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
May 24, 2019	2019_575214_0007	003748-19	Critical Incident System

Licensee/Titulaire de permis

Henley House Limited
200 Ronson Drive Suite 305 TORONTO ON M9W 5Z9

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

The Henley House
20 Ernest Street St. Catharines ON L2N 7T2

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

CATHY FEDIASH (214)

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 21, 22, 26, March 5, 8, 15, 21, April 2, 2019.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Assistant Director of Care (ADOC); Registered staff; Personal Support Workers (PSW's); Physician; Physiotherapist (PT); Resident Assessment Instrument (RAI) Coordinator; Unit Clerk; Director of Quality and Innovation; Chief Operating Officer and residents.

During the course of the inspection, the inspector(s) observed staff to resident interactions and the provision of care; reviewed Critical Incident System (CIS) submission; resident clinical records; relevant policies and procedures; the home's internal investigation notes; and staff training records

The following Inspection Protocols were used during this inspection: Hospitalization and Change in Condition

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

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

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

WN #1: The Licensee has failed to comply with 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 plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with s. 8(1)(a)(b) which requires every licensee of a long-term care home to ensure that there is an organized program of nursing services for the home to meet the assessed needs of the residents; and an organized program of personal support services for the home to meet the assessed needs of the residents.

A review of CIS #2909-000004-19, submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, indicated that resident #001 required a specified level of assistance with an activity of daily living (ADL). On a specified date, an identified alteration of the resident's skin integrity was noted. The CIS indicated that the resident had an identified symptom to a specified area on their body.

On the following morning, staff noted that resident #001 had difficulty with an identified action during a specified ADL. An identified person was notified and a specified test was ordered. The CIS indicated that on the following morning, the specified test was conducted. The test indicated an identified outcome and the resident was transferred to an identified location the same day where an identified diagnoses was confirmed. A specified treatment was given and they were transferred back to the long term care facility the same day.

1. A review of the licensee's policy titled, "Lifts & Transfers-General" (05-42 and dated with a revision date of December 2017) and in place at the time of this inspection, indicated the following:

• Staff is responsible to check the care plan and be aware of the identified assessed ADL for each resident. Any difficulties with the assessed ADL or change in resident are to be reported to the Charge nurse immediately.

• At any time, if staff feel a resident's ADL status needs to be upgraded they are to alert the unit lead immediately. For the safety of the resident and staff, a resident's ADL technique may be upgraded by the unit lead until a proper identified assessment can be completed. The unit lead will complete the identified assessment in Point Click Care (PCC) and instruct staff on proper technique to be used. Referral for an identified re-assessment is to be completed and resident is to be reassessed by an identified resource for proper techniques to conduct the identified ADL.

• A specified device is to be used for:

-all residents who are non weight bearing;
-all residents who are unreliable & uncooperative

2. A review of the licensee's policy titled, "Lift & Transfer Assessment" (05-45 and dated with a revision date of September 2013) and in place at the time of this inspection, indicated the following:

• The Physiotherapist or Registered staff member will complete an identified assessment in PCC:

-On return from hospital;
-At significant change in health status

• The PSW will: Inform the registered staff member of any change in the resident's status affecting the identified ADL for reassessment and care plan revision.

3. A review of the licensee's policy titled, "Incident Reporting" (08-41 and dated with a revision date of October 2016) and in place at the time of this inspection, indicated the following:

• Any unexpected situation or event which results in an unsafe situation causing harm or potential harm to the resident will be investigated on an identified Incident Investigation form and the Risk Management Tool completed in PCC.

The registered staff member will complete, in full, a new incident in the Risk Management section in PCC for the following:

-unexplained, identified symptoms, on movement.

NOTE: An identified person confirmed that it was the licensee's expectation that PSW's would report unexplained identified symptoms on movement, to registered staff in order to complete a new incident in the Risk Management section in PCC.

4. A review of the licensee's policy titled, "Incident Investigation" (02-19 and dated February 2017) and in place at the time of this inspection, indicated the following:

Under Tips for Note taking, it indicated that:

Notes are very important part of any investigation.
Notes need to be done IMMEDIATELY or as soon as possible after an incident.

- Number your pages - number your pages with black pen and date each page.

- Never leave blank spaces or several empty lines

- Ensure your notes are legible for others to review.

- At the end of the notes, sign immediately after the last sentence. Make sure every note that is part of the investigation is signed and dated by the note maker.

Under Interview Guidelines:

- Spell out the full names of all parties involved; do not just use first names.

- Always print your name and witness name beside signatures.

- Always use the Statement Checklist form prior to any interview.

- Allow interviewee to review completed statement and make additions or changes as they wish.

• Sign all written statements and have them witnessed.

Under Interview of Witness who is a Staff Member:

• Give the witness an identified form and ask them to write or print out their statement. When complete, read over it privately while the witness waits. Write out questions that you want to ask after reading their statement. Go back in and ask your questions and record their answers with the assistance of the note taker. If the note taker is able to record the interview in a written form that is legible, you may use it as the actual statement. If not, after the interview, take some time to go over the notes with the note taker and transcribe the interview on computer so it is clear and legible. Then have the witness review this statement and make any additions or changes then sign.

a) A review of the home's investigative notes indicated that the home had conducted an interview on an identified date, with staff #101, who indicated that on a specified evening, they were conducting an identified ADL for resident #001, with staff #107.

Staff #101 indicated specified actions that took place during the ADL. Staff #101 indicated that while conducting the specified ADL, the resident had verbalized an identified symptom and then staff #101 and #107, completed the ADL.

Staff #101 indicated that following completion of the ADL, they looked but did not see anything wrong. Staff #101 indicated that the specified ADL happened really fast and that they had not reported this to the nurse. Staff #101 indicated that the resident had verbalized an identified symptom in the past, but thought that something may have happened during completion of the identified ADL.

During an interview with staff #101 and the MOHLTC Inspector on an identified date, they confirmed specified actions that took place during the ADL. Staff #101 indicated that during the ADL, the resident verbalized an identified symptom to a specified area on their body. The MOHLTC Inspector asked why a specific action had not taken place during the ADL and the staff indicated that they had not thought about that action. Staff #101 indicated that when the ADL was completed, the resident had not verbalized or showed any identified symptoms.

The MOHLTC Inspector asked regarding documentation of the resident's identified actions during the ADL, as noted in the home's investigative notes. Staff #101 described the identified actions and confirmed that these actions had not occurred when completing

the specified ADL in the past, that the staff member had been present for. Staff #101 stated that they had not reported this identified event to the charge nurse.

A review of a document dated with a specified date and confirmed with the DOC, indicated that staff #101 was no longer employed at the long term care home for identified reasons.

b) A review of the home's investigative notes indicated that staff #108 had indicated that on an identified date, during a specific time of the day, resident #001, had demonstrated an identified outcome during participation in a specified ADL. The notes indicated that staff #105 had heard staff #108 verbalize a specified direction to resident #001, during the ADL.

During an interview with staff #108 on an identified date, they indicated that resident #001 had demonstrated an identified outcome during participation in a specified ADL and that they verbalized a specified direction to the resident. The staff member indicated that this was not new and that a few times in the past, the resident demonstrated the specified actions during the ADL. Staff #108 indicated that they verbalized what had occurred during the ADL, the same day, to staff #105.

A review of the home's investigative notes indicated that staff #105, had documented on an identified date, that resident #001 had demonstrated an identified outcome during participation in a specified ADL and that sometimes the resident had not done a specified action and staff needed to verbalize a specific direction to the resident. Staff #105 documented they had not received any reports regarding this resident during their shift.

The MOHLTC Inspector interviewed staff #105 on an identified date. The staff member indicated they overheard staff #108 verbalize a specific direction to the resident. Staff #105 indicated that they had assumed the resident had demonstrated the identified outcome and had not assessed the resident in relation to this assumption. Staff #105 confirmed that they had documented their assumption in the home's investigative notes; however, had not documented this information in the resident's clinical record or in the Risk Management section in PCC and had not assessed the resident for the use of a specified device. An interview with the DOC on a specified date, confirmed that the identified outcome of the resident during the ADL was an unreliable outcome.

A review of a document dated with a specified date and confirmed with the Administrator, indicated that staff #105 received an identified outcome for awareness of resident #001's

identified actions and outcome during the ADL and not reporting, documenting, assessing or investigating this information.

c) A review of resident #001's progress notes indicated that on an identified date and time, documentation indicated that PSW staff reported to staff #103 that the resident had an identified alteration to their skin integrity. Staff #103 assessed and documented identified details of their assessment and verbalization of an identified symptom by the resident. The progress note indicated that the orders section in PCC had been updated for specified monitoring of the altered skin integrity and a message left for the Power of Attorney (POA) and a note was made in the doctor's book.

A review of the home's investigative notes indicated that staff #112, had documented that on the evening of a specified date, staff #110 had assisted them with an identified ADL for resident #001. Staff #112 indicated that when they assisted the resident with the identified ADL, the resident verbalized an identified symptom. Upon completion of the identified ADL, they noticed the resident had an identified area of altered skin integrity and staff #112 reported the above information to staff #103.

During an interview with staff #112 on an identified date, with the MOHLTC Inspector, they indicated that staff #110 was assisting them with an identified ADL for resident #001. The staff member indicated that during the ADL, the resident verbalized a specified symptom. Staff #112 said that the resident had difficulty with the identified ADL. Staff #112 indicated that upon completion of the ADL, they observed an identified alteration to the resident's skin integrity. Staff #112 confirmed that the identified ADL had been completed without any identified incident. Staff #112 indicated they reported the resident's verbalized symptom and altered skin integrity, immediately to staff #103.

During an interview with staff #103 on an identified date, they indicated that they had been informed by PSW staff #100 on the evening of an identified date, resident #001 had demonstrated an identified symptom during a specified ADL and staff observed an identified alteration to their skin integrity. Staff #103 indicated that they conducted an identified assessment and the resident's only complaint was verbalization of an identified symptom, following an identified action. The MOHLTC Inspector asked if they had assessed the resident's ability to continue the ADL in the same manner. Staff #103 indicated that they notified staff #120 and asked them to assess the resident. Staff #103 indicated they had not assessed the resident's ability to continue the ADL, in the same manner.

During an interview with staff #120 on an identified date, with the MOHLTC Inspector, they indicated that staff #103 and #112 had notified them on an identified date, that resident #001 had a specified alteration to their skin integrity and asked them to assess. Staff #120 described their observations of the specified alteration to the resident's skin integrity and that the resident verbalized a specified symptom, when asked. The staff described specified details of their assessment and the resident's response to the assessment, including verbalization of a specified symptom to an identified area. The staff member indicated that they asked staff #103 to complete an identified assessment; administer identified drugs and to monitor the alteration to the resident's skin integrity.

A review of the resident's progress notes and assessment section in PCC, indicated that a specified assessment and a specified referral note had not been completed following this ADL and identification of altered skin integrity. During an interview with the MOHLTC Inspector on an identified date, staff #103 indicated that they had not assessed the resident's ability to continue the ADL in the current manner.

d) A review of resident #001's progress notes dated with an identified date and time, indicated that a referral to an identified resource was made by staff #105, for a request to assess for specified equipment for an identified reason. The progress note indicated that the resident had an identified alteration to their skin integrity and verbalized a specified symptom. The progress note indicated that the resident was not able to perform a specified action.

A review of the home's investigative notes indicated that staff #105 had documented that on an identified date, they assessed resident #001, prior to performing a specified ADL and noted an identified area of altered skin integrity. They indicated that again, the resident had demonstrated a specified action and specified symptom.

During an interview with staff #105 on an identified date, they indicated that on a specified date and time of day, they assisted staff #106 to complete an identified ADL with resident #001. Staff #105 indicated they performed a specified action during the ADL as the resident was not able to participate in the manner they had been previously assessed to. The staff member indicated that the resident verbalized a specified symptom and pointed to an identified area on their body. The staff member indicated they administered a specified drug. The MOHLTC Inspector asked the staff member if the resident was re-assessed for their ability to perform the ADL, and an identified device implemented following this ADL in which the resident was not able to participate in the

manner they had previously been assessed to. The staff member indicated that this was their mistake and provided an identified reason why and that a specified assessment had not been completed.

e) A review of the homes investigative notes indicated that staff #104 had documented that on an identified date, they assisted the resident with a specified ADL. Staff #104 indicated that they had noticed that the resident had an identified alteration to their skin integrity and had verbalized a specified symptom and that they reported this to staff #103.

An interview was conducted with staff #104 and the MOHLTC Inspector, on an identified date. The staff member confirmed they had worked on a specified date and time. The staff member indicated that on this date, they were preparing to perform an identified ADL with resident #001 and just before the ADL, they noticed an identified alteration to the resident's skin integrity. Staff #104 indicated that they went immediately to report the altered skin integrity to staff #103. Staff #104 confirmed they were not aware of the altered skin integrity, prior to this. Staff #104 indicated that staff #103 indicated they were aware of the altered skin integrity and that a specified test was to be completed the following day. Staff #104 indicated that they and staff #101 then provided the identified ADL and the resident verbalized an identified symptom. The MOHLTC Inspector asked if the resident was able to perform an identified action during the ADL and staff #104 indicated that the resident was able to and described other specified actions that had occurred to the resident during the ADL. Staff #104 indicated they thought the resident may have been demonstrating an identified symptom. Staff #104 indicated they then assisted the resident with a different specified ADL. The MOHLTC Inspector asked if the resident was able to perform a specific action during the different ADL and if they had an identified symptom. Staff #104 indicated that the resident was able to perform the specified action and that they had verbalized the identified symptom. Staff #104 indicated that they asked the resident the location of the identified symptom and the resident rubbed an identified area on their body. Staff #104 were asked if they reported the resident's actions during the first ADL and their verbalization of the identified symptom to the charge nurse. Staff #104 indicated that they informed staff #103 of the alteration to the residents skin integrity and their specified verbalized symptom; however, could not remember if they reported the resident's specified actions during the ADL and thought that the resident had been demonstrating a different, identified symptom. The MOHLTC Inspector asked staff #104 if they had received a report at the start of their shift indicating the resident's altered skin integrity and the previous actions demonstrated by the resident during the identified ADL, on the previous shift. Staff #104 indicated that

they had not been made aware or they would not have performed the specified ADL with the resident in the manner that they had.

An interview with staff #103 was conducted, on an identified date. The MOHLTC Inspector had asked if the staff member had received a report regarding resident #001 at the start of their shift. Staff #103 indicated that they received a report that the resident had verbalized an identified symptom and that identified altered skin integrity remained. Staff #103 indicated that staff #105 had asked them to notify the physician of the resident's altered skin integrity and to ask for a specified test. Staff #103 indicated that they first assessed the resident before calling the physician and checked the altered skin integrity which was not demonstrating an identified symptom but that the resident verbalized a different identified symptom. Staff #103 indicated that they called the physician and obtained an order for a specified test and informed the POA. The MOHLTC Inspector asked if they had been made aware of the resident's abilities in performing an identified ADL, earlier on this date. Staff #103 indicated that staff #105 had verbalized an identified outcome with the resident during the specified ADL, that had occurred earlier in the day. The MOHLTC Inspector asked if they were aware of who assisted the resident with their specified ADL on an identified date and time, and the staff member indicated that staff #101 and 104 had. The staff member indicated that staff #104 had informed them of the resident's alteration to their skin integrity prior to conducting the specified ADL, which the staff member responded that they were aware of the alteration to the resident's skin integrity from the previous evening and that a specified test had been ordered. Staff #103 indicated that they verbalized to the staff that the resident had an identified alteration to their skin integrity and to call if any problems with the specified ADL and that no one reported any identified outcomes to them on this shift.

f) A review of resident #001's progress notes for an identified date and time, indicated that a specified test had been conducted. The test indicated an identified outcome and the resident was transferred to an identified location the same day where an identified diagnoses was confirmed. A specified treatment was given and they were transferred back to the long term care facility the same day.

A review of an identified progress note on a specified date and time, indicated that a referral to an identified resource was documented for the reason of assessing the resident's abilities for a specified ADL due to an identified diagnoses.

A progress note dated later on the same date, indicated that the resident had returned

back to the long term care facility with an identified diagnoses and a specific treatment in place.

A specified progress note dated the following day and signed by an identified person indicated that staff were to perform the identified ADL using specified equipment.

Review of the resident's clinical record indicated that an identified assessment in PCC had not been completed for the resident on their return from an identified location and with an identified diagnoses.

A review of the resident's clinical records indicated that the first assessment for the resident's ability to perform an identified ADL, following their return from an identified location, was dated eight days later. The assessment signed by staff #123, indicated that the reason for referral was for an identified diagnoses. Under the analysis section of this assessment, it was indicated that the resident was able to perform the identified ADL in a specified manner prior to their new diagnoses and were now assessed as requiring the use of specified equipment.

g) During this inspection, the census review was increased to include two other residents who had been transferred to a specified location for identified reasons. A review of a progress note for resident #003, dated on an identified date and time, indicated that the resident was transferred to a specified location for an identified reason. A progress note dated the following day, indicated that the resident would be staying at an identified location to receive treatment for a specified diagnoses.

A review of a specified progress note on an identified date, for a referral to an identified resource, indicated that the resident had returned back to the long term care facility and required an identified assessment related to a specified diagnoses.

Review of five progress notes dated over a period of eight identified dates, following the residents return back to the long term care facility, indicated that the resident had been demonstrating an identified symptom and/or an identified outcome.

A progress note dated 20 days following the residents return back to the long term care home, indicated that a request for referral to an identified resource had been completed and indicated that the POA requested the resident to have a specified treatment as they were demonstrating a specific symptom due to an identified diagnoses.

A review of the resident's clinical records indicated that an identified assessment in PCC had not been completed on the resident's return from an identified location. The first assessment following their return back to the long term care home, was dated 33 days later.

h) A review of the home's investigative notes indicated that the home had obtained an identified number of staff statements and conducted an identified number of staff interviews. A review of these statements and interviews indicated the following:

For staff statements:

-All staff statements were written or typed on plain paper. A statement continuation form was not provided for any of the statements obtained.

-The statement pages were observed to have not been numbered.

-Three of the staff statements had not included the full name of the staff member. One contained initials; one contained the first initial and last name and one contained the first name only.

-One staff statement contained no date to identify when it had been written.

-The staff statements ranged in documented dates of completion over an identified period of five days. A review of the staff interviews indicated that the first interview was documented as occurring six business days after receiving the last staff statement and the last interview was documented as occurring 11 business days after receiving the last staff statement.

For staff interviews:

-Two interviews were observed to have been written on plain paper and eight interviews were observed to have been documented on a form titled, "Witness Statement Continuation".

-Two interviews were observed to not contain page numbers.

-One interview was observed to have page numbers documented as starting at page seven of thirteen with no explanation as to where page one to six was located. An

interview with the DOC indicated that pages one to six were in relation to a separate issue and not this CIS.

-One staff interview was observed to have a staff response that stopped in mid-sentence with a blank space following and then resumed with a question. An interview with the DOC indicated that it was thought that the staff member had stopped speaking in mid-sentence.

-The staff interviews were observed to all be handwritten and documented by more than one person. Three of the staff interviews were mostly illegible and required the MOHLTC Inspector to review these interviews with the DOC, who was not the transcriber of the interviews. The transcriber of the interviews was no longer employed at the facility.

-Nine of the staff interviews were observed to not be signed off after the last sentence.

-One of the staff interviews which was documented in handwriting, had been documented by two different persons requiring clarification from the DOC that the interview conducted was the same interview that had been documented by two different persons.

-While the staff interviews identified who was present for the interview, they had not identified who was asking the interview questions and who was documenting the responses and had not contained the printed name and witness name, including signatures.

-All staff interviews observed had contained no documentation that the interviewee reviewed the completed statements and whether any additions or changes were made. All staff interviews were observed to have not been signed by the interviewee.

During an interview with an identified person, they confirmed that the homes investigative polices were not followed and that they were unable to read the staff interviews as they were not legible. [s. 8. (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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A review of a progress note for resident #003, with a specified date and time, indicated that the resident was transferred to an identified location for a specified reason. A progress note dated the following day, indicated that the resident would be staying at an identified location to receive treatment for a specified diagnoses. A review of a specified progress note dated four days later, for a referral to an identified resource, indicated that the resident had returned back to the long term care facility and required an identified assessment related to a specified diagnoses.

A review of the resident's electronic care plan for an identified ADL following their return back to the long term care facility, indicated that their care plan was reviewed and revised from previously requiring an identified level of assistance, to now requiring a higher identified level of assistance to complete the identified ADL. The date of revision for this ADL intervention was 30 days following their return back to the long term care facility.

A review of a progress note dated on the date of the resident's return back to the long term care facility, indicated that a referral had been sent to an identified resource, indicating the resident's return back to the facility; their identified diagnoses and request for a specified assessment.

A progress note dated 20 days later, indicated that a referral to the same identified resource had been completed and indicated that the POA requested the resident to have a specified treatment due to their identified diagnoses.

A review of the resident's clinical records indicated that an identified assessment in PCC had been completed by the identified resource, staff #123, 35 days following the residents return back to the long term care facility.

During an interview with staff #123 on an identified date, the MOHLTC Inspector inquired regarding what had occurred when the initial identified referral was sent on the date of the resident's return to the facility and when a second identified referral was sent again 20 days later. Staff #123 indicated that they had a meeting with the home's management in an identified month and year, regarding how to obtain the specified referrals as they had been checking a specified area of data in PCC and did not feel that they had received all of the identified referrals. Staff #123 confirmed that they were informed to run a report of an identified progress note type. Staff #123 indicated that this may have been one of the times when the identified referral note for resident #003 had not been in a specified area of data on PCC and may have been missed. Staff #123 indicated that they did not know exactly why the initial identified referral had not been received. The MOHLTC Inspector inquired when would staff #123 complete a specified assessment for a resident and staff #123 indicated that they would complete this assessment on admission; quarterly and with a significant change in the resident's status.

A review of the resident's assessments and progress notes in PCC, following their return back to the long term care facility, had not identified that the specified assessment had been completed until 35 days following the residents return back to the long term care facility.

During an interview with staff #128 on an identified date, they verbalized the resident's specified ADL plan of care had not been revised until 30 days following the residents return to the long term care facility , following a conversation that they had with PSW staff who indicated that the resident now required an identified level of assistance with a

specified ADL. Staff #128 confirmed that PSW staff were not able to assess the resident's identified level of assistance for this ADL and that resident #003's specified ADL plan of care had not been based on an assessment of their needs and preferences. [s. 6. (2)]

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

A review of CIS #2909-000004-19, submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, indicated that resident #001 required a specified level of assistance with an activity of daily living (ADL). On a specified date, an identified alteration of the resident's skin integrity was noted. The CIS indicated that the resident had an identified symptom to a specified area on their body.

On the following morning, staff noted that resident #001 had difficulty with an identified action during a specified ADL. An identified person was notified and a specified test was ordered. The CIS indicated that on the following morning, the specified test was conducted. The test indicated an identified outcome and the resident was transferred to an identified location the same day where an identified diagnoses was confirmed. A specified treatment was given and they were transferred back to the long term care facility the same day.

Review of a progress note dated on a specified date and time, indicated that, resident #001 had an identified alteration to their skin integrity, of an unknown cause. A progress noted dated two days later, indicated the resident had an identified diagnoses.

A review of the residents current, electronic care plan, in place just prior to the CIS, indicated under three specified ADL's, that the resident required an identified level of assistance to complete these ADL's.

A review of events leading up to the CIS indicated the following:

a) A review of the home's investigative notes indicated that the home had conducted an interview with staff #114, who identified they had worked on a specified shift on an identified date and were supervising staff #127 as they did not know the floor. Staff #114 indicated that they had not provided any hands on care to resident #001 on this shift, as staff #127 had completed an identified ADL.

A review of the home's investigative notes indicated that the home had conducted an interview with staff #127, who identified they had worked the specified shift on the identified date. They indicated that for identified reasons, the full time staff on the identified unit was not present and they replaced them on this unit. They indicated that staff #114 had told them which resident's required care and that they helped them. Staff #127 indicated that they had completed specified care task's for resident #001 in an identified manner.

During an interview with staff #114, the confirmed they worked on a specified shift on an identified date. The staff member indicated that they were in an identified area; however did not provide any specified care directly and that staff #127 had completed an identified ADL. Staff #114 indicated that the resident was smiling and had not verbalized or showed an identified symptom.

During an interview with staff #127, they confirmed they worked on a specified shift on an identified date and had provided care to resident #001. The staff member indicated that they completed an identified ADL task with an identified level of assistance. Staff #127 indicated that they normally worked in another identified position. They indicated that they were aware of the identified level of assistance that the resident required for specified ADL's, but that many times, the required level of assistance was not always available. Staff #127 indicated that they had not been trained on resident #001's care; that it was the first time they provided care to the resident; they had not had a chance to review their care plan and were not aware which residents required identified levels of assistance.

b) A review of the home's investigative notes indicated that the home had conducted an interview with staff #115, who confirmed they had worked on an identified shift and date. The staff member confirmed they had provided care to resident #001 around a specified time. The staff member indicated that they completed an identified task for the resident. The investigative notes indicated that the staff was asked what the resident's care plan said regarding the identified task that the staff member had completed, and it was identified as requiring a specified level of assistance that had not been provided.

During an interview with staff #115, it was confirmed that the staff member had worked a specified shift on an identified date and had provided care to resident #001. The staff member indicated that they provided two specified task's. The staff member indicated they were aware that the resident required an identified level of assistance for these specified tasks; however, indicated that they only received assistance with three or four

residents.

c) A review of the home's investigative notes indicated that the home had conducted an interview with staff #117, who confirmed they had worked a specified shift on an identified date and had provided care to resident #001. The staff member indicated that they provided an identified ADL to the resident.

During an interview with staff #117, it was confirmed that the staff member had worked the specified shift on an identified date and had provided care to resident #001. The staff member indicated that they had provided an identified ADL to the resident in a specified manner and were aware that the resident required the identified ADL to be provided in a different specified manner. The staff member indicated that there is not always the amount of assistance available to provide the identified ADL in the manner required. [s. 6. (7)]

3. The licensee failed to ensure that the resident was 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 was no longer necessary.

a) A review of CIS #2909-000004-19, submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, indicated that resident #001 required a specified level of assistance with an activity of daily living (ADL). On a specified date, an identified alteration of the resident's skin integrity was noted. The CIS indicated that the resident had an identified symptom to a specified area on their body.

On the following morning, staff noted that resident #001 had difficulty with an identified action during a specified ADL. An identified person was notified and a specified test was ordered. The CIS indicated that on the following morning, the specified test was conducted. The test indicated an identified outcome and the resident was transferred to an identified location the same day where an identified diagnoses was confirmed. A specified treatment was given and they were transferred back to the long term care facility the same day.

Review of a progress note dated with an identified date and time, indicated that resident #001 had an identified area of altered skin integrity, of an unknown cause. Progress noted dated two days later, indicated the resident had an identified diagnoses.

A review of resident #001's progress notes indicated that on the date of the identified

diagnoses, a referral note was sent to an identified resource. The progress note indicated that the referral was for an assessment of an identified ADL as the resident had a specified diagnoses and treatment in place.

A specified progress note, dated the following day and signed by an identified person, indicated that staff were able to complete an identified ADL for the resident with specified equipment.

A review of the resident's electronic care plan for an identified ADL, following their return from a specified location, indicated that the resident's care plan was reviewed and revised to include a specified level of assistance and specified equipment that was required for the identified ADL. The created date of this intervention was on an identified date which was six days following an identified progress note that indicated that staff were able to perform the identified ADL with specified equipment.

A review of the electronic care plan for the identified ADL, indicated a specified goal for the next four months. The most current revised date for this goal was dated, approximately 20 months prior to this inspection.

An interview with the DOC confirmed that the resident's plan of care, specifically an identified ADL goal had not been reviewed and revised every six months and their plan of care for an identified ADL, had not been reviewed and revised when their care needs changed.

b) During this inspection, the census review was increased to include two other residents who had been transferred to a specified location for identified reasons. A review of a progress note for resident #003, dated on an identified date and time, indicated that the resident was transferred to a specified location for an identified reason. A progress note dated the following day, indicated that the resident would be staying at an identified location to receive treatment for a specified diagnoses.

A review of a specified progress note on an identified date, for a referral to an identified resource, indicated that the resident had returned back to the long term care facility and required an identified assessment related to a specified diagnoses.

Review of five progress notes dated over a period of eight identified dates, following the residents return back to the long term care facility, indicated that the resident had been demonstrating an identified symptom and/or an identified outcome.

A progress note dated 20 days following the residents return back to the long term care home, indicated that a request for referral to an identified resource had been completed and indicated that the POA requested the resident to have a specified treatment as they were demonstrating a specific symptom due to an identified diagnoses.

A review of the resident's electronic care plan for an identified ADL, indicated under interventions that the resident required a specified level of assistance for the ADL. The revised date of this intervention was 29 days following the resident's return to the long term care home.

An interview with staff #128, on an identified date, confirmed that the resident's plan of care in relation to their identified ADL, had not been reviewed and revised when their care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and to 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 the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A review of CIS #2909-000004-19, submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, indicated that resident #001 required a specified level of assistance with an activity of daily living (ADL)). On a specified date, an identified alteration of the resident's skin integrity was noted. The CIS indicated that the resident had an identified symptom to a specified area on their body.

On the following morning, staff noted that resident #001 had difficulty with an identified action during a specified ADL. An identified person was notified and a specified test was ordered. The CIS indicated that on the following morning, the specified test was conducted. The test indicated an identified outcome and the resident was transferred to an identified location the same day where an identified diagnoses was confirmed. A specified treatment was given and they were transferred back to the long term care facility the same day.

Review of a progress note dated on a specified date and time, indicated that, resident #001 had an identified alteration to their skin integrity, of an unknown cause. A progress noted dated two days later, indicated the resident had an identified diagnoses.

A review of events leading up to the CIS indicated the following:

a) A review of resident #001's clinical records on an identified date, included an identified document. This document indicated that the resident had a specified ADL provided on an identified date, by staff #104. A review of the specified ADL task documentation in the Point of Care (POC) documentation system for this identified date, indicated that the resident had the specified ADL provided on this date by staff #100.

During a review of the home's investigative notes, staff #104 had indicated that they had not provided the specified ADL to the resident on the identified date and that staff #100 had verbalized to them that they documented staff #104's initials on the resident's identified document.

During a review of the home's investigative notes, staff #100 indicated that they documented on the resident's POC task for an identified ADL on a specified date and had documented on the other identified document that staff #104 had completed the

resident's identified ADL. During an interview with staff #100, they indicated that there had been changes to an identified schedule on the specified date and they thought the resident had received their ADL on this date and documented another staff's initials in error on both the identified document and in the POC task documentation. Staff #100 indicated that the resident received their identified ADL the day prior by staff #107.

A review of the resident's identified ADL documentation, had not identified any documentation that the resident received a specified ADL on the date that was indicated. During a review of the home's investigative notes, staff #107 had indicated that the specified ADL was provided by them on the date that was indicated.

During an interview with staff #107, they confirmed that they had provided the specified ADL to resident #001 on the indicated date; however, had not documented this ADL as they were not aware that they could document an provided ADL as needed (prn).

An interview with staff #120, confirmed that the resident had not received their identified ADL on the identified date it had been documented and no documentation was in place for the identified ADL that the resident had received the day prior.

b) A review of the home's investigative notes indicated that staff #108 had indicated that on an identified date, during a specific time of the day, resident #001, had demonstrated an identified outcome during participation in a specified ADL. The notes indicated that staff #105 had heard staff #108 verbalize a specified direction to resident #001, during the ADL.

A review of an identified POC task, indicated that on this date, the resident had a specified ADL completed by staff #108 at an identified time of the day.

An interview with staff #108 on an identified date, indicated that staff on the previous shift had initiated the specified ADL. Staff #108 indicated that when they arrived for their shift on this date, they assisted the resident with the specified ADL that the previous shift had initiated. They indicated they had documented for providing the specified ADL task on this date as the task in POC was set up for their specified shift and the shift following; however not for the shift prior to the one they worked, and were unsure what they should document. Staff #108 confirmed that resident #001 had demonstrated an identified outcome during participation in a specified ADL and that they verbalized a specified direction to the resident. The staff member indicated that this was not new and that a few times in the past, the resident demonstrated the specified actions during the ADL. Staff

#108 indicated that they verbalized what had occurred during the ADL, the same day, to staff #105.

A review of the home's investigative notes indicated that staff #105, had documented on an identified date, that resident #001 had demonstrated an identified outcome during participation in a specified ADL and that sometimes the resident had not done a specified action and staff needed to verbalize a specific direction to the resident. Staff #105 documented they had not received any reports regarding this resident during their shift.

A review of the resident's progress notes for this identified date, had not identified any documentation regarding the need to verbalize the specified direction to the resident and had not included any documented assessments or interventions, in response.

During an interview with staff #105, on an identified date, they indicated they overheard staff #108 verbalize a specific direction to the resident. Staff #105 indicated that they had assumed the resident had demonstrated the identified outcome and had not assessed the resident in relation to this assumption. Staff #105 confirmed that they had documented their assumption in the home's investigative notes; however, had not documented this information in the resident's clinical record or in the Risk Management section in PCC.

c) A review of the home's investigative notes indicated that staff #103 had documented on an identified date and time, that staff reported to them that resident #001 had an identified alteration to their skin integrity and that the resident had verbalized an identified symptom. Staff #103, indicated that they immediately reported this to staff #120, who came to assess the resident.

A review of resident #001's progress notes on an identified date, had identified that staff #103 had documented they completed an identified assessment and noted identified alteration to the resident's skin integrity; verbalization of an identified symptom; monitoring of the identified altered skin integrity; and contact made to identified persons. No documentation was noted by staff #120 of their assessment, including interventions put into place or the resident's response to the interventions.

During an interview with staff #120 on an identified date, they indicated that on a specified date, they were informed of the resident's altered skin integrity and assessed the resident. They indicated what they had observed while conducing the assessment, including the residents verbalization of an identified symptom. Staff #120 indicated that

they directed staff #103 to conduct a specified assessment; administer identified drugs and to monitor the area of altered skin integrity. The staff member indicated that the resident's identified symptom was at an identified degree.

Staff #120 confirmed that they had not documented their assessment, including any interventions or the resident's response to the interventions as they felt this would be double documenting.

d) A review of the home's investigative notes indicated that staff #105 had documented on an identified date and time that they had assessed resident #001and noted an identified alteration to their skin integrity to a specified area. They indicated that again, the resident demonstrated an identified outcome following assistance with a specified ADL and the resident's verbalization of a specified symptom. Staff #105 documented that they asked staff #126 to assess an identified area on the resident's body.

During an interview with staff #105, they confirmed that on the identified date, they asked staff #126 to assess resident #001 and that staff #126 did assess the resident and indicated to contact an identified person for a specified reason.

A review of resident #001's progress notes for this date, had not included any documentation that staff #105 had asked staff #126 to assess the resident.

During an interview with staff #126 on an identified date, they confirmed that they had been asked by staff #105 to assess resident #001 on a specified date. They indicated that they had not observed the alteration to the resident's skin integrity for a specified reason; however, they did conduct a specified action and indicated that the resident verbalized a specified symptom. Staff #126 confirmed they indicated to staff #105 to contact an identified person for a specified reason. Staff #126 confirmed that they had not documented their assessment, including interventions put into place, in the resident's clinical record. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A review of CIS #2909-000004-19, submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, indicated that resident #001 required a specified level of assistance with an activity of daily living (ADL). On a specified date, an identified alteration of the resident's skin integrity was noted. The CIS indicated that the resident had an identified symptom to a specified area on their body.

On the following morning, staff noted that resident #001 had difficulty with an identified action during a specified ADL. An identified person was notified and a specified test was ordered. The CIS indicated that on the following morning, the specified test was conducted. The test indicated an identified outcome and the resident was transferred to an identified location the same day where an identified diagnoses was confirmed. A specified treatment was given and they were transferred back to the long term care facility the same day.

Review of a progress note dated on a specified date and time, indicated that, resident #001 had an identified alteration to their skin integrity, of an unknown cause. A progress noted dated two days later, indicated the resident had an identified diagnoses.

A review of events leading up to the CIS indicated the following:

A review of the home's investigative notes indicated that the home had conducted an interview on an identified date, with staff #101, who indicated that on a specified evening, they were conducting an identified ADL for resident #001, with staff #107.

Staff #101 indicated that they provided an identified action while staff #107 provided an identified ADL. Staff #101 indicated that they and staff #107 then provided another specified ADL and identified actions that the resident demonstrated, including verbalization of a specified symptom, during this ADL.

Staff #101 indicated that following completion of the ADL, they looked but did not see anything wrong. Staff #101 indicated that the specified ADL happened really fast and that they had not reported this to the nurse. Staff #101 indicated that the resident had verbalized an identified symptom in the past, but thought that something may have happened during completion of the identified ADL.

A review of the residents current, electronic care plan, in place just prior to the CIS, indicated under three specified ADL's, that the resident required an identified level of assistance to complete these ADL's and for one of the identified ADL's, it indicated it was to be provided in a specified manner.

During an interview with staff #101 and the MOHLTC Inspector on an identified date, they confirmed specified actions that took place during the ADL. Staff #101 indicated that during the ADL, the resident verbalized an identified symptom to a specified area on their body. The MOHLTC Inspector asked why a specific action had not taken place during the ADL and the staff indicated that they had not thought about that action. Staff #101 indicated that when the ADL was completed, the resident had not verbalized or showed any identified symptoms.

The MOHLTC Inspector asked regarding specified documentation, as noted in the home's investigative notes. Staff #101 described the identified actions and confirmed that these actions had not occurred when completing the specified ADL in the past, that the staff member had been present for. Staff #101 described the ADL had occurred in a specified manner.

The MOHLTC Inspector reviewed the resident's care plan in relation to two identified

ADL's. Staff #101 indicated they were not aware the identified ADL's were to be provided in a specified manner.

Staff #101 stated that the identified ADL had occurred in a specified manner and confirmed that they had not reported the events that occurred with resident #001 to the nurse. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that no person mentioned in subsection (1) of s. 76,

which indicated that all staff at the home had received training as required by this section had performed their responsibilities before receiving training in the following area: s.76 (2) 10., which indicated, All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that were relevant to the person's responsibilities.

A review of CIS #2909-000004-19, submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, indicated that resident #001 required a specified level of assistance with an activity of daily living (ADL). On a specified date, an identified alteration of the resident's skin integrity was noted. The CIS indicated that the resident had an identified symptom to a specified area on their body.

On the following morning, staff noted that resident #001 had difficulty with an identified action during a specified ADL. An identified person was notified and a specified test was ordered. The CIS indicated that on the following morning, the specified test was conducted. The test indicated an identified outcome and the resident was transferred to an identified location the same day where an identified diagnoses was confirmed. A specified treatment was given and they were transferred back to the long term care facility the same day.

a) A review of resident #001's progress notes dated with an identified date and time and completed by staff #123, indicated that they were attempting to obtain specified equipment, with no success. The progress note indicated that they were able to arrange to have a different specified equipment. The progress note further indicated that staff were able to complete an identified ADL with specified equipment. A review of the resident's clinical records in PCC, indicated that an identified assessment, conducted eight days later, was documented by staff #123.

A review of the licensee's policy titled, "Lift & Transfer Assessment", (05-45 with a revised date of September 2013), indicated that staff #123 and other identified staff, would complete a specified assessment in PCC, for specified reasons.

During an interview with staff #123, they indicated that they had commenced employment at the home during an identified month and year. The MOHLTC Inspector had asked if they had received orientation training in regards to the licensee's policies and procedures, specifically, the policy identified above as well as a specified licensee's, mandatory policy. Staff #123, indicated that they had been provided an orientation binder of policies to review and sign off as reviewed and confirmed that they had received this

orientation binder from the home, three days prior. Staff #123 confirmed that they were not aware of the identified assessment and had not received training on orientation in relation to this policy or a specified licensee, mandatory policy.

b) During an interview with staff #121, they confirmed an identified date that staff #107 was hired. During an interview with the DOC, it was indicated that staff #107, had been a new hire at the home. The MOHLTC Inspector requested orientation training documentation in relation to a specified program for staff #107.

The DOC provided a policy titled, "Orientation Program" (08-26 and dated September 2010), which indicated that orientation would consist of a classroom structure where all policies, procedures, mandatory education would be covered. The DOC also provided check list documents titled, "General Orientation Program" and "PSW Orientation Program" and indicated these were checklists that new staff complete during a two day orientation session and that new staff also completed a return demonstration of a specified task in the home during a five day training session while on the floor.

The DOC provided a document titled, "Education Attendance Record" with the topic of presentation indicating General Orientation and dated the same date of hire for staff #107. This document had the name of staff #107 documented as being present on this date for orientation training; however, the education attendance record had not identified what training had occurred this date. A document for the second day of orientation training was unable to be located at the time of this inspection and the DOC confirmed that they were unable to locate the orientation checklists for staff #107 at the time of this inspection. The DOC was unable to confirm that staff #107, had received orientation training in relation to an identified program, prior to performing their responsibilities.

c) During an interview with staff #121, they confirmed an identified date that staff #112 was hired. The MOHLTC Inspector requested orientation training documentation in relation to an identified program for staff #112.

The DOC provided a policy titled, "Orientation Program" (08-26 and dated September 2010), which indicated that orientation would consist of a classroom structure where all policies, procedures, mandatory education would be covered. The DOC also provided check list documents titled, "General Orientation Program" and "PSW Orientation Program" and indicated these were checklists that new staff complete during a two day orientation session and that new staff also completed a return demonstration of a specified task in the home during a five day training session while on the floor.

The DOC was unable to locate the Education Attendance Record sign in sheet for this staff member; however, did provided a "General Orientation Program" and a "PSW Orientation Program" checklist dated the same date that staff #112 was hired and signed with staff #112's name. A review of these checklists had not identified that this staff member had received orientation training in the specified licensee's program. The DOC confirmed on an identified date, that orientation training for staff #112, in relation to the identified program, was unable to be located. [s. 76. (2) 10.]

2. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents annual retraining in accordance with O. Reg. 79/10, s. 219(1) in the area of Transferring and positioning techniques in accordance with O. Reg. 79/10, s. 36 in relation to the following: [76(7) 6]

During an interview with the DOC, it was indicated that the home uses Surge Learning, an online learning management system for their training needs. The DOC indicated that the home conducted specified training in an identified month and year. The DOC indicated that the home had identified that several staff had not had a specified designation assigned in the Surge Learning data base and as a result, did not receive the specified training module assigned to them to complete. The DOC indicated that the home had identified that several staff had their Surge Learning access designated in an identified manner and as a result, had no access to the training module. The DOC indicated that the home identified that some staff were present in the home and completed the training module and then had their access changed to an identified designation.

A review of the home's training records in relation to the specified program in an identified year, indicated that the home had a specified number of direct care staff and that not all direct care staff had received training. The DOC confirmed that not all direct care staff had received training in a specified program. [s. 76. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no person mentioned in subsection (1) of s. 76, which indicates that all staff at the home have received training as required by this section have performed their responsibilities before receiving training in the following area: s.76 (2) 10., which indicates, All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the person's responsibilities and to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents annual retraining in accordance with O. Reg. 79/10, s. 219(1) in the area of Transferring and positioning techniques in accordance with O. Reg. 79/10, s. 36 in relation to the following: [76(7) 6], to be implemented voluntarily.

Issued on this 17th day of June, 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) :	CATHY FEDIASH (214)
Inspection No. / No de l'inspection :	2019_575214_0007
Log No. / No de registre :	003748-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 24, 2019
Licensee / Titulaire de permis :	Henley House Limited 200 Ronson Drive, Suite 305, TORONTO, ON, M9W-5Z9
LTC Home / Foyer de SLD :	The Henley House 20 Ernest Street, St. Catharines, ON, L2N-7T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Heather Colyer

To Henley House Limited, 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)

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, r. 8(1) (b).

Specifically, the licensee must:

a) Conduct mandatory education sessions for all direct care staff including the home's Physiotherapist on the following policies and procedures:

• The licensee's policy titled, "Lifts & Transfers-General" " (05-42 and dated with a revision date of December 2017)

• The licensee's policy titled, "Lift & Transfer Assessment" (05-45 and dated with a revision date of September 2013)

• The licensee's policy titled, "Incident Reporting" (08-41 and dated with a revision date of October 2016)

The education must contain an interdisciplinary approach to identifying, reporting and assessing the lift and transfer needs for resident's who demonstrate any change in their status affecting their lift and or transfer abilities and must contain the following specific components from the above policies and procedures:

• At any time, if staff feel a resident's lift or transfer status needs to be upgraded they are to alert the unit lead immediately. The unit lead will complete the

Primacare Lift and Transfer Assessment in PCC and instruct staff on proper technique to be used. Referral for physiotherapy lift and transfer re-assessment is to be completed and the resident is to be reassessed by physiotherapy for proper lift and transfer techniques.

- The mechanical lift (or transfer machine as appropriate) is to be used for:

  -all residents who are non weight bearing;
  -all residents who are unreliable and uncooperative.

- The Physiotherapist or Registered Staff will complete the Primacare Lift and Transfer Assessment in PCC for residents on return from hospital and at significant change in health status.

- The PSW will inform the registered staff member of any change in the resident's status, including unexplained pain or tenderness on movement, affecting the lift/transfer for reassessment and care plan revision and upon being notified by the PSW, the registered staff will complete, in full, a new incident in the Risk Management section in PCC.

b) Develop and implement an auditing process, at intervals determined by the home, that ensures an interdisciplinary approach to identifying, reporting and assessing the lift and transfer needs for resident #001 and all other residents who demonstrate any change in their status affecting their lift and or transfer abilities. Records will be maintained of audits conducted.

c) Conduct mandatory education sessions for all management staff who are responsible for incident investigations. The educational sessions shall include, but not limited to the following policy and procedure:

The licensee's policy titled, "Incident Investigation" (02-19 and dated February 2017).

Grounds / Motifs :

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 plan, policy, protocol, procedure, strategy or system was in compliance with

and was implemented in accordance with applicable requirements under the Act and in accordance with s. 8(1)(a)(b) which requires every licensee of a long-term care home to ensure that there is an organized program of nursing services for the home to meet the assessed needs of the residents; and an organized program of personal support services for the home to meet the assessed needs of the residents.

A review of CIS #2909-000004-19, submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, indicated that resident#001 required a specified level of assistance with an activity of daily living (ADL). On a specified date, an identified alteration of the resident's skin integrity was noted. The CIS indicated that the resident had an identified symptom to a specified area on their body.

On the following morning, staff noted that resident #001 had difficulty with an identified action during a specified ADL. An identified person was notified and a specified test was ordered. The CIS indicated that on the following morning, the specified test was conducted. The test indicated an identified outcome and the resident was transferred to an identified location the same day where an identified diagnoses was confirmed. A specified treatment was given and they were transferred back to the long term care facility the same day.

1. A review of the licensee's policy titled, "Lifts & Transfers-General" (05-42 and dated with a revision date of December 2017) and in place at the time of this inspection, indicated the following:

• Staff is responsible to check the care plan and be aware of the identified assessed ADL for each resident. Any difficulties with the assessed ADL or change in resident are to be reported to the Charge nurse immediately.

• At any time, if staff feel a resident's ADL status needs to be upgraded they are to alert the unit lead immediately. For the safety of the resident and staff, a resident's ADL technique may be upgraded by the unit lead until a proper identified assessment can be completed. The unit lead will complete the identified assessment in Point Click Care (PCC) and instruct staff on proper technique to be used. Referral for an identified re-assessment is to be completed and resident is to be reassessed by an identified resource for proper

techniques to conduct the identified ADL.

• A specified device is to be used for:

-all residents who are non weight bearing;
-all residents who are unreliable & uncooperative

2. A review of the licensee's policy titled, "Lift & Transfer Assessment" (05-45 and dated with a revision date of September 2013) and in place at the time of this inspection, indicated the following:

• The Physiotherapist or Registered staff member will complete an identified assessment in PCC:

-On return from hospital;
-At significant change in health status

• The PSW will: Inform the registered staff member of any change in the resident's status affecting the identified ADL for reassessment and care plan revision.

3. A review of the licensee's policy titled, "Incident Reporting" (08-41 and dated with a revision date of October 2016) and in place at the time of this inspection, indicated the following:

• Any unexpected situation or event which results in an unsafe situation causing harm or potential harm to the resident will be investigated on an identified Incident Investigation form and the Risk Management Tool completed in PCC.

The registered staff member will complete, in full, a new incident in the Risk Management section in PCC for the following:

-unexplained, identified symptoms, on movement.

NOTE: An identified person confirmed that it was the licensee's expectation that PSW's would report unexplained identified symptoms on movement, to registered staff in order to complete a new incident in the Risk Management

section in PCC.

4. A review of the licensee's policy titled, "Incident Investigation" (02-19 and dated February 2017) and in place at the time of this inspection, indicated the following:

Under Tips for Note taking, it indicated that:

Notes are very important part of any investigation.
Notes need to be done IMMEDIATELY or as soon as possible after an incident.

- Number your pages - number your pages with black pen and date each page.
- Never leave blank spaces or several empty lines
- Ensure your notes are legible for others to review.
- At the end of the notes, sign immediately after the last sentence. Make sure every note that is part of the investigation is signed and dated by the note maker.

Under Interview Guidelines:

- Spell out the full names of all parties involved; do not just use first names.
- Always print your name and witness name beside signatures.
- Always use the Statement Checklist form prior to any interview.
- Allow interviewee to review completed statement and make additions or changes as they wish.
- Sign all written statements and have them witnessed.

Under Interview of Witness who is a Staff Member:

- Give the witness an identified form and ask them to write or print out their

statement. When complete, read over it privately while the witness waits. Write out questions that you want to ask after reading their statement. Go back in and ask your questions and record their answers with the assistance of the note taker. If the note taker is able to record the interview in a written form that is legible, you may use it as the actual statement. If not, after the interview, take some time to go over the notes with the note taker and transcribe the interview on computer so it is clear and legible. Then have the witness review this statement and make any additions or changes then sign.

a) A review of the home's investigative notes indicated that the home had conducted an interview on an identified date, with staff #101, who indicated that on a specified evening, they were conducting an identified ADL for resident #001, with staff #107.

Staff #101 indicated specified actions that took place during the ADL. Staff #101 indicated that while conducting the specified ADL, the resident had verbalized an identified symptom and then staff #101 and #107, completed the ADL.

Staff #101 indicated that following completion of the ADL, they looked but did not see anything wrong. Staff #101 indicated that the specified ADL happened really fast and that they had not reported this to the nurse. Staff #101 indicated that the resident had verbalized an identified symptom in the past, but thought that something may have happened during completion of the identified ADL.

During an interview with staff #101 and the MOHLTC Inspector on an identified date, they confirmed specified actions that took place during the ADL. Staff #101 indicated that during the ADL, the resident verbalized an identified symptom to a specified area on their body. The MOHLTC Inspector asked why a specific action had not taken place during the ADL and the staff indicated that they had not thought about that action. Staff #101 indicated that when the ADL was completed, the resident had not verbalized or showed any identified symptoms.

The MOHLTC Inspector asked regarding documentation of the resident's identified actions during the ADL, as noted in the home's investigative notes. Staff #101 described the identified actions and confirmed that these actions had not occurred when completing the specified ADL in the past, that the staff

member had been present for. Staff #101 stated that they had not reported this identified event to the charge nurse.

A review of a document dated with a specified date and confirmed with the DOC, indicated that staff #101 was no longer employed at the long term care home for identified reasons.

b) A review of the home's investigative notes indicated that staff #108 had indicated that on an identified date, during a specific time of the day, resident #001, had demonstrated an identified outcome during participation in a specified ADL. The notes indicated that staff #105 had heard staff #108 verbalize a specified direction to resident #001, during the ADL.

During an interview with staff #108 on an identified date, they indicated that resident #001 had demonstrated an identified outcome during participation in a specified ADL and that they verbalized a specified direction to the resident. The staff member indicated that this was not new and that a few times in the past, the resident demonstrated the specified actions during the ADL. Staff #108 indicated that they verbalized what had occurred during the ADL, the same day, to staff #105.

A review of the home's investigative notes indicated that staff #105, had documented on an identified date, that resident #001 had demonstrated an identified outcome during participation in a specified ADL and that sometimes the resident had not done a specified action and staff needed to verbalize a specific direction to the resident. Staff #105 documented they had not received any reports regarding this resident during their shift.

The MOHLTC Inspector interviewed staff #105 on an identified date. The staff member indicated they overheard staff #108 verbalize a specific direction to the resident. Staff #105 indicated that they had assumed the resident had demonstrated the identified outcome and had not assessed the resident in relation to this assumption. Staff #105 confirmed that they had documented their assumption in the home's investigative notes; however, had not documented this information in the resident's clinical record or in the Risk Management section in PCC and had not assessed the resident for the use of a specified device. An interview with the DOC on a specified date, confirmed that

the identified outcome of the resident during the ADL was an unreliable outcome.

A review of a document dated with a specified date and confirmed with the Administrator, indicated that staff #105 received an identified outcome for awareness of resident #001's identified actions and outcome during the ADL and not reporting, documenting, assessing or investigating this information.

c) A review of resident #001's progress notes indicated that on an identified date and time, documentation indicated that PSW staff reported to staff #103 that the resident had an identified alteration to their skin integrity. Staff #103 assessed and documented identified details of their assessment and verbalization of an identified symptom by the resident. The progress note indicated that the orders section in PCC had been updated for specified monitoring of the altered skin integrity and a message left for the Power of Attorney (POA) and a note was made in the doctor's book.

A review of the home's investigative notes indicated that staff #112, had documented that on the evening of a specified date, staff #110 had assisted them with an identified ADL for resident #001. Staff #112 indicated that when they assisted the resident with the identified ADL, the resident verbalized an identified symptom. Upon completion of the identified ADL, they noticed the resident had an identified area of altered skin integrity and staff #112 reported the above information to staff #103.

During an interview with staff #112 on an identified date, with the MOHLTC Inspector, they indicated that staff #110 was assisting them with an identified ADL for resident #001. The staff member indicated that during the ADL, the resident verbalized a specified symptom. Staff #112 said that the resident had difficulty with the identified ADL. Staff #112 indicated that upon completion of the ADL, they observed an identified alteration to the resident's skin integrity. Staff #112 confirmed that the identified ADL had been completed without any identified incident. Staff #112 indicated they reported the resident's verbalized symptom and altered skin integrity, immediately to staff #103.

During an interview with staff #103 on an identified date, they indicated that they had been informed by PSW staff #100 on the evening of an identified date,

resident #001 had demonstrated an identified symptom during a specified ADL and staff observed an identified alteration to their skin integrity. Staff #103 indicated that they conducted an identified assessment and the resident's only complaint was verbalization of an identified symptom, following an identified action. The MOHLTC Inspector asked if they had assessed the resident's ability to continue the ADL in the same manner. Staff #103 indicated that they notified staff #120 and asked them to assess the resident. Staff #103 indicated they had not assessed the resident's ability to continue the ADL, in the same manner.

During an interview with staff #120 on an identified date, with the MOHLTC Inspector, they indicated that staff #103 and #112 had notified them on an identified date, that resident #001 had a specified alteration to their skin integrity and asked them to assess. Staff #120 described their observations of the specified alteration to the resident's skin integrity and that the resident verbalized a specified symptom, when asked. The staff described specified details of their assessment and the resident's response to the assessment, including verbalization of a specified symptom to an identified area.
The staff member indicated that they asked staff #103 to complete an identified assessment; administer identified drugs and to monitor the alteration to the resident's skin integrity.

A review of the resident's progress notes and assessment section in PCC, indicated that a specified assessment and a specified referral note had not been completed following this ADL and identification of altered skin integrity. During an interview with the MOHLTC Inspector on an identified date, staff #103 indicated that they had not assessed the resident's ability to continue the ADL in the current manner.

d) A review of resident #001's progress notes dated with an identified date and time, indicated that a referral to an identified resource was made by staff #105, for a request to assess for specified equipment for an identified reason. The progress note indicated that the resident had an identified alteration to their skin integrity and verbalized a specified symptom. The progress note indicated that the resident was not able to perform a specified action.

A review of the home's investigative notes indicated that staff #105 had documented that on an identified date, they assessed resident #001, prior to

performing a specified ADL and noted an identified area of altered skin integrity. They indicated that again, the resident had demonstrated a specified action and specified symptom.

During an interview with staff #105 on an identified date, they indicated that on a specified date and time of day, they assisted staff #106 to complete an identified ADL with resident #001. Staff #105 indicated they performed a specified action during the ADL as the resident was not able to participate in the manner they had been previously assessed to. The staff member indicated that the resident verbalized a specified symptom and pointed to an identified area on their body. The staff member indicated they administered a specified drug. The MOHLTC Inspector asked the staff member if the resident was re-assessed for their ability to perform the ADL, and an identified device implemented following this ADL in which the resident was not able to participate in the manner they had previously been assessed to. The staff member indicated that this was their mistake and provided an identified reason why and that a specified assessment had not been completed.

e) A review of the homes investigative notes indicated that staff #104 had documented that on an identified date, they assisted the resident with a specified ADL. Staff #104 indicated that they had noticed that the resident had an identified alteration to their skin integrity and had verbalized a specified symptom and that they reported this to staff #103.

An interview was conducted with staff #104 and the MOHLTC Inspector, on an identified date. The staff member confirmed they had worked on a specified date and time. The staff member indicated that on this date, they were preparing to perform an identified ADL with resident #001 and just before the ADL, they noticed an identified alteration to the resident's skin integrity. Staff #104 indicated that they went immediately to report the altered skin integrity to staff #103. Staff #104 confirmed they were not aware of the altered skin integrity, prior to this. Staff #104 indicated that staff #103 indicated they were aware of the altered skin integrity and that a specified test was to be completed the following day. Staff #104 indicated that they and staff #101 then provided the identified ADL and the resident verbalized an identified symptom. The MOHLTC Inspector asked if the resident was able to perform an identified action during the ADL and staff #104 indicated that the resident was able to and

described other specified actions that had occurred to the resident during the ADL. Staff #104 indicated they thought the resident may have been demonstrating an identified symptom. Staff #104 indicated they then assisted the resident with a different specified ADL. The MOHLTC Inspector asked if the resident was able to perform a specific action during the different ADL and if they had an identified symptom. Staff #104 indicated that the resident was able to perform the specified action and that they had verbalized the identified symptom. Staff #104 indicated that they asked the resident the location of the identified symptom and the resident rubbed an identified area on their body. Staff #104 were asked if they reported the resident's actions during the first ADL and their verbalization of the identified symptom to the charge nurse. Staff #104 indicated that they informed staff #103 of the alteration to the residents skin integrity and their specified verbalized symptom; however, could not remember if they reported the resident's specified actions during the ADL and thought that the resident had been demonstrating a different, identified symptom. The MOHLTC Inspector asked staff #104 if they had received a report at the start of their shift indicating the resident's altered skin integrity and the previous actions demonstrated by the resident during the identified ADL, on the previous shift. Staff #104 indicated that they had not been made aware or they would not have performed the specified ADL with the resident in the manner that they had.

An interview with staff #103 was conducted, on an identified date. The MOHLTC Inspector had asked if the staff member had received a report regarding resident #001 at the start of their shift. Staff #103 indicated that they received a report that the resident had verbalized an identified symptom and that identified altered skin integrity remained. Staff #103 indicated that staff #105 had asked them to notify the physician of the resident's altered skin integrity and to ask for a specified test. Staff #103 indicated that they first assessed the resident before calling the physician and checked the altered skin integrity which was not demonstrating an identified symptom but that the resident verbalized a different identified symptom. Staff #103 indicated that they called the physician and obtained an order for a specified test and informed the POA. The MOHLTC Inspector asked if they had been made aware of the resident's abilities in performing an identified ADL, earlier on this date. Staff #103 indicated that staff #105 had verbalized an identified outcome with the resident during the specified ADL, that had occurred earlier in the day. The MOHLTC Inspector asked if they were aware of who assisted the resident with their specified ADL on an identified

date and time, and the staff member indicated that staff #101 and 104 had. The staff member indicated that staff #104 had informed them of the resident's alteration to their skin integrity prior to conducting the specified ADL, which the staff member responded that they were aware of the alteration to the resident's skin integrity from the previous evening and that a specified test had been ordered. Staff #103 indicated that they verbalized to the staff that the resident had an identified alteration to their skin integrity and to call if any problems with the specified ADL and that no one reported any identified outcomes to them on this shift.

f) A review of resident #001's progress notes for an identified date and time, indicated that a specified test had been conducted. The test indicated an identified outcome and the resident was transferred to an identified location the same day where an identified diagnoses was confirmed. A specified treatment was given and they were transferred back to the long term care facility the same day.

A review of an identified progress note on a specified date and time, indicated that a referral to an identified resource was documented for the reason of assessing the resident's abilities for a specified ADL due to an identified diagnoses.

A progress note dated later on the same date, indicated that the resident had returned back to the long term care facility with an identified diagnoses and a specific treatment in place.

A specified progress note dated the following day and signed by an identified person indicated that staff were to perform the identified ADL using specified equipment.

Review of the resident's clinical record indicated that an identified assessment in PCC had not been completed for the resident on their return from an identified location and with an identified diagnoses.

A review of the resident's clinical records indicated that the first assessment for the resident's ability to perform an identified ADL, following their return from an identified location, was dated eight days later. The assessment signed by staff

#123, indicated that the reason for referral was for an identified diagnoses. Under the analysis section of this assessment, it was indicated that the resident was able to perform the identified ADL in a specified manner prior to their new diagnoses and were now assessed as requiring the use of specified equipment.

g) During this inspection, the census review was increased to include two other residents who had been transferred to a specified location for identified reasons. A review of a progress note for resident #003, dated on an identified date and time, indicated that the resident was transferred to a specified location for an identified reason. A progress note dated the following day, indicated that the resident would be staying at an identified location to receive treatment for a specified diagnoses.

A review of a specified progress note on an identified date, for a referral to an identified resource, indicated that the resident had returned back to the long term care facility and required an identified assessment related to a specified diagnoses.

Review of five progress notes dated over a period of eight identified dates, following the residents return back to the long term care facility, indicated that the resident had been demonstrating an identified symptom and/or an identified outcome.

A progress note dated 20 days following the residents return back to the long term care home, indicated that a request for referral to an identified resource had been completed and indicated that the POA requested the resident to have a specified treatment as they were demonstrating a specific symptom due to an identified diagnoses.

A review of the resident's clinical records indicated that an identified assessment in PCC had not been completed on the resident's return from an identified location. The first assessment following their return back to the long term care home, was dated 33 days later.

h) A review of the home's investigative notes indicated that the home had obtained an identified number of staff statements and conducted an identified number of staff interviews. A review of these statements and interviews

indicated the following:

For staff statements:

-All staff statements were written or typed on plain paper. A statement continuation form was not provided for any of the statements obtained. .

-The statement pages were observed to have not been numbered.

-Three of the staff statements had not included the full name of the staff member. One contained initials; one contained the first initial and last name and one contained the first name only.

-One staff statement contained no date to identify when it had been written.

-The staff statements ranged in documented dates of completion over an identified period of five days. A review of the staff interviews indicated that the first interview was documented as occurring six business days after receiving the last staff statement and the last interview was documented as occurring 11 business days after receiving the last staff statement.

For staff interviews:

-Two interviews were observed to have been written on plain paper and eight interviews were observed to have been documented on a form titled, "Witness Statement Continuation".

-Two interviews were observed to not contain page numbers.

-One interview was observed to have page numbers documented as starting at page seven of thirteen with no explanation as to where page one to six was located. An interview with the DOC indicated that pages one to six were in relation to a separate issue and not this CIS.

-One staff interview was observed to have a staff response that stopped in mid-sentence with a blank space following and then resumed with a question. An interview with the DOC indicated that it was thought that the staff member had

stopped speaking in mid-sentence.

-The staff interviews were observed to all be handwritten and documented by more than one person. Three of the staff interviews were mostly illegible and required the MOHLTC Inspector to review these interviews with the DOC, who was not the transcriber of the interviews. The transcriber of the interviews was no longer employed at the facility.

-Nine of the staff interviews were observed to not be signed off after the last sentence.

-One of the staff interviews which was documented in handwriting, had been documented by two different persons requiring clarification from the DOC that the interview conducted was the same interview that had been documented by two different persons.

-While the staff interviews identified who was present for the interview, they had not identified who was asking the interview questions and who was documenting the responses and had not contained the printed name and witness name, including signatures.

-All staff interviews observed had contained no documentation that the interviewee reviewed the completed statements and whether any additions or changes were made. All staff interviews were observed to have not been signed by the interviewee.

During an interview with an identified person, they confirmed that the homes investigative polices were not followed and that they were unable to read the staff interviews as they were not legible.

The severity of this issue 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 level 2 as it related to two of three residents reviewed. The home had a level 2 history of on-going non-compliance with this section of the Act that included:

• Voluntary Plan of Correction (VPC) issued on August 11, 2016, (2016_247508_0012),

• Voluntary Plan of Correction (VPC) issued on March 29, 2017, (2017_553536_0003)

(214)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 14, 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 24th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CATHY FEDIASH

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