Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 21, 22, 23, 27, Nov 9, 21, 2011	2011_027192_0039	Follow up

Licensee/Titulaire de permis

DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC
2121 ARGENTIA ROAD, SUITE 301, MISSISSAUGA, ON, L5N-2X4

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

HARDY TERRACE
612 Mount Pleasant Road, R. R. #2, BRANTFORD, ON, N3T-5L5

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

During the course of the inspection, the inspector(s) spoke with Director of Care, Assistance Director of Care, Registered Nurse, and Personal Support Workers related to H-001879-11.
(This inspection contains information relevant to complaint intake H-001960-11)

During the course of the inspection, the inspector(s) Reviewed medical records, policy and procedure and observed care.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following subsections:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change;
(b) the care set out in the plan is no longer necessary; or
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that a specified resident was reassessed when there was increased edema, redness, and inflammation of a specified area, following a fall that resulted in injury.
No Head to Toe skin assessment was completed for this resident at the time of admission, but notes reviewed from the time of admission did not indicate any redness, inflammation or edema of the specified area. The specified resident sustained a fall that resulted in injury. Discussion with Director of Care confirms that the resident appears to be experiencing an inflammation in the injured area, possibly related to infection. The physician was not notified of the increased redness, edema and inflammation.
2. The licensee has failed to ensure that the care plan for the specified resident sets out clear directions to staff and others who provide direct care to the resident.
a) The plan of care in effect for a specified resident on September 23, 2011 stated that the resident had medical device. Physician order requests the removal of the medical device. Progress notes indicate that the medical device was removed. No other directions are provided for staff. There is no toileting routine, brief size is not identified.
b) A specified resident was observed sitting in a specified chair on September 21, 22 and 23, 2011. This chair acts as a restraint in that it prevents the resident from rising independently. The use of this chair is not included in the plan of care, repositioning and checking routines are not identified for staff to follow.
c) The specified resident was identified to be having difficulty with choking - no direction was provided for staff to ensure that the resident was in an upright position during meals. The resident was observed in a reclined chair for meals observed on September 21, 22, and 23, 2011.

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management
Specifically failed to comply with the following subsections:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home.
A specified resident was admitted to the home. At the time of admission it was identified that the resident had a history of falls and that a bed alarm was required. The specified resident sustained falls resulting in the use of a restraint. No bed alarm was available for three days following admission. Documentation indicates that the resident spent night and day in a specified chair because the bed alarm was not available. A review of the maintenance record indicates that no follow-up communication was made with the maintenance person to secure an alarm. The Director of Care confirms that the bed alarm was not available and that there was no follow-up with maintenance to secure a bed alarm.

Additional Required Actions:

CO # - 003 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 subsections:

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the policy related to Fall Prevention and Management (NM-II-F005) dated December 2009 was complied with. The policy requires:
a) that "head injury routine be implemented if trauma to the head is suspected, or if the resident is on anticoagulant therapy or if it was an unwitnessed fall."
A specified resident sustained falls in 2011. The second fall resulted in an injury. Documentation in the progress notes indicates that head injury routine was initiated and that the resident's blood pressure was 210/108. No documentation of the Head Injury routine could be provided by the home. The Director of Care and Assistant Director of Care were unable to locate the head injury documentation.
b) when a fall occurs "plan and implement corrective actions immediately, e.g. bedrail, bed/chair alarm, proper footwear, monitoring protocol, adequate lighting, dry floor etc."
A specified resident was placed in a chair that prevented independent mobility and acted as a restraint following two falls. No other immediate corrective actions were trialed. A bed alarm, had been requested, but was not available.

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following subsections:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that residents requiring the use of a Personal Assistance Service Device (PASD) to assist in routine activity of living have the PASD included in the plan of care, have tried alternatives to a PASD, use the least restrictive PASD, use of the PASD has been approved by the physician, Registered Nurse or Registered Practical Nurse or other person identified in the Act, that use of the PASD has been consented to by the resident or their substitute decision maker and that the plan of care provides for everything reviewed under subsection (5). 2007, c. 8, s. 33 (4).

A specified resident was noted to have two half rails up on the bed. Staff interviewed indicated that bed rails are up at all times when in bed, to aid in bed mobility. The plan of care indicates 1/2 rails on all open sides of bed, used daily. Check resident every hour during the night for safety, two bedrails upright while in bed for comfort and safety. No consent is available in the medical record as confirmed by the Registered Nurse and the Director Of Care. There is no documentation in the medical record related to alternatives tried.

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 ensuring that use of a Personal Assistance Services Device (PASD) to assist a resident with a routine activity of living is included in the plan of care only if s. (4)1-5 are satisfied, to be implemented voluntarily.

WN #5: 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 subsections:

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

A specified resident was observed on September 22, 2011 to have signs and symptoms of infection. The resident states the identified area is painful. A review of the medical record found that in 2011 there is a physician order indicating treatment for the inflamed area. No documentation of increased redness is noted in the progress notes or on the 24 hour shift report. It was confirmed with the Director of Care, Registered Practical Nurse, and Registered Nurse that the increase in redness is a change in status for the resident. The increase in redness was not communicated within the team and the resident was not reassessed with this change in condition.

A specified resident was observed on September 22, 2011 to have redness and inflammation of a specified area. On September 23, 2011 the resident is receiving a treatment 5 times daily administered by registered staff. A review of the physician's orders indicates there is a history of infection in the specified area. The most recent documentation in the progress notes indicates that the resident had a bath on a specified date in 2011. There is no documentation of redness to the area in the progress notes, or on the 24 hour report sheets. The increase in redness was not communicated within the team and the resident was not reassessed with this change in condition.
2. The licensee failed to ensure that care was provided to a specified resident as set out in the plan of care.
a) The plan of care for the resident indicates that they are to be positioned in an upright position for meals, requires a two handled soup cup, lipped plate, and non-skid mat.
During meal time observation on September 21, 22 and 23, 2011 the resident did not use a two handled soup mug and no non-skid mat was provided. The specified resident was not positioned in an upright position for the lunch meal on either day. On September 21, 2011 the resident was leaning to the right and on September 22, 2011 the resident remained in a reclined position in a wheelchair, barely able to reach the meal on the table. On September 23, 2011 the resident was leaning significantly to the left. Interview with the Director of Care indicates that the resident is no longer to use a non-skid mat at meals and this was removed from the plan of care during the course of the inspection.`
b) The plan of care for the specified resident indicates that skin integrity is compromised and that staff should recognize and report signs of skin breakdown. During the lunch meal on September 22, 2011 the resident was noted to be scratching at areas of altered skin integrity. Staff were heard on two occasions discouraging the resident from scratching. A review of the progress notes and 24 hour report found no documentation or communication related to altered skin integrity. The resident was observed to have open areas and healed scratch marks. Interview with the RN indicates that it would be expected that if the resident has altered skin integrity, staff would report this for communication on the 24 hour shift report and documentation in the progress notes. Interview with the Director of Care confirms this expectation of staff and added that it is important to initiate treatment creams as soon altered skin integrity is noted.
c) A specified resident was observed on September 22, 2011 to have a designated area of inflammation. A review of the medical record found that there is a physician order for treatment. A review of the Treatment Administration Record noted that the treatment ordered has not consistently been signed as being completed. The antibiotic was not initiated as ordered by the physician for increased redness and discomfort.

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 ensuring that the plan of care is reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary and that care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a specified resident was not restrained by the use of a physical device other than in accordance with section 31 .
The resident sustained two falls that resulted in an injury. Following the second fall the resident was placed in a chair which prevented independent mobility.

a) The plan of care for the specified resident does not include the significant risk that the resident or another resident would suffer serious bodily harm if the resident was not restrained. There is indication that the resident was attempting to exit the bed, a behaviour that was acknowledged prior to admission. A request for a bed monitor was made by the family at the time of admission, but was not provided. The Director of Care confirmed that the significant risk of serious bodily harm for the resident was not identified in the plan of care.
b) The licensee failed to ensure that the plan of care for a specified resident included alternatives to restraining that were considered and tried, but had not been effective in addressing the risk. The resident was restrained after sustaining falls in 2011. No alternatives to restraint were initiated. The bed alarm identified as necessary at the time of admission was not put in place for three days. The resident was identified as being at risk for falls with an unsteady gait at the time of admission, but was ambulatory with a walker.
c) No order from a physician or registered nurse in the extended class was obtained for the use of the restraint. As of September 23, 2011 there is no order for restraint.
d) No consent for the use of a restraint is evident on the medical record - confirmed by the Director of Care
e) There is no record of hourly checks and two hourly position changes for the specified resident. The Director of Care confirms that monitoring of the resident had not been completed.
f) There is no documentation that the resident's condition was reassessed and the effectiveness of the restraining evaluated by a member of the registered staff.

The use of a restraint for the specified resident is not identified on the plan of care. Discussion with the Registered Nurse and the Director of Care confirm that the resident was unable to exit the restraint without assistance. The plan of care created September 23, 2011 does not address the restraint.

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 ensuring that no resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining and snack service that includes at a minimum, the following elements: monitoring of all residents during meals.

A specified resident was identified to be at a moderate nutritional risk due to several identified risk factors.The resident was observed to take less than 30% of the meal at supper on September 22, 2011. No staff member was supervising the resident during the meal, no family member was in attendance. The Dietary Aid was noted to clear the table after the resident had left the table. A PSW responsible for care was asked how she would know how much the resident had taken of the meal - the PSW indicated that the Dietary Aid would tell her. The Dietary Aid was interviewed and indicated that the Personal Support Workers would have observed the resident's intake. When asked how much the resident had taken of the meal she indicated greater than 50%. A review of the medical record on September 23, 2011 found that it was recorded that the resident took 50% of the evening meal on September 22, 2011.
The resident's intake was not observed or accurately recorded within the medical record.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following subsections:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.
3. Comfort care measures.
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that monitoring of a specified resident's responses to, and the effectiveness of pain management strategies were completed.
No pain assessment was completed post fall, in spite of an injury. Analgesic was given to the resident on two occasions. The effectiveness of medication given was not recorded on the Medication Administration Record or in the progress notes where the registered staff and the Director of Care indicated it would be found. Notes made related to the administration of the analgesic are unclear. They do not include the medication administered, the reason for its administration or follow-up on its effect. The specified resident was observed with continued discomfort, a grimace on the face and was rubbing the side of his head.

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 ensuring that there is monitoring of residents' responses to , and the effectiveness of , the pain management strategies, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a specified resident is receiving two baths weekly as per the plan of care, and that care provided is documented. The specified resident is dependent on staff for all care. The plan of care identifies that the resident is to be bathed twice weekly. A review of the flow sheet completed by Personal Support Workers for September indicates that the resident was not bathed on specified dates when bathing was scheduled to have been provided. Interview with Registered Nurse indicates that a refusal would be documented on the flow sheet and that staff would report the refusal to registered staff for documentation in the progress notes. There is no indication on the flow sheet that the resident refused bathing.

Issued on this 21st day of November, 2011

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

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBORA SAVILLE (192)
Inspection No. / No de l'inspection :	2011_027192_0039
Type of Inspection / Genre d'inspection:	Follow up
Date of Inspection / Date de l'inspection :	Sep 21, 22, 23, 27, Nov 9, 21, 2011
Licensee / Titulaire de permis :	DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC 2121 ARGENTIA ROAD, SUITE 301, MISSISSAUGA, ON, L5N-2X4
LTC Home / Foyer de SLD :	HARDY TERRACE 612 Mount Pleasant Road, R. R. #2, BRANTFORD, ON, N3T-5L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PAUL ROOYAKKERS

To DIVERSICARE CANADA MANAGEMENT SERVICES CO., 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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

Order / Ordre :

A. The licensee shall develop and submit a plan for the assessment of residents admitted for a specified program and the development of an accurate, current, plan of care that will be maintained to provide clear direction to staff and others who provide care to the resident, throughout the duration of the resident's stay. The plan shall be implemented.

The plan shall be submitted electronically to Nursing Inspector Debora Saville, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office at debora.saville@ontario.ca by November 25, 2011.

Grounds / Motifs :

1. The licensee failed to ensure that the care plan sets out the planned care for the resident and clear directions to staff and others who provide direct care to the resident.

The licensee has failed to ensure that the care plan for a specified resident sets out clear directions to staff and others who provide direct care to the resident.

a) The plan of care in effect for a specified resident on September 23, 2011 stated that the resident had a medical device. Physician order requests the removal of the medical device. Progress notes indicate that the medical device was removed. No other directions are provided for staff.

b) A specified resident was observed sitting in a specified chair on September 21, 22 and 23, 2011. This chair acts as a restraint in that it prevents the resident from rising independently. The use of this chair is not included in the plan of care, repositioning and checking routines are not identified for staff to follow.

c) A specified resident was identified to be having difficulty with choking - no direction was provided for staff to ensure that the resident was in an upright position during meals. The resident was observed in a reclined achair for meals observed on September 21, 22, and 23, 2011. It is noted that the resident was in a wheelchair for lunch on September 23, 2011. (192)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 25, 2011

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change;
(b) the care set out in the plan is no longer necessary; or
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Order / Ordre :

A. The licensee shall develop and submit a plan to ensure that all future admissions to a specified program are reassessed and the care plan reviewed and revised with any change in the resident's care needs. This plan shall be implemented.

The plan shall be submitted electronically to Nursing Inspector Debora Saville, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office at debora.saville@ontario.ca by the end of business on November 25, 2011.

Grounds / Motifs :

1. The licensee failed to ensure that a specified resident was reassessed when there were changes to his care needs.
a) The specified resident developed inflammation of a specified area following a fall that resulted in injury. No Head to Toe skin assessment was completed for this resident at the time of admission, but notes reviewed from the time of admission did not indicate any preexisting inflammation of the area. The specified resident sustained a fall that resulted in injury. Discussion with Director of Care confirms that redness and inflammation to the area was not documented at the time of admission and that the resident appears to be experiencing an inflammation possibly related to infection. The physician was not notified of the increased redness, edema and inflammation.
b) The specified resident was identified to have had choking episodes. A referral to the Registered Dietitian was requested, but had not been completed. No assessment of the resident's positioning needs was completed. The resident was observed to be positioned in a reclined position for all meals observed September 21, 22, and 23, 2011 increasing his risk of choking.
c) The specified resident was admitted with a medical device in place. The medical device was removed, no treatment plan was established with this change in care needs. (192)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 25, 2011

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. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Order / Ordre :

The licensee shall ensure that a system is in place to ensure the timely access and placement of equipment, supplies, devices and assistive aids required under the falls prevention and management program.

Grounds / Motifs :

1. The licensee failed to ensure that equipment, supplies, devices and assistive aids referred to in subsection 49 (1) are readily available at the home.
A specified resident was admitted. At the time of admission it was identified that the resident had a history of falls and that a bed alarm was required. The resident sustained falls, one resulting in use of a specified chair that prevented him from mobilizing independently. No bed alarm was available for three days from admission. Documentation indicates that the resident spent night and day in the specified chair because the bed alarm was not available. No follow-up was made with maintenance. The Director of Care confirms that the bed alarm was not available and that there was no follow-up with maintenance to secure a bed alarm for the resident. (192)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2011

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. 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 :

A) The licensee shall develop and submit a plan that includes the re-instruction all registered staff related to the Falls Prevention Program specifically including the process for completing head injury routine, the circumstances under which head injury routine is to be initiated, the duration of the assessment period and the location of related documentation for assessments completed. In addition, the plan shall include implementation of an auditing process to ensure that when an incident occurs that should trigger the initiation of head injury routine, this assessment is initiated, documented and evaluated.
B) The plan shall include re-instruction of all staff related to the Falls Prevention Program specifically including strategies to minimize the risk of falls and mitigation of injury related to falls.

The plan shall be implemented.

The plan shall be submitted electronically to Nursing Inspector Debora Saville, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office at debora.saville@ontario.ca by November 25, 2011.

Grounds / Motifs :

1. The licensee failed to ensure that the policy related to Fall Prevention and Management (NM-II-F005) dated December 2009 was complied with. The policy requires:
a) that "head injury routine be implemented if trauma to the head is suspected, or if the resident is on anticoagulant therapy or if it was an unwitnessed fall."
A specified resident sustained falls. The second fall resulted in an injury. Documentation in the progress notes indicates that head injury routine was initiated and that the resident's blood pressure was elevated. No documentation of the Head Injury routine could be provided by the home. The Director of Care and Assistant Director of Care were unable to locate the head injury documentation.
b) "plan and implement corrective actions immediately, e.g. bedrail, bed/chair alarm, proper footwear, monitoring protocol, adequate lighting, dry floor etc."
A specified resident was placed in a chair that prevented independent mobility and acted as a restraint following falls. No other immediate corrective actions were trialed. A bed alarm, had been requested at the time of admission, but was not available. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 15, 2011

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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 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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of November, 2011

Signature of Inspector / Signature de l'inspecteur : Debora Saville

Name of Inspector / Nom de l'inspecteur : DEBORA SAVILLE

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