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

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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 24, 2020	2020_821640_0022	002966-20, 020851-20	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Grey
595 9th Avenue East OWEN SOUND ON N4K 3E3

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

Grey Gables Home for the Aged
206 Toronto Street South MARKDALE ON N0C 1H0

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

HEATHER PRESTON (640)

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): November 12, 13 and 16, 2020

The following Critical Incident System (CIS) report was reviewed:

Log #020851-20 related to a fall with fracture

A Follow Up inspection was conducted related to Compliance Order #001 from inspection #2020_781729_0004 related to RN staffing with a compliance due date of November 2, 2020.

During the course of the inspection, the inspector toured the home, observed the provision of care, reviewed staffing schedules, clinical records, policy and procedure and conducted interviews.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Resident Assessment Instrument/Minimum Data Set (RAI/MDS) Coordinator, PSW/Resident Care Coordinator, the Director of Care (DOC) and the Executive Director (ED).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
1 VPC(s)
2 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
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2020_781729_0004	640

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. (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 when care set out in the plan was not effective, that different approaches were considered in the revision of the plan of care for resident #001, #003 and #004.

i) Resident #001 had sustained six falls from admission. They were assessed to be at high risk for falls since admission.

The care plan had not been revised until after the resident’s third fall. The resident fell three times following this intervention and there were no changes to the plan of care.

The resident was at risk of further falls and injuries and had suffered a fractured and other injuries as a result of a fall.

ii) Resident #003 had sustained seven falls in two months. All were un-witnessed falls and two resulted in injury.

They were assessed to be at high risk for falls since their admission.

The care plan had not been revised since admission until after the residents sixth fall. Three days later, the resident was found on the floor.

The resident was at risk of further falls and potential injury from those falls.

iii) Resident #004 had sustained six falls in two months. Three of which were un-witnessed falls.

They were assessed to be at high risk for falls since their admission.

The care plan had not been revised during this time to prevent falls or reduce the risk of falling.

The resident was at risk of further falls and potential injury from those falls.

Sources: CIS report #M606-000011-20, resident's care plan, progress notes, assessments, interview of RPN #102, RN #108, the DOC and other staff interviews. [s. 6. (11) (b)]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the "Falls Prevention and Management" policy that included the "Head Injury Routine" were complied with, for residents #001, 003 and #004.

O. Reg. 79/10, s. 30 (1) requires that for each of the required programs under section 48, there must be a written description of the program that includes relevant policies and protocols and provides for methods to reduce risk and monitor outcomes.

O. Reg. 79/10, s. 49 (1) requires that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not conduct head injury routine (HIR) assessments at all required times and had not completed the full HIR assessment components at all times.

i) Resident #001 had an un-witnessed fall and an HIR was initiated immediately following the fall.

The third required HIR assessment was incomplete as per the licensee's policy.

The resident had another unwitnessed fall. The clinical record contained an HIR form with three required assessments completed. The form did not have a date. A note on the form did coincide with a physician order written that date, to discontinue the HIR at a specific time. Two required assessments, prior to that time, were not conducted as per the licensee's policy.

ii) Resident #003 sustained seven un-witnessed falls in two months.

On three identified dates, staff did not initiate an HIR as per the licensee's policy.

The DOC said HIR was required to be initiated for all un-witnessed falls of residents who were not cognitive. Resident #003 had a Cognitive Performance Scale (CPS) of 6 indicating severe cognitive impairment.

On two other HIR assessments, staff did not complete the assessments according to policy and one according to the physician order.

The licensee's policy directed staff to wake a resident when an HIR assessment was required.

iii) Resident #004 had an unwitnessed fall.

HIR was initiated following the fall and was incomplete on two required entries for hour one and hour two. The document had a note written that stated, “resident sleeping”.

HIR was not conducted on specific times that were noted to be required by the RN.

The risk to the resident was the potential of not identifying symptoms of a head injury in a timely fashion.

Sources: CIS report #M606-000011-20, clinical record, progress notes, HIR assessment forms, interview of RPN #103 and RN #106 and #108 and the licensee's policy “Falls Prevention and Management”, policy #VII-G-30.10 with a revised date of November 2019 and “Head Injury Routine”, policy #VII-G-30.20 with a revised date of November 2019.
[s. 8. (1) (a),s. 8. (1) (b)]

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. 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 failed to ensure that a resident exhibiting altered skin integrity, including skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

i) Resident #001 had an un-witnessed fall and sustained skin injuries and a fracture.

The clinical record was reviewed and there was no assessment of the areas of altered skin integrity.

An RN said the assessments were required and had not been done for any of the areas of altered skin integrity following the fall.

ii) Resident #005 fell and sustained an open area.

The resident record, specifically the assessments, were reviewed and staff had not conducted an initial skin assessment of the wound as noted by the Director of Care.

The residents did not have initial or weekly assessments of their wounds which put them at risk for infection or other negative outcome.

Sources: Resident’s clinical record, progress notes, assessment tab in PCC and interview of RN #106, the DOC and other staff. [s. 50. (2) (b) (i)]

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 the licensee must ensure that a resident exhibiting altered skin integrity, including skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

Issued on this 24th day of November, 2020

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

Original report signed by the inspector.

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HEATHER PRESTON (640)
Inspection No. / No de l'inspection :	2020_821640_0022
Log No. / No de registre :	002966-20, 020851-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 24, 2020
Licensee / Titulaire de permis :	Corporation of the County of Grey 595 9th Avenue East, OWEN SOUND, ON, N4K-3E3
LTC Home / Foyer de SLD :	Grey Gables Home for the Aged 206 Toronto Street South, MARKDALE, ON, N0C-1H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shannon Cox

To Corporation of the County of Grey, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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
(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).

Order / Ordre :

The licensee must comply with the LTCHA, 2007, s. 6 (11).

Specifically, the licensee must:

Review and revise the fall prevention care plan considering different approaches to reduce the risk of falling for residents #001, #003 and #004.

Grounds / Motifs :

1. The licensee failed to ensure that when care set out in the plan was not effective, that different approaches were considered in the revision of the plan of care for resident #001, #003 and #004.

i) Resident #001 had sustained six falls from admission. They were assessed to be at high risk for falls since admission.

The care plan had not been revised until after the resident's third fall. The resident fell three times following this intervention and there were no changes to the plan of care.

The resident was at risk of further falls and injuries and had suffered a fractured and other injuries as a result of a fall.

ii) Resident #003 had sustained seven falls in two months. All were un-witnessed falls and two resulted in injury.

They were assessed to be at high risk for falls since their admission.

The care plan had not been revised since admission until after the residents sixth fall. Three days later, the resident was found on the floor.

The resident was at risk of further falls and potential injury from those falls.

iii) Resident #004 had sustained six falls in two months. Three of which were un-witnessed falls.

They were assessed to be at high risk for falls since their admission.

The care plan had not been revised during this time to prevent falls or reduce the risk of falling.

The resident was at risk of further falls and potential injury from those falls.

Sources: CIS report #M606-000011-20, resident's care plan, progress notes, assessments, interview of RPN #102, RN #108, the DOC and other staff interviews.

An order was made by taking the following into account:

Severity: The risk of harm was minimal risk/minimal harm as there was risk of harm with further falls.

Scope: The scope was widespread as there were three of three residents reviewed that were affected.

Compliance history: The home had a previous non-compliance for the other sections of the LTCHA, 2007 in the past 36 months.

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 22, 2021

Order # / No d'ordre : 002 **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 comply with O. Reg. 79/10 s. 8 (1).

Specifically the licensee must:

1) Provide re-training to all registered staff regarding the licensee's fall prevention and head injury policies.
2) Keep a record of that training and ensure that record is available in the home.

3) Conduct an audit of the initiated HIR assessments following the training for a period of three months or until such time as the audit identifies over 90% compliance.
4) Provide re-training to all registered staff to ensure that all physician orders related to HIR, have both the date and time the order was taken, documented on the physician order sheet.
5) Keep a record of that training and ensure that record is available in the home.

Grounds / Motifs :

1. The licensee has failed to ensure the “Falls Prevention and Management” policy that included the “Head Injury Routine” were complied with, for residents #001, 003 and #004.

O. Reg. 79/10, s. 30 (1) requires that for each of the required programs under section 48, there must be a written description of the program that includes

relevant policies and protocols and provides for methods to reduce risk and monitor outcomes.

O. Reg. 79/10, s. 49 (1) requires that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not conduct head injury routine (HIR) assessments at all required times and had not completed the full HIR assessment components at all times.

i) Resident #001 had an un-witnessed fall and an HIR was initiated immediately following the fall.

The third required HIR assessment was incomplete as per the licensee's policy.

The resident had another un-witnessed fall. The clinical record contained an HIR form with three required assessments completed. The form did not have a date. A note on the form did coincide with a physician order written that date, to discontinue the HIR at a specific time. Two required assessments, prior to that time, were not conducted as per the licensee's policy.

ii) Resident #003 sustained seven un-witnessed falls in two months.

On three identified dates, staff did not initiate an HIR as per the licensee's policy.

The DOC said HIR was required to be initiated for all un-witnessed falls of residents who were not cognitive. Resident #003 had a Cognitive Performance Scale (CPS) of 6 indicating severe cognitive impairment.

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HIR was initiated following the fall and was incomplete on two required entries for hour one and hour two. The document had a note written that stated, "resident sleeping".

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The risk to the resident was the potential of not identifying symptoms of a head injury in a timely fashion.

Sources: CIS report #M606-000011-20, clinical record, progress notes, HIR assessment forms, interview of RPN #103 and RN #106 and #108 and the licensee's policy "Falls Prevention and Management", policy #VII-G-30.10 with a revised date of November 2019 and "Head Injury Routine", policy #VII-G-30.20 with a revised date of November 2019.

An order was made by taking the following into account:

Severity: The risk of harm was minimal risk/minimal harm as there was risk of harm without the completion of the HIR assessments.

Scope: The scope was widespread as there were three of three residents reviewed affected.

Compliance history: The home had a previous non-compliance for the other sections of the LTCHA, 2007 in the past 36 months.

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 09, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 24th day of November, 2020

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Heather Preston

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