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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 11, 2018	2018_661683_0018 (A1)	001383-18, 008515-18, 009558-18, 025963-18	Critical Incident System

Licensee/Titulaire de permis

PLEASANT MANOR RETIREMENT VILLAGE
15 ELDEN STREET BOX 500 UNKNOWN ON L0S 1T0

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

Pleasant Manor Retirement Village
15 Elden Street Box 500 Virgil ON L0S 1T0

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

Amended by LISA BOS (683) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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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*

Change made to resident number under example B) for s. 6(1)(a).

Issued on this 11st day of December, 2018 (A1)

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

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
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Pleasant Manor Retirement Village
15 Elden Street Box 500 Virgil ON L0S 1T0

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

Amended by LISA BOS (683) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 21, 23, 26 and 27, 2018.

The following intakes were completed during the inspection:

log #001383-18, CIS #2799-000001-18 - related to continence care and bowel management

log #008515-18, CIS #2799-000004-18 - related to falls prevention and management

log #009558-18, CIS #2799-000005-18 - related to falls prevention and management

log #025963-18, CIS #2799-000006-18 - related to falls prevention and management

During the course of the inspection, the inspector(s) spoke with the Director, the Director of Clinical Services, the Therapeutic Recreation Supervisor, registered staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) reviewed resident clinical records, reviewed policies and procedures, reviewed investigation notes, reviewed training records and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention

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

4 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 :

(A1)
1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A) A review of Critical Incident (CI) log # 025963-18 / 2799-000006-18 indicated that on an identified date, resident #002 sustained a fall which resulted in an identified injury. A review of the CI identified a specific intervention that was to be put in place to prevent recurrence.

Resident #002 was observed on two consecutive dates, sitting in an identified mobility device, and the specific intervention initiated as a result of the CI was observed to be in place.

A review of the written plan of care for resident #002 on an identified date, indicated that they were at an identified risk of falls and identified specific interventions in place to prevent falls. The falls prevention intervention initiated as a result of the fall on the identified date was not identified in the written plan of care.

In an interview with the Director of Clinical Services on an identified date, they indicated that after resident #002's fall on an identified date, a specific falls

prevention intervention was put in place. They acknowledged that the specific falls prevention intervention should be identified in their written plan of care. The Director of Clinical Services confirmed that resident #002's written plan of care was not updated to identify the specific falls prevention intervention that was added as a result of their fall on the identified date.

The home did not ensure that resident #002's written plan of care set out the planned care for the resident related to an identified falls prevention intervention.

B) A review of CI log #008515-18 / 2799-000004-18 indicated that on an identified date, resident #003 was being transported in an identified mobility device when a sudden movement caused the resident to fall which resulted in identified injuries.

A review of the written plan of care for resident #003 on an identified date indicated that they were at an identified risk of falls and there were specific interventions in place to prevent falls.

In an interview with registered staff #106 on an identified date, they confirmed that the resident had a specific falls prevention intervention in place and it was not identified in their written plan of care.

In an interview with the Director of Clinical Services on an identified date, they acknowledged that the specific falls prevention intervention was identified under Point of Care (POC) tasks, but it was not identified in their written plan of care.

The home did not ensure that resident #003's written plan of care set out the planned care for the resident related to a specific falls prevention intervention. [s. 6. (1) (a)]

2. 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 changed or care set out in the plan was no longer necessary.

A review of CI log #001383-18 / 2799-000001-18 indicated that on an identified date, resident #001 was transferred to hospital with identified medical conditions. According to the CI, resident #001 had a specific medical device, that drained an identified amount of a specific fluid of an identified colour, on an identified shift, on

an identified date. A clinical record review indicated that resident #001 was admitted to the home with a specific medical condition which required a specific intervention. Resident #001 had an identified output that ranged between identified amounts per shift between an identified time period. Progress notes did not include any further follow up or assessment of resident #001 in response to the change in their health status or symptoms exhibited on an identified date, until a specific time. During an interview on an identified date, registered staff #101 stated that if there was a change in the resident's medical condition then the resident would be assessed. Registered staff #101 could not recall resident #001 and whether or not they were assessed at that time. A review of the investigative notes of the incident indicated that PSW #103 reported to registered staff #104 that resident #001 had pain in an identified area and identified a health concern at an identified time, on an identified date. During an interview on an identified date, PSW #103 confirmed that they did inform registered staff #104 at an identified time, on an identified date, that the resident had a change in their medical status and that they were complaining of discomfort in an identified area. During an interview on an identified date, the Director of Clinical Services stated that resident #001 was not reassessed and the plan of care was not reviewed by registered staff #101 or #104 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 there is a written plan of care for each resident that sets out the planned care for the resident and 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee 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 policy, the policy was complied with.

In accordance with O. Reg. 79/10 s. 51 (1) the licensee was required to ensure that the continence care and bowel management program must, at a minimum, provide for the following: (1) treatments and interventions to promote continence.

Specifically, staff did not comply with an identified policy regarding continence care, from an identified date, that directed registered staff to obtain a physician or registered nurse extended class (RNEC) order for an identified procedure.

The licensee submitted a CI log #001383-18 / 2799-000001-18 on an identified date that involved resident #001 being transferred to hospital with a significant change. A review of the investigative notes and clinical records indicated that resident #001 experienced ongoing pain through the evening on an identified date. The next day, at an identified time, resident #001 had pain in an identified area with identified changes in their health status. The physician was notified and resident #001 was sent to the hospital with identified health concerns. A clinical record review indicated that on an identified date, resident #001 had an identified medical device at an identified time and then a different medical device at an identified time inserted by registered staff #104 in response to the change in their health status. Further record review indicated that there were no medical orders directing registered staff for the insertion of either type of identified medical device. During an interview on an identified date, the Director of Clinical Services stated that registered staff #104 had not contacted the on-call physician and inserted both medical devices without a medical order. During an interview on an identified date, staff #102 reported that resident #001 was not near death or considered palliative on an identified date, and that the policy for the identified medical device was not complied with by registered staff #104. [s. 8. (1) (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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of CI log #009558-18, 2799-000005-18 indicated that on an identified date, resident #006 was found in an identified room lying on the floor. The resident identified pain in a specific area and was sent to hospital for assessment where they were diagnosed with an identified injury.

A review of the clinical record for resident #006 indicated that they were at an identified risk of falls related to specific conditions. A review of the written plan of care for resident #006 identified specific interventions in place to prevent falls. A review of the clinical record did not identify a post fall assessment for resident #006's fall on an identified date.

In interviews with registered staff #107 and #108 on an identified date, they reviewed the documentation in Point Click Care (PCC) and acknowledged that a post fall assessment was not completed for resident #006's fall on an identified date.

The home did not ensure that when resident #006 fell on an identified date, a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

Additional Required Actions:

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

WN #4: 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.

The licensee failed to ensure that interventions related to an identified medical device for resident #001 completed by staff were documented.

The licensee submitted a CI log #001383-18 / 2799-000001-18 on an identified date, that involved resident #001 being transferred to hospital with identified medical conditions. A clinical record review indicated that resident #001's written plan of care included an intervention initiated on an identified date, that involved measuring an identified output at specific times. Further clinical record review revealed that there were no signatures found on the electronic treatment record on four identified dates. A review of the POC documentation system indicated that on two identified dates there were no signatures found or output measurement documented on those shifts by the PSW staff. During an interview on an identified date, staff #102 stated that it was both the registered staff and PSW staff who were responsible for measuring and documenting the identified output. During an interview on an identified date, the Director of Clinical Services confirmed that the signatures on the identified dates were missing and the staff failed to ensure that interventions to measure the identified output for resident #001 on every shift were documented. [s. 30. (2)]

Issued on this 11st day of December, 2018 (A1)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by LISA BOS (683) - (A1)
Inspection No. / No de l'inspection :	2018_661683_0018 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	001383-18, 008515-18, 009558-18, 025963-18 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 11, 2018(A1)
Licensee / Titulaire de permis :	PLEASANT MANOR RETIREMENT VILLAGE 15 ELDEN STREET, BOX 500, UNKNOWN, ON, L0S-1T0
LTC Home / Foyer de SLD :	Pleasant Manor Retirement Village 15 Elden Street, Box 500, Virgil, ON, L0S-1T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tim Siemens

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To PLEASANT MANOR RETIREMENT VILLAGE, you are hereby required to comply with the following order(s) by the date(s) set out below:

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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health 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 11st day of December, 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by LISA BOS (683) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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