in charge.

A review of the clinical monitoring record identified the resident's pain level was documented at a maximum level. RN #109 who assessed the resident's pain confirmed the pain documentation and that the resident was experiencing pain.

An interview with PSW #112 who provided care to the resident following their fall revealed that the identified sounds the resident was making when they tried to change the resident's clothes led them to believe the resident was in pain.

The licensee failed to include that the hourly head injury routine including the clinical monitoring records and pain level had not been completed and indicated only that head injury monitoring was started for the first identified hours and that resident was stable and no concerns were noted by nurses.

3. One of the identified Critical Incident Reports revealed the resident's ambulated with a mobility device, identified as device B.

A review of the resident's written plan of care identified resident #001's need for an identified mobility device, identified as device A (not B as documented in the CI) for safety.

In separate interviews PSWs #101, #102 and PT #104 revealed the resident used mobility device A.

A review of the Risk Management Report of the unexpected incident, fall of resident #001, documented that prior to locating the resident, the resident's mobility device, device A was observed in an identified location and not with the resident, revealing that the resident had ambulated without their device.

The licensee omitted the information leading up to the critical incident that the resident's mobility device, device A, had been identified without the resident revealing that the resident had ambulated without their device.

4. One of the identified Critical Incident Reports revealed that the RN initially assessed the resident with no complaints of discomfort.

A review of the Risk Management Report of the unexpected incident and fall of resident #001 documented how PSW #111 discovered and described resident #001 at the time of the fall incident and the events leading up to the CI. The report documented, approximately one hour after the resident's fall, the resident's pain was documented at the maximum pain level. RN #109 documented the Risk Management Report.

An interview with RN #109 confirmed the documentation and revealed that the resident's facial and verbal gestures led them to their assessment that the resident had a maximum pain level. The RN further shared that the physician was not notified of the resident's change in status and pain.

An interview with RPN #110 revealed that the resident stated they were in pain and that an identified area of the their body was painful.

An interview with PSW #112 who provided care to the resident following their fall revealed that the identified sounds the resident was making when they tried to change the resident's clothes led them to believe the resident was in pain.

The licensee failed to accurately report resident's discomfort and pain.

5. One of the identified Critical Incident Reports revealed the Coroner's findings were 'cause of death was natural causes'. In an interview with the investigative Coroner the

cause of resident #001's unexpected incident was related to a fall and identified risk factors.

The licensee failed to accurately report the Coroner's findings.

During an interview with DOC #113 the Inspector compared the inspection finding with the CI's submitted to the MOHLTC. The DOC acknowledged the inconsistencies and omissions as pointed out by the Inspector. [s. 107. (4)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. 2. A description of the individuals involved in the incident, including, i. names of any residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or are responding to the incident. 3. Actions taken in response to the incident, including, i. what care was given or action taken as a result of the incident, and by whom, ii. whether a physician or registered nurse in the extended class was contacted, iii. what other authorities were contacted about the incident, if any, iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and v. the outcome or current status of the individual or individuals who were involved in the incident. 4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence. 5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Two Critical Incident (CI) Reports were submitted to the Ministry of Health and Long Term Care (MOHLTC) on identified dates indicating an unexpected incident, fall and injury, related to resident #001.

On an identified date, the MOHLTC received an anonymous complaint related to the home not following proper procedures related to the unexpected incident, fall and injury of resident #001.

A record review of resident #001's medical records documented the resident had a fall and decline in health.

A review of the Risk Management Report of the unexpected incident, fall of resident #001, documented how PSW #111 described resident #001 at the time of the fall incident and the events leading up to the CI. An interview with PSW #111 revealed knowledge of how resident #001 required the use of a mobility device for safety and described the events leading up the CIs and the resident's fall. RN #109 documented the Risk Management Report.

A further review of the resident's health record failed to reveal a post-fall assessment using a clinically appropriate assessment instrument following the residents fall. An interview with RN #109 confirmed that it had not been completed as was required.

A review of the home's policy entitled "Falls Prevention and Management Program", policy number RC-15-01-01; Last updated: February 2017, directed registered staff to implement the Post-fall Clinical Pathway which included the Post Fall assessment and Post-Fall Huddle.

An interview with DOC #105 revealed that a Post Fall Assessment, located in PCC, was required to be completed following every resident fall and was part of the Risk Management protocol. The DOC confirmed that RN #109 had forgotten to complete the assessment at the time of resident #001's fall. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident has fallen, the resident been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 21st day of March, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANE BROWN (110)
Inspection No. / No de l'inspection :	2019_414110_0003
Log No. / No de registre :	001552-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 8, 2019
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Guildwood 60 Guildwood Parkway, SCARBOROUGH, ON, M1E-1N9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susanne Babic

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with the LTCHA, 2007, s. 6. (7).

The licensee is ordered to:
1. Educate all direct care staff, including registered staff on the risks associated with residents using identified items as ambulatory aids and not implementing the plan of care while sharing the MOHLTC inspection report leading up to the critical incident involving resident #001's fall.
2. At every shift report, for a minimum of a one year period, registered staff shall remind PSWs of the requirement to ensure resident's who ambulate with mobility aids are provided with the mobility aids in keeping with the resident's written plan of care.
3. A record shall be keep of steps #1 and #2.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

Two Critical Incident (CI) Reports were submitted to the Ministry of Health and Long Term Care (MOHLTC) on identified dates indicating an unexpected incident, fall and injury, related to resident #001.

On an identified date, the MOHLTC received an anonymous complaint related to the home not following proper procedures related to the unexpected incident, fall and injury of resident #001.

A record review of resident #001’s medical records documented the resident had a fall in the home and a decline in health.

A review of the Risk Management Report of the unexpected incident, fall of resident #001 documented how PSW #111 described resident #001 at the time of the fall and the events leading up to the CI. An interview with PSW #111 revealed knowledge of how resident #001 required the use of a mobility device for safe ambulation and described the events leading up to the resident's fall.

A review of the resident's written plan of care identified resident #001's need for an identified mobility device to ambulate safely.

An interview with Physiotherapist (PT) #104 shared that resident #001 was at high risk for falls without the use of their mobility device.

An interview with PSW #112, resident #001's caregiver during the identified shift of the reported CIs, shared the events leading up to the CI which included observing the resident's mobility device in an identified location without the resident.

The inspection revealed additional findings whereby on the identified date and time leading up to the CI, resident #001 was observed ambulating without their mobility device and that a staff had knowledge that resident #001 was ambulating without their device. An interview with DOC #105 identified the staff as PSW #106 and identified other staff PSW #108 and RPN #114 who were also present at the same identified date and time.

During an interview with PSW #106 the Inspector shared additional findings of the identified shift leading to the CI involving resident #001. PSW #106 was unable to recall the events of that shift leading up to the resident's fall and the CI.

In an interview with the investigative Coroner the cause of resident #001's unexpected incident was related to a fall and identified risk factors.

An interview with DOC #113 confirmed that resident #001's care set out in the plan of care was not provided to the resident as specified in the plan as resident #001 was not provided their mobility device as set out in their plan of care. [s. 6. (7)]

The severity of this issue was determined to be a level 3 as there was actual harm to resident #001 as the resident used a chair as a mobility aid and not a walker as specified by the plan of care. As a result the resident sustained a fall and died of a traumatic neck injury related to a fall while being on anti coagulants. The scope of the issue was a level 1 isolated.
The home had a level 4 compliance history as there was ongoing non-compliance with VPC or CO within the last 3 years that included:
-Compliance Order (CO) issued September 7, 2018 related to s. 6(1)(a) in report #2018_594624_0009.
-Written notification (WN) issued September 7, 2018 related to s. 6.(1)(a), s. 6.(1)(c), and 6.(10)(b) in report #2018_594624_0009.
-Voluntary Plan of Correction (VPC) issued September 26, 2017 related to s. 6.(1)(a) and s. 6.(7) in report #2017_644507_0010.
-WN issued September 26, 2017 related to s. 6.(1)(a) and s. 6.(7) in report #2017_644507_0010 in report #2017_644507_0010.

(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2019

Order # / Ordre no : 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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with the LTCHA, 2007, s. 19 (1).

The licensee is ordered to:
1. Educate all staff on the O.Reg. 79/10, s.5 definition of "neglect" the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. The education shall include the critical incident of resident #001 and acknowledge the pattern of inaction.
2. Maintain a record of education for review by the Inspector.

Grounds / Motifs :

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

For the purposes of the Act and Regulations, O.Reg. 79/10, s. 5 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Two Critical Incident (CI) Reports were submitted to the Ministry of Health and Long Term Care (MOHLTC) on identified dates indicating an unexpected incident, fall and injury, related to resident #001.

On an identified date, the MOHLTC received an anonymous complaint related to the home not following proper procedures related to the unexpected incident,

fall and injury of resident #001.

A review of the Risk Management Report of the unexpected incident, fall of resident #001, documented how PSW #111 described resident #001 at the time of the fall incident and the events leading up to the CI. The report identified the resident’s pain level at a maximum level.

An interview with PSW #111 revealed knowledge of how resident #001 required the use of a mobility device to ambulate safely and described the events leading up the CIs and the resident's fall.

A review of the resident's written plan of care identified resident #001's need for an identified mobility device.

A record review of a progress note documented an assessment at an identified date, time and time period following the resident’s fall that reported the resident had an identified decline in health.

A record review of resident #001’s medical records documented the resident had a fall in the home and a decline in health.

The inspection revealed additional findings whereby on the identified date and time leading up to the CI resident #001 was observed ambulating without their mobility device and that a staff had knowledge of resident #001 ambulating without their device. An interview with DOC #105 identified the staff as PSW #106 and identified other staff PSW #108 and RPN #114 who were also present.

In separate interviews with PSW #106 and #108 the Inspector shared additional findings of resident #001 on the identified shift leading to the CI. PSW #106 and #108 were both unable to recall the events of that shift leading up to the resident's fall and the CI.

The licensee failed to take action when resident #001 was observed ambulating without their mobility device as specified in the resident’s plan of care.

Post resident fall.

2. The home's policy entitled "Falls Prevention and Management Program"; policy number RC-15-01-01; Last updated: February 2017, directed staff in the management of a post fall to treat any injuries and manage pain.

A review of the Risk Management Report of the unexpected incident and fall of resident #001 documented how PSW #111 discovered and described resident #001 at the time of the fall incident and the events leading up to the CI. During an interview with PSW #111, they revealed knowledge that resident #001 required the use of a mobility device to ambulate safely and described the events leading up the CIs and the resident at the time of the fall. The report documented, approximately one hour after the resident's fall, the resident's pain at the maximum pain level. RN #109 documented the Risk Management Report.

An interview with RN #109 confirmed the documentation and revealed that the resident's facial and verbal gestures led them to their assessment that the resident had a maximum pain level. The RN further shared that the physician was not notified of the resident's change in status and pain.

An interview with PSW #112 who provided care to the resident following their fall revealed that the identified sounds the resident was making when they tried to change the resident's clothes led them to believe the resident was in pain.

A record review of four "Clinical Monitoring Record V-3 Q 1 hr Neuro Check" forms following the initial resident RN assessment were completed by RPN #110. The documentation failed to reassess the resident's pain level as prompted by and required by the clinical monitoring record. An interview with RPN #110 confirmed that they did not complete the pain level assessments but had documented observations related to the resident's pain.

A review of the four Clinical Monitoring Record's identified documentation of resident complaints of pain in identified areas.

An interview with RPN #110 revealed that the resident stated they were in pain and that an identified area of the their body was painful. When the Inspector asked how the resident's pain was managed RPN #110 stated they focused on

another visually injured area of the resident's by applying a treatment and confirmed that no medication was given for pain and stated they were still waiting to see if the resident was going to the hospital.

A record review of resident's historical pain levels in point click care and interviews with PSW #001 and #002 confirmed that resident #001 did not usually complain of pain prior to this fall and both staff shared that the resident never really complained.

An interview with DOC #113 confirmed that the resident's pain level should have been assessed every hour as part of the clinical monitoring record and that the physician should have been informed of the resident's pain level.

The licensee failed to contact the physician to report the resident's fall, injury and pain level and therefore failed to take action to manage the resident's pain.

3. The home's policy entitled "Falls Prevention and Management Program"; policy number RC-15-01-01; Last updated: February 2017, directed staff in the management of a post fall to complete an initial physical and neurological assessment and If a resident hits their head or is suspected of hitting their head (e.g. unwitnessed fall) to complete the Clinical Monitoring Record.

A record review identified that the post fall injury routine, documented in the "Clinical Monitoring Record V-3 Q 1 hr Neuro Check" for the identified dates and times were all incomplete and that the neurological assessments, were blank.
An interview with RPN #110 who was responsible for completing the Clinical Monitoring Records stated that they were unsure of how to complete the assessments and revealed that they did not have a proper instrument. The RPN #110 revealed that they had not shared their lack of knowledge with the RN in charge.

A record review of the Medication Administration Record (MARS) for the identified date of the CI revealed a regularly scheduled medication, identified as medication type
A.

An interview with PSW #112 who provided care to the resident following their fall revealed that the described sounds the resident was making when they tried to change the resident's clothes led them to believe the resident was in pain. The PSW shared that they asked the resident where the pain was and the resident did not respond and just made sounds suggestive of being in pain.

A record review of a progress note documented an assessment at an identified date, time and time period following the resident's fall that reported the resident had an identified decline in health.

A record review of resident #001's medical records documented the resident had a fall in the home and a decline in health.

In an interview with the investigative Coroner the cause of resident #001's unexpected incident was related to a fall and identified risk factors.

An interview with DOC #113 confirmed the identified blank assessments were part of the clinical monitoring tool and neurological assessment of a resident. The DOC stated it was an expectation that these assessments be completed every hour for the first 4 hours than every 8 hours for 72 hours. The DOC confirmed the clinical monitoring tool was not completed as required.

The licensee failed to take action by not completing a neurological assessment of the resident, following an unwitnessed fall and resulting in an identified injury
.

An interview DOC #113 confirmed a pattern of inaction towards resident #001.
[s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm to resident #001 as direct care staff, including registered staff failed to provide the required assessments and care to the resident post fall and when a significant change in health status occurred. The resident died of a traumatic neck injury related to a fall while being on anticoagulants.. The scope of the issue was a level 1 isolated.
The home had a level 4 compliance history as there was ongoing non-compliance with VPC or CO within the last 3 years that included:

-Compliance Order (CO) and Written Notification issued September 26, 2017 related to s. 19(1) in report #2017_644507_0010.

(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2019

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with the LTCHA, 2007, r. 8. (1)

The licensee is ordered to:
1. Ensure, by way of the registered staff signature, that all registered staff are educated of the requirements in the homes' policy entitled "Falls Prevention and Management Program" ; policy number RC-15-01-01; Last updated: February 2017, specifically Post Fall Management and the "Clinical Monitoring Record V-3 Q 1 hr Neuro Check" and what steps needs to be taken and when.
2. Educate registered staff on the initial physical and neurological assessments and through the signing of a signature, ensure all registered staff are knowledgeable in completing all components of the homes' "Clinical Monitoring Record".
3. Educate all registered staff on the nursing care requirements when a resident presents with a change in status and has a Level 1 Medical Directive.
4. Include a review of the home's policy related to Fall Prevention and Management, in the Orientation and Training of all newly hired registered staff.
5. The DOC will audit every unwitnessed fall in the home for at a minimum of a 6 month period to ensure that the homes's policy had been adhered to.
6. The audits shall include but not be limited to the completion of the Clinical Monitoring Record, Post Fall Assessment Tool and Huddle, Notification of POA/SDM/family, Physician/NP and the management of resident's pain .
7. A record shall be kept of all steps 1-6 and the audits, including the follow-up action taken should the policy not be followed by a registered staff for review by an Inspector.

Grounds / Motifs :

1. 1. The Licensee has failed to comply with its Falls Prevention and Management Program RC-15-01-01. According to Ontario Regulation (O. Reg.) 79/10, s. 8 (1) b, Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

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

O. Reg. 79/10, s 30 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Inspector #110 reviewed the home's policy entitled "Falls Prevention and Management Program" ; policy number RC-15-01-01; Last updated: February 2017, which indicated the following:
Post Fall Management
1. Implement Post-fall Clinical Pathway
a. Complete an initial physical and neurological assessment;
b. Determine if the resident can be safely monitored and treated within the home or if transfer to acute care is required;
c. Treat any injuries and manage pain;
d. If a resident hits head or is suspected of hitting head (e.g. unwitnessed fall) complete Clinical Monitoring Record, Appendix 10
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
3. Notify the POA/SDM/family, physician/NP and management as required.

Two Critical Incident (CI) Reports were submitted to the Ministry of Health and Long Term Care (MOHLTC) on identified dates indicating an unexpected incident, fall and injury, related to resident #001.

On an identified date, the MOHLTC received an anonymous complaint related to the home not following proper procedures related to the unexpected incident, fall and injury of resident #001.

A review of the Risk Management Report of the unexpected incident, fall of resident #001, documented how PSW #111 described resident #001 at the time of the fall incident and the events leading up to the CI. An interview with PSW

#111 revealed knowledge of how resident #001 required the use of a mobility device to ambulate safely and then described the events leading up the CIs and the resident's fall.

A record review of resident #001's medical records documented unexpected incident was related to a fall in the home.

A record review of a progress note documented an assessment at an identified date, time and time period following the resident's fall that reported an identified decline in health.

An interview with RN #103 and DOC #105 confirmed that the clinical monitoring record is the neurological assessment of the resident and part of the home's post fall policy when the resident hits their head or is suspected of hitting their head like in the case of an unwitnessed fall.

A record review identified that the post fall injury routine, documented in the "Clinical Monitoring Record V-3 Q 1 hr Neuro Check" for the identified dates and times were all incomplete and that the neurological assessments, were blank. An interview with RPN #110 who was responsible for completing the Clinical Monitoring Records stated that they were unsure of how to complete the assessment and revealed that they did not have a proper instrument. The RPN #110 revealed that they had not shared their lack of knowledge with the RN in charge.

A further record review revealed that the physician/NP was not notified of resident #001's fall. An interview with RN #109 confirmed that the physician/NP had not been contacted.

A record review revealed the absence of the Post-Fall Assessment and Post-Fall Huddle. An interview with RN #109 confirmed a Post-Fall Assessment and Post-Fall Huddle had not been completed.

A review of the Risk Management Report of the unexpected incident and fall of resident #001 documented, approximately one hour after the resident's fall , the resident's pain at the maximum pain level. RN #109 documented the Risk Management Report.

An interview with RN #109 confirmed the documentation and revealed that the resident's facial and verbal gestures led them to their assessment that the resident had a maximum pain level. The RN further shared that the physician was not notified of the resident's change in status and pain level.

An interview with PSW #112 who provided care to the resident following their fall revealed that the identified sounds the resident was making when they tried to change the resident's clothes led them to believe the resident was in pain.

An interview with RPN #110 revealed that the resident stated they were in pain and that an identified area of the their body was sore. When the Inspector asked how the resident's pain was managed RPN #110 stated they focused on another visually injured area of the resident's by applying ice and confirmed that no medication was given for pain and stated they were still waiting to see if the resident was going to the hospital.

In an interview with the investigative Coroner the cause of resident #001's unexpected incident was related to a fall and identified risk factors.

The licensee failed to ensure the home's policy Falls Prevention and Management Program RC-15-01-01 by way of failing to complete a neurological assessment by completing the Clinical Monitoring Record, completing a Post-Fall Assessment including the Post-Fall Team Huddle, notifying the physician/NP and managing pain following resident #001's fall in the identified date of the CI. [s. 8. (1) (a),s. 8. (1) (b

The severity of this issue was determined to be a level 3 as there was actual harm to resident #001 as the resident had not been assessed in accordance to the home's falls assessments policies after sustaining a fall. The resident died of a traumatic neck injury related to a fall while being on anti coagulants. The scope of the issue was a level 1 isolated.
The home had a level 3 compliance history as there was one or more related non compliance within the last 3 years that included:
-Voluntary Plan of Correction (VPC) and Written Notification issued September 26, 2017 related to r. 8. (1) in report #2018_594624_0009.

(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2019

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Order / Ordre :

The licensee must be compliant with the LTCHA, 2007, r. 107. (4).

The licensee is ordered to create a plan for the following:
1. Ensure all Critical Incident Reports submitted to the MOHLTC include all relevant and accurate details of the incident including but not limited to:
a. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
b. Actions taken in response to the incident, including, i. what care was given or action taken as a result of the incident, and by whom, ii. whether a physician or registered nurse in the extended class was contacted, iii. what other authorities were contacted about the incident, if any,
c. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence
2. The plan shall ensure all critical incident reports are reviewed by the administrator to ensure accurate reporting. Should details or corrections be required the home shall immediately or within 24 hours amend the CI.
4. A home delegate shall audit all CI reports x 1 year to ensure the accurate reporting of information and develop and implement a plan that outlines corrective actions taken and by whom, if staff fail to complete the CI reports as required.
5. A record shall be kept of all documents and audits for review by an Inspector.

Please submit the written plan for achieving compliance for inspection 2019_414110_0003 to Diane Brown, LTC Home's Inspector, MOHLTC, by email to CentralEastSAO.MOH@ontario.ca within two weeks of receipt of this order. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. 1. r. 107. (4)The licensee failed to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. 2. A description of the individuals involved in the incident, including, i. names of any

residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or are responding to the incident. 3. Actions taken in response to the incident, including, i. what care was given or action taken as a result of the incident, and by whom, ii. whether a physician or registered nurse in the extended class was contacted, iii. what other authorities were contacted about the incident, if any, iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and v. the outcome or current status of the individual or individuals who were involved in the incident. 4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence. 5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

Two Critical Incident (CI) Reports were submitted to the Ministry of Health and Long Term Care (MOHLTC) on identified dates indicating an unexpected incident, fall and injury, related to resident #001.

On an identified date, the MOHLTC received an anonymous complaint related to the home not following proper procedures related to the unexpected incident, fall and injury of resident #001.

Upon completion of an on-site inspection of the critical incident and a review of both CI reports submitted to the MOHLTC the following inaccuracies and omissions were reported:

1. One of the identified Critical Incident Reports stated that a named physician was informed around at an identified time when the resident had fallen and that no specific instructions were given.

A record review of resident #001's progress notes and the Risk Management Report along with an interview with RN#109, who worked the identified shift, confirmed that a doctor including the named physician had not been informed of the resident's fall and therefore no specific instructions were given.

The licensee inaccurately reported that the physician was notified post resident fall and that no specific instructions were given.

2. One of the identified Critical Incident Reports reported that neurological monitoring started for resident #001 for the first identified hours and that the resident was stable and no concerns were noted by nurses.

A record review identified that the post fall injury routine, documented in the "Clinical Monitoring Record V-3 Q 1 hr Neuro Check" for the identified dates and times were all incomplete and that the neurological assessments, were blank. An interview with RPN #110 who was responsible for completing the Clinical Monitoring Records stated that they were unsure of how to complete the assessment and revealed that they did not have a proper instrument. The RPN #110 revealed that they had not shared their lack of knowledge with the RN in charge.

A review of the clinical monitoring record identified the resident's pain level was documented at a maximum level. RN #109 who assessed the resident's pain confirmed the pain documentation and that the resident was experiencing pain.

An interview with PSW #112 who provided care to the resident following their fall revealed that the identified sounds the resident was making when they tried to change the resident's clothes led them to believe the resident was in pain.

The licensee failed to include that the hourly head injury routine including the clinical monitoring records and pain level had not been completed and indicated only that head injury monitoring was started for the first identified hours and that resident was stable and no concerns were noted by nurses.

3. One of the identified Critical Incident Reports revealed the resident's ambulated with a mobility device, identified as device B.

A review of the resident's written plan of care identified resident #001's need for an identified mobility device, identified as device A (not B as documented in the CI) for safety.

In separate interviews PSWs #101, #102 and PT #104 revealed the resident used mobility device A.

A review of the Risk Management Report of the unexpected incident, fall of resident #001, documented that prior to locating the resident, the resident's mobility device, device A was observed in an identified location and not with the resident, revealing that the resident had ambulated without their device.

The licensee omitted the information leading up to the critical incident that the resident's mobility device, device A, had been identified without the resident revealing that the resident had ambulated without their device.

4. One of the identified Critical Incident Reports revealed that the RN initially assessed the resident with no complaints of discomfort.

A review of the Risk Management Report of the unexpected incident and fall of resident #001 documented how PSW #111 discovered and described resident #001 at the time of the fall incident and the events leading up to the CI. The report documented, approximately one hour after the resident's fall, the resident's pain was documented at the maximum pain level. RN #109 documented the Risk Management Report.

An interview with RN #109 confirmed the documentation and revealed that the resident's facial and verbal gestures led them to their assessment that the resident had a maximum pain level. The RN further shared that the physician was not notified of the resident's change in status and pain.

An interview with RPN #110 revealed that the resident stated they were in pain and that an identified area of the their body was painful.

An interview with PSW #112 who provided care to the resident following their fall revealed that the identified sounds the resident was making when they tried to change the resident's clothes led them to believe the resident was in pain.

The licensee failed to accurately report resident's discomfort and pain.

5. One of the identified Critical Incident Reports revealed the Coroner's

findings were 'cause of death was natural causes'. In an interview with the investigative Coroner the cause of resident #001's unexpected incident was related to a fall and identified risk factors.

The licensee failed to accurately report the Coroner's findings.

During an interview with DOC #113 the Inspector compared the inspection finding with the CI's submitted to the MOHLTC. The DOC acknowledged the inconsistencies and omissions as pointed out by the Inspector. [s. 107. (4)]

The severity of this issue was determined to be a level 2 as there was potential for actual risk by way of not accurately reporting the events related to the critical incident of resident #001 . The scope of the issue was a level 1 isolated.
The home had a level 2 compliance history with previous unrelated non compliance within the last 3 years.
(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 8th day of March, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : DIANE BROWN

Service Area Office / Bureau régional de services : Central East Service Area Office