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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 13, 2018	2018_695156_0007	025600-18, 025758-18	Complaint

Licensee/Titulaire de permis

Idlewyld Manor
449 Sanatorium Road HAMILTON ON L9C 2A7

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

Idlewyld Manor
449 Sanatorium Road HAMILTON ON L9C 2A7

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

CAROL POLCZ (156)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 26, 27, October 1, 2, 3, 4, 9, 10, 15, 17, 18, 2018

CIS Log #004023-18 and Log #025779-18 were inspected concurrently with complaint inspection 2018_695156_0007, Log #025600-18, Log #025758-18. Non-compliance related to O. Reg 79/10 s. 8 (1) b) and LTCHA s. 6 (7) were issued as compliance orders and O. Reg 79/10 s. 53 (1) was issued as a VPC which were identified during the CIS inspections and are included on this complaint inspection report.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Director of Nursing (DON), registered nursing staff, Personal Support Worker (PSW) staff, Recreationist, Behavioural Supports Ontario (BSO) Care Support Worker, Nursing Administrative Assistant, residents and families.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain

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

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.
- **0 AMP(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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber in relation to PRN (as required) medication not given for pain as ordered when the resident complained of pain.

Resident #001 had a physician's order for analgesic medication as required (PRN). On an identified date in September, 2018, resident #001 sustained a fall. The resident complained of pain and was given the PRN analgesic medication. Telephone interview with registered staff #109 who was on duty for the day shift following the fall, reported that the resident did not verbalize pain, was drowsy but able to take their medications for the morning medication pass. The registered staff reported that it was not until two hours later when alerted by PSW staff that the resident was unable to get up and complained of pain. As confirmed by progress notes as well as interview with registered staff #109, the resident was not given any pain medication and no assessments for injury or pain assessments were completed, although the resident was complaining of pain. There was no documentation in the progress notes until three hours later where it was noted by registered staff #109 that the resident complained of pain and would be put on the list to see the doctor.
On the afternoon shift, registered staff #111 had the charge nurse assess the resident as they appeared to be in pain. The resident was transferred to hospital where they received treatment for the injury.

Resident #001 was not administered analgesic as prescribed, when they complained of pain on an identified date in September, 2018, and remained in pain until transferred to hospital 5.5 hours later.

Please note: this non-compliance was issued as a result of complaint log #025758-18 and CIS log #025600-18. [s. 131. (2)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. In accordance with O. Reg 79/10, s. 30(1) the licensee was required to have an organized program for each of the interdisciplinary programs under section 48 of this regulation, which included a fall prevention and management program, and was required to have relevant policies, procedures and protocols for the program.
Specifically, staff did not comply with the licensee's policies:

"Falls Prevention and Management Program: Post Fall Assessment and Management RC-11-01-05" last updated February 14, 2017 and "Emergency and Incident Procedures, Head Injury Routine RC-10-01-07" last reviewed in February, 2017 and confirmed as current in the home by the DOC on an identified date in September, 2018, identified that registered nursing staff were to initiate the Head Injury Routine (HIR) for all un-witnessed falls and falls that had resulted in a possible head injury or when the resident was receiving anticoagulant therapy; monitor every hour for the first four hours, and then every four hours for 24 hours post fall for signs of neurological changes ie: include facial droop, behaviour change or weakness affecting one side of the body.

Interview with the DON on an identified date in October, 2018, confirmed that the Neurological Assessment Record was the same as the HIR and that the expectation of the home was that the resident be woken up if asleep to complete the HIR as outlined

above.

A) i) On an identified date in September, 2018, resident #001 sustained an unwitnessed fall. The HIR was initiated, however, was not completed for five assessments as it was noted that the resident was sleeping. Another assessment was blank. The HIR was not completed as confirmed with the DOC on an identified date in October, 2018.
ii) On an identified date in September, 2018, resident #001 sustained an unwitnessed fall. The HIR was initiated, however, was not completed for two assessments as it was noted that the resident was sleeping. Another assessment was blank. The HIR was not completed as confirmed with the DOC on an identified date in October, 2018.

B) i) On an identified date in September, 2018, resident #002 sustained an unwitnessed fall. The HIR was not initiated as confirmed with the DON on an identified date in October, 2018.
ii) On an identified date in September, 2018, resident #002 sustained an unwitnessed fall. The HIR was not initiated as confirmed with the DON on an identified date in October, 2018.

C) i) On an identified date in January, 2018, resident #003 sustained an unwitnessed fall. The HIR was not initiated as confirmed with the DON on an identified date in October, 2018.
ii) On an identified date in February, 2018, resident #003 sustained an unwitnessed fall. The HIR was initiated, however, 8/12 assessments were not completed and some entries were completed at different intervals than outlined in the policy as confirmed with the DON on an identified date in October, 2018.

The licensee failed to ensure that the "Head Injury Routine" policy was complied with.

Please note: this non-compliance was issued as a result of complaint log #025758-18 and CIS log #025600-18, log #004023-18 and log #025779-18 [s. 8. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that direct care staff were provided training in falls prevention and management.

A) Not all direct care staff were provided with training in falls prevention and management as confirmed with the Administrator on an identified date in October, 2018. For 2017, 5% of PSW staff and 10% of registered nursing staff had not been trained in falls prevention and management.

B) On an identified date in September, 2018, resident #001 sustained a fall. The resident complained of pain. The resident was given PRN analgesic medication and settled. The resident was transferred to hospital the following day and underwent surgery for the injury.
According to the Administrator of the home, the usual orientation for new registered staff was to shadow another registered staff for 3-4 shifts and receive all mandatory training prior to completing the shift on their own. Registered staff #109 who was on duty on the identified date in September, 2018, during the day shift was hired in August, 2018, and had not been trained in falls prevention and management prior to completing their shift as confirmed by the Administrator on an identified date in October, 2018 and registered staff #109 during interview on an identified date in October, 2018. [s. 221. (1) 1.]

2. The licensee failed to ensure that all direct care staff were provided training in pain management, including recognition of specific and non-specific signs of pain.

A) Not all direct care staff were provided with training in pain management, including the recognition of specific and non-specific signs of pain as confirmed with the Administrator on an identified date in October, 2018. For 2017, 28% of registered nursing staff had not been trained and PSW staff were not included in the training at all.

B) On an identified date in September, 2018, resident #001 sustained a fall. The resident complained of pain. The resident was given PRN analgesic medication and settled. The resident was provided with their regularly scheduled medications the next morning. Telephone interview with registered staff #109 who was on duty for the day shift following the fall, reported that the resident did not verbalize pain, was drowsy but able to take their medications for the morning medication pass. The registered staff reported that it was not until two hours later when alerted by PSW staff that the resident was unable to get up and complained of pain. As confirmed by progress notes as well as interview with registered staff #109, the resident was not given any pain medication and no assessments for injury or pain assessments were completed, although the resident was complaining of pain. There was no documentation in the progress notes until three hours later where it was noted by registered staff #109 that the resident complained of pain and would be put on the list to see the doctor.
On the afternoon shift, registered staff #111 had the charge nurse assess the resident as they appeared to be in pain. The resident was transferred to hospital where they were treated for the injury.

Registered staff #109 was hired in August, 2018, had not been trained in pain management, including recognition of specific and non-specific signs of pain as confirmed by the Administrator on an identified date in October, 2018, and registered staff #109 during interview on an identified date in October, 2018.

Please note: this non-compliance was issued as a result of complaint log #025758-18 and CIS log #025600-18, log #004023-18 and log #025779-18 [s. 221. (1) 4.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 provided to the resident as specified in the plan.

Resident #003 sustained an unwitnessed fall on an identified date in February, 2018. The resident complained of pain and sustained injury. At the time of the fall, the plan of care indicated that the resident had a medical device as a falls prevention intervention. CIS 2931-000004-18 submitted by the home also indicated that the resident was to have the medical device in place. Interview with staff #130 on an identified date in October, 2018, who found the resident after the fall and called for assistance confirmed that the medical device was not in place as per the plan of care. The planned care for the resident was not provided for as per the plan of care.

Please note: this non-compliance was issued as a result of CIS log #004023-18. [s. 6. (7)]

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.

The plan of care for resident #002 indicated that a medical device was to be in place as an intervention.

Resident #002 sustained an unwitnessed fall on an identified date in September, 2018.

On another identified date in September, 2018, resident #002 sustained an unwitnessed

fall.

On another identified date in September, 2018, resident #002 sustained an unwitnessed fall. The resident was transferred to the hospital and underwent treatment for their injuries.

Interview with the DON on an identified date in October, 2018, confirmed that resident #002 had a medical device in place as of an identified date in September, 2018. At the time of the falls, six and seven days later, the medical device was not in place as indicated in the progress notes. The planned care for the resident was not provided as per the plan of care.

Please note: this non-compliance was issued as a result of CIS log #025779-18. [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs had changed or care set out in the plan was no longer necessary.

Resident #001 sustained an unwitnessed fall on an identified date in September, 2018. During the night, the resident displayed behaviours, received treatment and was monitored.

Later in the shift, the resident was found seated on the floor. The resident was assessed and no injuries were noted but the resident had exhibited other medical symptoms. The following day, the resident received specific medical interventions.

Subsequently, the resident sustained another fall on an identified date, resulting in the resident being transferred to hospital and received treatment for their injuries.

After the first fall, the resident was placed on "Risk rounds" where it was noted that the resident displayed a risk. The MDS Falls Risk Assessment dated the same day, deemed the resident to be at risk for falls. The home policy indicated several interventions for residents at risk for falls including the bed to be in the lowest position, use of bed/chair alarms, hip protectors, etc; however, the plan of care for the resident did not include any of these interventions as confirmed with registered staff #105 and the DOC on an identified date in September, 2018.

Interview with the DOC on an identified date in September, 2018, confirmed that the plan of care was not reviewed and revised when the resident's care needs had changed and no falls prevention strategies had been put in place to prevent falls or minimize injury related to falls. The resident sustained subsequent falls that resulted in injury.

Please note: this non-compliance was issued as a result of complaint log #025758-18 and CIS log #025600-18. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following were developed to meet the needs of residents with responsive behaviours: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. 3. Resident monitoring and internal reporting protocols.

Resident #002 was noted to exhibit wandering behaviours and progress notes indicated that the resident continually displayed behaviours. Interview with the DON on an identified date in October, 2018, confirmed that resident #002 had exhibited the behaviours since admission, however, strategies to prevent or minimize this behaviour had not been developed or included in the plan of care. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that resulted in responsive behaviours or written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours or resident monitoring and internal reporting protocols had not been developed for resident #002.

Please note: this non-compliance was issued as a result of CIS log #025779-18. [s. 53. (1)]

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 following are developed to meet the needs of residents with responsive behaviours: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. 3. Resident monitoring and internal reporting protocols., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The following is further evidence to support the compliance order #001 issued on September 11, 2018 during complaint inspection 2018_743536_0006 to be complied on October 31, 2018.

The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The Licensee failed to protect resident #001 from neglect by staff in the home. In accordance with Ontario Regulations 79/10 s. (5) neglect is defined as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

The clinical record of resident #001 was reviewed. The Critical Incident (CI) report submitted to the Ministry of Health and Long Term Care (MOHLTC) was reviewed. On an identified date in September, 2018, resident #001 sustained an unwitnessed fall. According to the progress notes written by registered staff #106, prior to the fall, the resident displayed a behaviour. The resident was assisted back to bed by a PSW and after an identified time, the PSW heard the resident calling out and the resident was found on the floor. The initial head to toe assessment was completed. The resident complained of a soreness to a specified area. Neurovitals were started. The resident complained of pain and PRN analgesic was administered. The resident was provided with their regularly scheduled medications the following morning. Telephone interview with registered staff #109 who was on duty during the dayshift reported that the resident did not verbalize pain but able to take their medications for the morning medication pass. The registered staff reported that it was not until two hours later when they were alerted by PSW staff that the resident was unable to get up and complained of pain. As

confirmed by progress notes as well as interview with registered staff #109, the resident was not given any pain medication and no pain assessments
were completed, although the resident was complaining of pain. There was no documentation in the progress notes until two hours later where it was noted by registered staff #109 that the resident complained of pain and would be put on the list to see the doctor.
Three hours later, on an identified shift, registered staff #111 had the charge nurse assess the resident as the resident seemed to be in pain. Half an hour later, the resident was transferred to hospital where they subsequently underwent treatment for their injuries.

a) Interview with registered staff #109 on an identified date in October, 2018, confirmed that they should have provided PRN pain medication to the resident when the resident initially complained of pain. The staff confirmed that in hindsight they should have called the family to see if they wished the resident to be transferred to the hospital at that time.
b) Interview with registered staff #111 on an identified date in September, 2018, reported that when they completed an assessment the following day, the resident complained of pain and felt that the resident should have been sent to hospital earlier.
c) Interview with the DOC on an identified date in October, 2018, confirmed that the inaction of the staff in relation to administration of PRN pain medication and not sending the resident to the hospital for further assessment demonstrated a pattern of inaction and met the definition of neglect.

The licensee failed to protect the resident from neglect by staff based on inaction that jeopardized the health, safety and well-being of resident #001 after the fall on an identified date in September, 2018.

Please note: this non-compliance was issued as a result of complaint log #025758-18 and CIS log #025600-18.

The above is further evidence to support the order issued on September 11, 2018 during complaint inspection 2018_743536_0006 to be complied October 31, 2018. [s. 19. (1)]

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

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques to assist residents with eating, including safe positioning of residents who required assistance were followed.

Resident #001 had an order for a specified diet and required the feeding assistance of one staff. The resident was observed by the inspector to be in bed on an identified date during the inspection, at lunch time. PSW #108 entered the room and when the inspector asked if the resident ate anything today, the PSW explained that the resident had been asleep and pointed to a glass of juice on the table with an assistive device in it. The PSW stated that they were using the assistive device to try to put some of the juice into the resident's mouth because the resident would not take any of the juice from the cup. The PSW stated that they received the assistive device from registered staff #107 but knew that it should not be used to feed the resident. The assistive device was then thrown into the garbage.

The licensee's policy "Feeding and Meal Assistance" FS-04-01-23 last updated on January 25, 2017 indicated "to ensure safe swallowing, care must be taken to offer foods via teaspoon to residents who require total feeding assistance". Interview with the Administrator and Director of Nursing on an identified date in September, 2018, confirmed that staff were not to use the identified assistive device to feed residents as this was not a proper technique to assist residents with eating.

Please note: this non-compliance was issued as a result of complaint log #025758-18 and CIS log #025600-18. [s. 73. (1) 10.]

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*

Issued on this 20th day of November, 2018

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROL POLCZ (156)
Inspection No. / No de l'inspection :	2018_695156_0007
Log No. / Registre no:	025600-18, 025758-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 13, 2018
Licensee / Titulaire de permis :	Idlewyld Manor 449 Sanatorium Road, HAMILTON, ON, L9C-2A7
LTC Home / Foyer de SLD :	Idlewyld Manor 449 Sanatorium Road, HAMILTON, ON, L9C-2A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janine Mills

To Idlewyld Manor, you are hereby required to comply with the following order(s) by the date(s) set out below:

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. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with s. 131(2) of Ontario Regulation 79/10.

Specifically the licensee must ensure that resident #001 and all other residents are administered drugs in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber in relation to PRN (as required) medication not given for pain as ordered when the resident complained of pain.

Resident #001 had a physician's order for analgesic medication as required (PRN). On an identified date in September, 2018, resident #001 sustained a fall. The resident complained of pain and was given the PRN analgesic medication. Telephone interview with registered staff #109 who was on duty for the day shift following the fall, reported that the resident did not verbalize pain, was drowsy but able to take their medications for the morning medication pass. The registered staff reported that it was not until two hours later when alerted by PSW staff that the resident was unable to get up and complained of pain. As confirmed by progress notes as well as interview with registered staff #109, the resident was not given any pain medication and no assessments for injury or pain assessments were completed, although the resident was complaining of pain. There was no documentation in the progress notes until three hours later where it was noted by registered staff #109 that the resident complained of pain and would be put on the list to see the doctor.
On the afternoon shift, registered staff #111 had the charge nurse assess the resident as they appeared to be in pain. The resident was transferred to hospital where they received treatment for the injury.

Resident #001 was not administered analgesic as prescribed, when they complained of pain on an identified date in September, 2018, and remained in pain until transferred to hospital 5.5 hours later.

The severity of this issue was a level 3 as there was actual harm/risk to the resident. The scope was level 1 as it involved one of three residents. Compliance history was a level 2 as there was no previous noncompliance identified in the last 36 months.
(156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee must be compliant with s. 221(1) of Ontario Regulation 79/10.

Specifically the licensee must ensure that:

a) All staff who had not received training as of January 1, 2018 including staff #109 and who provide direct care to residents will be trained on falls prevention management and pain management including pain recognition of specific and non-specific signs of pain.

b) A record will be kept of this training, including the person who is responsible for providing the training, staff who participated. The record will identify the total number of all staff in the home and a total number of all staff who provide direct care in the home.

c) A record will be kept of the content of the training that was provided by the home.

Grounds / Motifs :

1. 1. The licensee failed to ensure that direct care staff were provided training in falls prevention and management.

A) Not all direct care staff were provided with training in falls prevention and management as confirmed with the Administrator on an identified date in October, 2018. For 2017, 5% of PSW staff and 10% of registered nursing staff had not been trained in falls prevention and management.

B) On an identified date in September, 2018, resident #001 sustained a fall. The resident complained of pain. The resident was given PRN analgesic medication and settled. The resident was transferred to hospital the following day and received treatment for the injury.

According to the Administrator of the home, the usual orientation for new registered staff was to shadow another registered staff for 3-4 shifts and receive all mandatory training prior to completing the shift on their own. Registered staff #109 who was on duty on the identified date in September, 2018, during the day shift was hired in August, 2018, and had not been trained in falls prevention and management prior to completing their shift as confirmed by the Administrator on an identified date in October, 2018 and registered staff #109 during interview on an identified date in October, 2018. [s. 221. (1) 1.]
(156)

2. 2. The licensee failed to ensure that all direct care staff were provided training in pain management, including recognition of specific and non-specific signs of pain.

A) Not all direct care staff were provided with training in pain management, including the recognition of specific and non-specific signs of pain as confirmed with the Administrator on an identified date in October, 2018. For 2017, 28% of registered nursing staff had not been trained and PSW staff were not included in the training at all.

B) On an identified date in September, 2018, resident #001 sustained a fall. The resident complained of pain. The resident was given PRN analgesic medication and settled. The resident was provided with their regularly scheduled medications the next morning. Telephone interview with registered staff #109

who was on duty for the day shift following the fall, reported that the resident did not verbalize pain, was drowsy but able to take their medications for the morning medication pass. The registered staff reported that it was not until two hours later when alerted by PSW staff that the resident was unable to get up and complained of pain. As confirmed by progress notes as well as interview with registered staff #109, the resident was not given any pain medication and no assessments for injury or pain were completed, although the resident was complaining of pain. There was no documentation in the progress notes until three hours later where it was noted by registered staff #109 that the resident complained of pain and would be put on the list to see the doctor.
On the afternoon shift, registered staff #111 had the charge nurse assess the resident as they appeared to be in pain. The resident was transferred to hospital where they underwent treatment for the injury.

Registered staff #109 was hired in August, 2018, had not been trained in pain management, including recognition of specific and non-specific signs of pain as confirmed by the Administrator on an identified date in October, 2018, and registered staff #109 during interview on an identified date in October, 2018.

The severity of this issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 3 as it related to three out of three required areas for mandatory training. The home had a level 3 compliance history of ongoing non-compliance with this section of the Act that included:
-Written Notification (WN)-September 23, 2016 (2016_343585_0013 (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 s. 8 (1) of Ontario Regulation 79/10.

Specifically the licensee must ensure that the licensee complies with the licensee's policies: "Falls Prevention and Management Program: Post Fall Assessment and Management RC-11-01-05" and "Emergency and Incident Procedures, Head Injury Routine RC-10-01-07". The policies identify that registered nursing staff are to initiate the Head Injury Routine (HIR) for all unwitnessed falls and falls that have resulted in a possible head injury or when the resident was receiving anticoagulant therapy; staff are directed to monitor every hour for the first four hours, and then every four hours for 24 hours post fall for signs of neurological changes ie: include facial droop, behaviour change or weakness affecting one side of the body.

Grounds / Motifs :

1. In accordance with O. Reg 79/10, s. 30(1) the licensee was required to have an organized program for each of the interdisciplinary programs under section 48 of this regulation, which included a fall prevention and management program, and was required to have relevant policies, procedures and protocols for the program.

Specifically, staff did not comply with the licensee's policies:

"Falls Prevention and Management Program: Post Fall Assessment and Management RC-11-01-05" last updated February 14, 2017 and "Emergency and Incident Procedures, Head Injury Routine RC-10-01-07" last reviewed in February, 2017 and confirmed as current in the home by the DOC on an identified date in September, 2018, identified that registered nursing staff were to initiate the Head Injury Routine (HIR) for all un-witnessed falls and falls that had resulted in a possible head injury or when the resident was receiving anticoagulant therapy; monitor every hour for the first four hours, and then every four hours for 24 hours post fall for signs of neurological changes ie: include facial droop, behaviour change or weakness affecting one side of the body.

Interview with the DON on an identified date in October, 2018, confirmed that the Neurological Assessment Record was the same as the HIR and that the expectation of the home was that the resident be woken up if asleep to complete the HIR as outlined above.

A) i) On an identified date in September, 2018, resident #001 sustained an unwitnessed fall. The HIR was initiated, however, was not completed for five assessments as it was noted that the resident was sleeping. Another assessment was blank. The HIR was not completed as confirmed with the DOC on an identified date in October, 2018.
ii) On an identified date in September, 2018, resident #001 sustained an unwitnessed fall. The HIR was initiated, however, was not completed for two assessments as it was noted that the resident was sleeping. Another assessment was blank. The HIR was not completed as confirmed with the DOC on an identified date in October, 2018.

B) i) On an identified date in September, 2018, resident #002 sustained an unwitnessed fall. The HIR was not initiated as confirmed with the DON on an identified date in October, 2018.
ii) On an identified date in September, 2018, resident #002 sustained an unwitnessed fall. The HIR was not initiated as confirmed with the DON on an identified date in October, 2018.

C) i) On an identified date in January, 2018, resident #003 sustained an unwitnessed fall. The HIR was not initiated as confirmed with the DON on an identified date in October, 2018.
ii) On an identified date in February, 2018, resident #003 sustained an unwitnessed fall. The HIR was initiated, however, 8/12 assessments were not

completed and some entries were completed at different intervals than outlined in the policy as confirmed with the DON on an identified date in October, 2018.

The licensee failed to ensure that the "Head Injury Routine" policy was complied with.

The severity of this issue was determined to be a level (2) as there potential for actual risk. The scope of the issue was a level (3) as it related to three of three residents reviewed. The home had a level (4) history as there was ongoing non-compliance with a VPC in unrelated areas. (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

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

Specifically the licensee must ensure that care set out in the plans of care for residents #002 and #003 and all other residents, related to medical devices are provided to the residents as specified in the plans.

Grounds / Motifs :

1. 1. 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.

Resident #003 sustained an unwitnessed fall on an identified date in February, 2018. The resident complained of pain and sustained an injury. At the time of the fall, the plan of care indicated that the resident had a medical device as a falls prevention intervention. CIS 2931-000004-18 submitted by the home also indicated that the resident was to have the medical device in place. Interview with staff #130 on an identified date in October, 2018, who found the resident after the fall and called for assistance confirmed that the medical device was not in place as per the plan of care. The planned care for the resident was not provided for as per the plan of care. (156)

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.

The plan of care for resident #002 indicated that a medical device was to be in place as an intervention.

Resident #002 sustained an unwitnessed fall on an identified date in September, 2018.

On another identified date in September, 2018, resident #002 sustained an unwitnessed fall.

On another identified date in September, 2018, resident #002 sustained an unwitnessed fall. The resident was transferred to the hospital and underwent treatment for their injuries.

Interview with the DON on an identified date in October, 2018, confirmed that resident #002 had a medical device in place as of an identified date in September, 2018. At the time of the falls, six and seven days later, the medical device was not in place as indicated in the progress notes. The planned care for the resident was not provided as per the plan of care.

The severity of this issue was a level 2 as there was actual harm/risk to the resident. The scope was level 2 as it involved two of three residents. Compliance history was a level 3 as there was previous noncompliance identified as a VPC in the last 36 months. (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s 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

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

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

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

Directeur
a/s 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

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

Issued on this 13th day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CAROL POLCZ

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