Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 25, 2019	2019_723606_0005	004366-18, 004452-18, 009360-18, 010283-18, 016776-18, 016781-18, 018126-18, 020271-18, 029782-18, 030494-18, 001510-19	Critical Incident System

Licensee/Titulaire de permis

Holland Christian Homes Inc.
7900 McLaughlin Road South BRAMPTON ON L6Y 5A7

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

Faith Manor Nursing Home
7900 Mclaughlin Road South BRAMPTON ON L6Y 5A7

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

JANET GROUX (606), KIYOMI KORNETSKY (743)

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 14, 15, 19, 20, 21, 22, 25, and 26, 2019.

The following Critical Incident System (CIS) intakes were inspected:
Log # 004366-18 regarding an allegation of staff to resident abuse.
Log # 018126-18 regarding resident to resident responsive behaviours.
Log #020271-18, Log #029782-18 and Log # 001510-19 regarding resident to resident abuse resulting in injury.
Log #020271-18. This intake was reviewed on February 14, 2019. The intake was bundled with other intakes related to resident to resident abuse during the inspection. The three highest risk intakes related to resident to resident abuse were inspected.
Under inspection #2019_723606_0005 for log # 02782-18, #018126-18, and #001510-19, the following area of non-compliance was identified: CO related to Long Term Care Homes Act (LTCHA), 2007 S.O. 2007, c.8, s. 19. Duty to Protect.

Log #004452-18, Log #010283-18 and Log # 030494-18 regarding fall prevention and management.

The following Follow up (FU) order intakes were inspected:
Log #016776-18, order #001 s. 6. (7) regarding Residents' Plan of Care;
Log #016781-18 order #002 s. 19. (1) regarding Prevention of Resident Abuse and Neglect; and
Log # 009360-18, order #001 s. 50. (2) regarding the home's Management of Skin and Wound.

During the course of the inspection, the inspector(s) spoke with the Adminstrator, Director of Resident Care (DRC), Behavioural Support of Ontario (BSO) Lead, Skin and Wound Lead, Falls Prevention and Management Lead, Physician, Physiotherapist, Orion Security Personnel, Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW), Recreation Aide, Substitute Decision Makers (SDM), and Residents.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed relevant documents, including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #001	2018_482640_0006	606

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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

A Critical Incident (CI) reported resident to resident physical abuse causing injury.

Resident #006's progress notes stated that the resident was hit by resident #007 as the two were walking side by side which caused resident #006 to fall. The resident was transferred to the hospital and required a medical intervention to an injury to an identified area of their body.

Personal Support Worker (PSW) #106 stated they witnessed resident #006 fall to the floor after being suddenly hit by resident #007. Registered Practical Nurse (RPN) # 111 stated that resident #006 fell and sustained an injury after being hit by resident #007.

B) A CI reported resident to resident physical abuse.

Resident #003's progress notes stated the resident wandered into resident #002's room and was struck by resident #002.

PSW #107 stated that resident #002 could be physically aggressive toward others and had been known to strike out depending on their mood. They stated that both resident #002 and #003 were identified to display responsive behaviours of a physical nature at times.

Recreation Aide (RA) #113 stated that resident #003 had wandered into resident #002's room and was slapped by resident #002 .They stated that resident #003 sustained an injury.

C) A CI reported resident to resident physical abuse causing injury.

Resident #004's progress notes stated that the resident had a physical altercation with resident #005 after resident #005 wandered into their room. The progress notes explained that resident #004 became upset and verbally abusive toward resident #005 and hit resident #005. Resident #005 then responded and struck resident #004.

Registered Nurse (RN) #114 and the Behavioural Support of Ontario (BSO) Lead #102 stated that a physical altercation happened between resident #004 and #005 and resulted in resident #004 to be struck and caused the resident a change in their condition and sustained an identified injury to an area of their body.

The licensee failed to protect residents #003, #004, and #006 from physical abuse. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #010's progress notes stated the resident had a number of skin integrity impairments to various areas of their body during an identified time period.

Resident #010's Point of Care (PCC) skin assessments were reviewed and did not show evidence that required weekly skin assessments were completed as required for the identified skin integrity impairments.

B) Resident #021's progress notes stated that the resident was assessed with an identified skin impairment. The physician ordered a treatment regime and directed the registered staff to monitor the affected area until resolved.

Resident #021's PCC weekly skin assessments were reviewed and did not show evidence that the required skin assessments were completed for a number of identified dates.

RPNs #116 and #117 stated that when a resident has been identified with a skin impairment, the registered staff should be completing a weekly skin assessment to monitor the status of the skin impairment.

The Director of Residence Care (DRC) confirmed that weekly skin assessments were not completed for the identified dates for residents #010 and #021.

The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [s. 50. (2) (b) (iv)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

Resident #010 was non-compliant with their prescribed treatment regime for an identified medical condition; and there was no evidence that staff were collaborating in order to effectively address the resident's responsive behaviors.

Resident #010 was identified with a medical condition due to an unknown cause and was prescribed by the physician an identified orthopedic device. Physiotherapist (PT) #105 applied the orthopedic device and the treatment administration record (TAR) directed staff to ensure that the orthopedic device was in place.

Documentation in the TAR showed that during an identified time periods, resident #010 had removed the identified orthopedic device on a numerous occasions and was later

discontinued.

The home's BSO lead #102, reported that if a resident was not compliant with a medical intervention staff would notify the physician and the physiotherapist would be involved. The BSO's progress notes during a time period did not include any new assessments to specifically address why resident #010 was not compliant with the medical intervention nor were any new suggestions or interventions provided in the plan of care to address this issue.

PT #105 said that they did not re-assess the resident after the initial application of the identified orthopedic device on an identified date nor did they trial any other interventions. They said that they likely did not reassess resident #010, because the resident had responsive behaviors. They reported that they were informed by staff that the resident was not compliant with keeping their orthopedic device on an identified date at which point they requested that the physician discontinued the orthopedic device.

An identified communication record used by the physician did not show evidence that the physician that resident #010 was non compliant to the medical intervention. Between an identified period of time, staff did not collaborate to address resident #010's behaviors around having the orthopedic device on; nor were any alternative or new interventions trialed to encourage the resident to wear it.

The licensee failed to ensure that staff and others involved in the different aspects of care of resident #010 collaborated with each other in their assessments; when they failed to collaboratively assess resident #010's non-compliant behavior around wearing their splint. 2007, c.8, s.6 (4)(a) [s. 6. (4) (a)]

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

A) A CI reported a resident to resident altercation resulting in injury.

Resident #004's progress notes stated residents #004 and #005 were involved in a physical altercation after resident #005 had wandered into resident #004's room. Resident #004 became upset and told resident #005 to leave their room and pushed resident #005 who then became resistive.

Resident #004's written care plan identified the resident with verbal and physical

aggression related to their cognitive impairment and disliked other residents from entering their room. The resident would display identified responsive behaviours toward a resident entering their room if not prevented.The care plan directed staff to redirect co-residents who attempt to enter their room to prevent resident #004 from becoming upset and physically aggressive.

Security Guard (SG) #109 who was assigned to monitor resident #005 on a one to one basis stated that the home provided them training and education regarding the residents' care plans related to their responsive behaviours prior to them commencing any resident care.

The DRC stated that during the home's investigation into the incident, SG #001 who was assigned to monitor resident #005 was interviewed and told the home that they allowed resident #005 to enter resident #004's because they thought resident #004 was not in the room at the time and it was okay.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan.

B) Resident #002 was at high risk for falls with a high number of documented falls in an identified year. As part of resident #002's falls interventions, the resident was placed on the home's Falling Leaf Program on an identified date. The program required an identified logo be placed to an identified area of their room and mobility aides. Resident #002 also required an identified falls prevention device whenever they were in an identified mobility aide.

Observations were completed on identified dates and was noted that the resident did not have an identified logo on identified areas of their room and mobility aide and was confirmed by PSW #124 and #125.

On an identified date, the resident was observed in their mobility aide without the fall prevention device correctly engaged.

The DRC confirmed that it was the home's expectation that the residents' plan of care be followed.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan; when they failed to follow their falls interventions.

C) Resident #010 was identified with a medical condition and did not receive the medical intervention as ordered by the physician.

Resident #010 was diagnosed with a medical condition and physician orders were written for the physiotherapist to provide an identified orthopedic device to treat the resident's medical condition.

PT #105 said they did not have the identified orthopedic device as ordered by the physician and therefore reconfigured an identified orthopedic device that was available to use for the resident.

The Treatment Administration Record (TAR) directed staff to monitor resident #010's medical condition a number of times a day and to ensure the resident's compliance to the treatment regime. Documentation in the TAR shows that in an identified time period, the resident had removed the orthopedic device on numerous occasions.

PT #105 confirmed that the resident never received the correct orthopedic device to treat the resident's medical condition.

The licensee failed to ensure that the care set out in resident #010's plan of care was provided to the resident as specified in the plan; when they failed to provide the resident a left wrist splint. 2007, c.8, s. 6(7). [s. 6. (7)]

3. The licensee failed to ensure that when a resident was reassessed and the plan of care reviewed and revised, that if the plan of care was being revised because care set out in the plan of has not been effective, the licensee shall ensure that different approaches were considered in the revision of the plan of care.

A CI reported resident #002 had an unwitnessed fall that resulted in an injury.

A record review found that the resident fell a high number of times during an identified period in an identified year.

Review of resident #002's plan of care found that no new interventions or approaches were trialed after the resident had an identified number of falls during a time period.

A progress note from the BSO Lead #102 documented that a referral was sent to the

Falls Lead Staff #103 on an identified date inquiring about a identified falls prevention device for resident #002; however fall prevention device was not added to the resident's TAR until an identified month.

RPN #112 reported that the resident wore a falls prevention device in addition to another falls prevention strategy. These interventions, however, were not implemented until after an identified time.

The Falls Lead Staff #103 said that the resident's plan of care was reviewed after each fall, and this included the identified time period. When asked why new approaches or interventions were not trialed to address the resident's frequent falls; the Falls Lead Staff #103 said that despite having implemented universal falls prevention strategies, the strategies did not work.

The licensee failed to ensure that different and new approaches were considered in the revision of the plan of care, when resident #002's plan of care related to falls prevention had not been effective. 2007, c.8, s.6(11) [s. 6. (11) (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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with O.Reg.79/10, s.49 (2), the licensee must ensure that when a resident has fallen, the resident is assessed and a post-fall assessment conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Specifically, staff did not comply with the licensee's "Falls Prevention and Management Program Policy", which directed staff to complete a Head Injury Routine (HIR) for any suspected trauma to the head, and that vital signs were recorded every 15 minutes for the first hour, hourly for the next three hours and every four hours for the next 24 hours.

A) A CI reported resident to resident physical abuse causing head injury.

Resident #003's progress notes stated the resident wandered into resident #002's room and sustained an identified injury after getting into a physical altercation with resident #002.

Resident #003's Neurological Assessment Record (NAR) on an identified date did not show evidence that the resident was assessed at an identified time as required according to the home's policy.

B) Resident #002 sustained multiple falls between an identified period. Staff initiated the HIR for this resident after an identified number of falls and failed to complete the NAR as per the home's Falls Prevention and Management Program Policy.

The HIR assessments reviewed were not completed for identified dates and times as required by the home's policy.

The licensee failed to follow the Home's policy "Falls Prevention and Management Program", last revised in January, 2018; when they failed complete HIR assessments as per their policy. [s. 8.]

Additional Required Actions:

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

Issued on this 9th day of April, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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) :	JANET GROUX (606), KIYOMI KORNETSKY (743)
Inspection No. / No de l'inspection :	2019_723606_0005
Log No. / No de registre :	004366-18, 004452-18, 009360-18, 010283-18, 016776-18, 016781-18, 018126-18, 020271-18, 029782-18, 030494-18, 001510-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 25, 2019
Licensee / Titulaire de permis :	Holland Christian Homes Inc. 7900 McLaughlin Road South, BRAMPTON, ON, L6Y-5A7
LTC Home / Foyer de SLD :	Faith Manor Nursing Home 7900 Mclaughlin Road South, BRAMPTON, ON, L6Y-5A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracy Kamino

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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 Holland Christian Homes Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_689586_0012, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must ensure that residents #006, #003, and #004 and any other resident are protected from abuse by anyone.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #002 from inspection #2018_689586_0012 issued on April 18, 2018, with a compliance date of April 23, 2018.

The licensee was ordered to complete the following:
A) The licensee must be compliant with s. 19 (1) of the LTCHA.
B) The licensee must ensure ensure that residents #016 and #020 are protected from physical abuse by a co-resident, and residents #008 and #027 are protected from emotional abuse by staff.
C) The licensee shall review the plans of care for residents #017 and #021 and revise, as necessary, the plans to ensure that all triggers are identified and possible interventions are put into place to mitigate and manage those behaviours and to ensure the safety of co-residents.
D) The licensee shall provide education to PSW staff #118 on resident abuse before the completion of their next scheduled shift. There shall be a record of the training provided to the employee. This record shall include the date that the training was completed, topics covered and who/how the training was completed.

The licensee completed parts B, C, and D but did not complete part A of the order.

The licensee has failed to ensure that residents were protected from abuse by anyone.

Critical Incident (CI) # 2745-000002-19 dated January 19, 2019, reported resident to resident physical abuse causing injury.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, physical abuse is the use of physical force by a resident that causes physical injury to another resident.

Resident #006's progress notes dated January 19, 2019, stated while leaving the dining room, the resident was hit on the chest by resident #007 as the two were walking side by side which caused resident #006 to fall and hit their head on the floor. On assessment, resident sustained a head injury and was transferred to hospital and received sutures to a laceration to the back of their head.

Personal Support Worker (PSW) #106 stated they witnessed resident #006 fall to the floor after being suddenly hit by resident #007. Registered Practical Nurse (RPN) # 111 stated that resident #006 fell and sustained a laceration to the back of their head and required sutures after being hit by resident #007.

B) CI #2745-000022-18 dated November 2, 2018, reported resident to resident physical abuse.

Resident #003's progress notes dated November 2, 2018, stated the resident wandered into resident #002's room and was slapped and scratched in the face by resident #002.

PSW #107 stated that resident #002 could be physically aggressive toward others and had been known to strike out depending on their mood. They stated that both resident #002 and #003 were identified to display responsive behaviours of a physical nature at times.

Recreation Aide (RA) #113 stated that resident #003 had wandered into resident #002's room and was slapped by resident #002 when they attempted to lay down in resident #002's bed. They stated that resident #003 sustained a scratch to their face caused by resident #002 slapping them.

C) CI #2745-000017-18 dated July 17, 2018, reported resident to resident physical abuse causing injury.
Resident #004's progress notes dated July 17, 2018, stated that the resident had a physical altercation with resident #005 after resident #005 wandered into their room. The progress notes explained that resident #004 became upset and verbally abusive toward resident #005 and hit resident #005. Resident #005 then responded and punched resident #004 in the face.

Registered Nurse (RN) #114 and the Behavioural Support of Ontario (BSO) Lead #102 stated that a physical altercation happened between resident #004 and #005 and resulted in resident #004 to be punched in the face which caused the resident to have pain and a loose tooth.

The licensee failed to protect residents #003, #004, and #006 from physical abuse.

The severity of Non-Compliance (NC) was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a 2 patterned as it related to three out of five residents reviewed. The home had a level 4 history with despite Ministry of Health (MOH) action (VPC, order), NC continues with original area of NC.

(606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 :

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 must be compliant with s. 50 (2) of the LTCHA.

Specifically, the licensee must ensure that residents #010 and #021 and any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #010's progress notes stated the resident had a number of skin integrity impairments to various areas of their body during an identified time period.

Resident #010's Point of Care (PCC) skin assessments were reviewed and did not show evidence that required weekly skin assessments were completed as required for the identified skin integrity impairments.

B) Resident #021's progress notes stated that the resident was assessed with an identified skin impairment. The physician ordered a treatment regime and directed the registered staff to monitor the affected area until resolved.

Resident #021's PCC weekly skin assessments were reviewed and did not show evidence that the required skin assessments were completed for a number of identified dates.

RPNs #116 and #117 stated that when a resident has been identified with a skin impairment, the registered staff should be completing a weekly skin assessment to monitor the status of the skin impairment.

The Director of Residence Care (DRC) confirmed that weekly skin assessments were not completed for the identified dates for residents #010 and #021.

The severity of Non-Compliance (NC) was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a 2 patterned as it related to two out of three residents reviewed. The home had a level 4 history with despite Ministry of Health (MOH) action (VPC, order), NC continues with original area of NC. (606)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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 : Apr 15, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2018_689586_0012, CO #001;

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 s. 6 (7) of the LTCHA.

The licensee shall ensure that the care set out in resident #002, #004, and #010 and any other resident's plan of care is provided to the resident as specified in the plan.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001 from inspection #2018_689586_0012 issued on April 18, 2018, with a compliance date of April 23, 2018.

The licensee was ordered the following:

A) The licensee must be compliant with s. 6 (7) of the LTCHA.

B) The licensee shall ensure that the care set out in resident #001's plan of care in relation to the level of assistance provided during care is provided to the resident as specified in the plan.

C) The licensee shall provide education to PSW staff #120 on the policies and procedures related to resident plans of care and falls prevention and management. There shall be a record of the training provided to the employee.This record shall include the date that the training was completed, topics covered and who/how the training was completed.

The licensee completed B, and C, but did not complete part A of the order.

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

A) A CI reported a resident to resident altercation resulting in injury.

Resident #004's progress notes stated residents #004 and #005 were involved in a physical altercation after resident #005 had wandered into resident #004's room. Resident #004 became upset and told resident #005 to leave their room and pushed resident #005 who then became resistive.

Resident #004's written care plan identified the resident with verbal and physical aggression related to their cognitive impairment and disliked other residents from entering their room. The resident would display identified responsive behaviours toward a resident entering their room if not prevented.The care plan directed staff to redirect co-residents who attempt to enter their room to prevent resident #004 from becoming upset and physically aggressive.

Security Guard (SG) #109 who was assigned to monitor resident #005 on a one to one basis stated that the home provided them training and education regarding the residents' care plans related to their responsive behaviours prior to them commencing any resident care.

The DRC stated that during the home's investigation into the incident, SG #001 who was assigned to monitor resident #005 was interviewed and told the home that they allowed resident #005 to enter resident #004's because they thought resident #004 was not in the room at the time and it was okay.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan.

B) Resident #002 was at high risk for falls with a high number of documented falls in an identified year. As part of resident #002's falls interventions, the resident was placed on the home's Falling Leaf Program on an identified date. The program required an identified logo be placed to an identified area of their room and mobility aides. Resident #002 also required an identified falls

prevention device whenever they were in an identified mobility aide.

Observations were completed on identified dates and was noted that the resident did not have an identified logo on identified areas of their room and mobility aide and was confirmed by PSW #124 and #125.

On an identified date, the resident was observed in their mobility aide without the fall prevention device correctly engaged.

The DRC confirmed that it was home's expectation that the residents' plan of care be followed.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan; when they failed to follow their falls interventions.

C) Resident #010 was identified with a medical condition and did not receive the medical intervention as ordered by the physician.

Resident #010 was diagnosed with a medical condition and physician orders were written for the physiotherapist to provide an identified orthopedic device to treat the resident's medical condition.

PT #105 said they did not have the identified orthopedic device as ordered by the physician and therefore reconfigured an identified orthopedic device that was available to use for the resident.

The Treatment Administration Record (TAR) directed staff to monitor resident #010's medical condition a number of times a day and to ensure the resident's compliance to the treatment regime. Documentation in the TAR shows that in an identified time period, the resident had removed the orthopedic device on numerous occasions.

PT #105 confirmed that the resident never received the correct orthopedic device to treat the resident's medical condition.

The licensee failed to ensure that the care set out in resident #010's plan of care

was provided to the resident as specified in the plan; when they failed to provide the resident a left wrist splint. 2007, c.8, s. 6(7).

The severity of Non-Compliance (NC) was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a 2 patterned as it related to three out of six residents reviewed. The home had a level 4 history with despite Ministry of Health (MOH) action (VPC, order), NC continues with original area of NC.

(606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

Order # / Ordre no : 004

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 O. Reg 79/10, s. 8 (1) (b) of the Long Term Care Homes Act (LTCHA).

Specifically, the licensee must comply with the home's policy"Falls Prevention and Management Program Policy", and the procedures identified within the policy related to the initiation and completion of head injury routine (HIR).

Grounds / Motifs :

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

In accordance with O.Reg.79/10, s.49 (2), the licensee must ensure that when a resident has fallen, the resident is assessed and a post-fall assessment conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Specifically, staff did not comply with the licensee's "Falls Prevention and Management Program Policy", which directed staff to complete a Head Injury Routine (HIR) for any suspected trauma to the head, and that vital signs were recorded every 15 minutes for the first hour, hourly for the next three hours and every four hours for the next 24 hours.

A) A CI reported resident to resident physical abuse causing head injury.

Resident #003's progress notes stated the resident wandered into resident #002's room and sustained an identified injury after getting into a physical altercation with resident #002.

Resident #003's Neurological Assessment Record (NAR) on an identified date did not show evidence that the resident was assessed at an identified time as required according to the home's policy.

B) Resident #002 sustained multiple falls between an identified period. Staff initiated the HIR for this resident after an identified number of falls and failed to complete the NAR as per the home's Falls Prevention and Management Program Policy.

The HIR assessments reviewed were not completed for identified dates and times as required by the home's policy.

The licensee failed to follow the Home's policy "Falls Prevention and Management Program" when they failed complete HIR assessments as per their policy. [s. 8.]

The severity of Non-Compliance (NC) was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a 2 patterned as it related to two out of three residents reviewed. The home had a level 2 history with one or more unrelated NC in the last three years. (606)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 15, 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 25th day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Janet Groux

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