Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Jul 19, 2019	2019_767643_0020	025790-17, 002630-18, 005500-18, 009483-18, 011021-18, 012217-18, 012247-18, 022850-18, 026260-18, 026262-18, 029977-18, 005279-19	Critical Incident System

Licensee/Titulaire de permis

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

Isabel and Arthur Meighen Manor
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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ADAM DICKEY (643), AMY PAGE (749), COREY GREEN (722), IVY LAM (646), TRACY MUCHMAKER (690)

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): July 17-21, and 24-27, 2019.

The following Critical Incident System (CIS) intakes were inspected during this inspection:
Log #029977-18; CIS #C603-000029-18 and Log #026260-18; CIS C603-000027-18 - related to suspected improper care,
Log #005279-19, Log #011021-18; CIS #C603-000017-18, Log #012247-18; C603-000020-18 and Log #012217-18; CIS C603-000021-18 - related to suspected abuse and responsive behaviours,
Log #005500-18; CIS C603-000010-18, Log #002630-18; CIS C603-000001-18 and Log #009483-18; CIS C603-000016-18 - related to falls prevention and management,
Log #022850-18; C603-000024-18 - related to safe and secure home, and
Log #026262-18; CIS C603-000026-18 and Log #025790-17; CIS C603-000025-17 related to injuries with unknown cause.

A WN and Voluntary Plan of Correction (VPC) related to O. Reg. 79/10, s. 8. (1) (b) identified in concurrent inspection 2019_767643_0019 (Log #005251-19) will be issued in this report.

A Written Notification related to LTCHA, 2007, S.O. 2007, c.8, s. 22. (1) identified in concurrent inspection 2019_767643_0019 (Log #005251-19) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Physiotherapist (PT), Behavioural Supports Ontario (BSO) Program Lead, Environmental Services Manager (ESM), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector(s) conducted observations of staff and resident interactions and the provision of care, reviewed resident health records, internal complaints records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **6 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 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, the plan, policy, protocol, procedure, strategy or system was complied with.

As required by the Regulation (O. Reg. 79/10, s. 48 (1). 1) the licensee was required to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home. As required by the Regulation (O. Reg. 79/10, s. 30 (1). 1) a written description of the program was required that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Review of the home's policy titled Fall Prevention Program, policy #06.24, last revised October 2018, showed that when a resident had fallen, the Registered Staff were to complete a thorough assessment of the resident, including a Head Injury Report if a head injury was suspected or if the fall was un-witnessed and there was evidence of head trauma; e.g. redness, swelling or bruising.

The home's Head Injury Routine (HIR) tool was reviewed by Inspector #749 which showed the frequency of checks to be documented:
- every 15 minutes for the first hour (four checks),
- every half hour for the second hour (two checks),
- every hour for the next two hours (two checks),
- every two hours for four hours (two checks),
- every four hours (three checks), then

- every shift for five shifts (total of 72 hours).

a. CIS report #C603-000001-18 was submitted to the Director regarding a fall incident on an identified date which resulted in resident #004 being transferred to hospital for assessment. Review of the CIS report showed that the resident was noted to have an identified injury.

Review of resident #004's progress notes showed the resident was found to have fallen un-witnessed on the above identified date and had complained of pain. The resident was sunsequently transferred to hospital for treatment.

Inspector #749 reviewed resident #004's HIR monitoring document from the above mentioned fall incident. The first documented assessment was completed 10 minutes after discovering the resident had fallen, 25 minutes following the first assessment, then every hour for the next three hours, then it indicated the resident was transferred to hospital.

In an interview with RPN #115, they stated the frequency listed on the bottom of the head injury routine tool is what the staff are to follow. Together, Inspector#749 and RPN #115 reviewed the head injury routine tool for resident #004, for the fall on the above identified date, specific to documented assessment frequency. RPN #115 verified staff did not follow the required frequency of checks.

In an interview with the DOC #101, when asked about the frequency of HIR checks and when it is to be documented, the DOC indicated what is at the bottom of the HIR tool is the correct frequency. When asked if staff received training on the head injury routine tool as part of fall prevention, DOC #101 indicated it is part of the documentation training. Together, Inspector #749 and DOC # 101 reviewed the head injury routine tool for resident #004, for the fall on the above identified date, specific to documented assessment frequency. DOC #101 verified that the frequency was not followed by staff.

b. CIS report #C603-000010-18 was submitted to the Director regarding a fall incident on an identified date, which resulted in resident #003 being transferred to hospital for assessment.

Inspector #749 reviewed resident #003's HIR monitoring document from the above identified date, for a fall that took place at a specified time. The first documented assessment was completed at the next three half-hour intervals, then one hour later, then

it indicated the resident was sent to hospital.

In an interview with RN #114, they stated the frequency of a HIR assessment should be completed every 15 minutes for an hour, every 30 for an hour, then every hour after that. Together, Inspector #749 and RN #114 reviewed the head injury routine tool for resident #003, for the fall on the above identified date, specific to documented assessment frequency. RN #114 verified staff did not follow the frequency of checks.

Together, Inspector #749 and DOC # 101 reviewed the head injury routine tool for resident #003, for the fall on the above identified date, specific to documented assessment frequency. DOC #101 verified that the assessment frequency was not followed by staff.

c. Due to identified noncompliance, the sample of residents reviewed was expanded to include resident #002.

Inspector #749 reviewed resident #002's HIR monitoring document from an identified date, for a fall that took place at a specified time. The documented assessments were completed at the time of the fall incident, one hour and 15 minutes later, two hours after the fall, two and one-half hours after the fall, three and one-half hours after the fall and eight and one-half hours following the fall. The HIR documentation showed "sleeping" four hours after the last mentioned assessment time, and four and seven hours after that "refused" was documented. An assessment was documented an additional four hours later, hour then "sleeping" was documented for two additional four hour periods.

Together, Inspector #749 and DOC # 101 reviewed the head injury routine tool for resident #002, for the above mentioned fall incident, specific to documented assessment frequency. DOC #101 verified that the frequency was not followed by staff. The DOC acknowledged that the staff had not documented the HIR for required frequency for residents #004, #003 and #002. [s. 8. (1) (b)]

2. According to the LTCHA, 2007, c. 8, s. 21, every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

Review of the home's policy titled Management of Complaints, Policy #1.1.24, Revised: June 2018, indicated the following under Application of Policy:
- where a written complaint has been received, the ED or designate will fill out the Client

Concern Form (CCF) for formal record purposes;
- the appropriate department head(s) shall initiate an investigation of the area(s) of concern and document accordingly on the CCF; and
- the appropriate department head(s) will record findings and recommendations of the investigation on the CCF and forward to the ED or designate for review and approval.

a. The following evidence related to resident #014 was found under inspection report 2019_767643_0019.

A letter of complaint by electronic mail (e-mail) was sent to the home from resident #014's SDM, related to concerns about the resident's care, and was forwarded by the home to the Director on an identified date.

Review of the home's internal complaints log did not show a CCF related to the complaint from resident #014's SDM.

Interview with the ED indicated that they had become aware of resident #014's SDM's concern 27 days prior to forwarding the letter to the Director, and had not followed the home's policy with regards to filling out the Client Concern Form (CCF). (646)

b. A written complaint letter was submitted by the home to the Director on an identified date, which was received by the home from resident #006's SDM, regarding resident care concerns.

Inspector #722 reviewed the home's complaints records, and identified a copy of the complaint letter addressed to the ED and DOC from an identified date, signed by resident #006's SDM. The complaint record included a response letter to the complainant, from an identified date two weeks later, and signed by the ED. Inspector #722 did not identify any further documentation related to this complaint in the complaints record.

The ED was interviewed by Inspector #722, and confirmed that the letter of complaint was received by resident #006's SDM on an identified date, during a face-to-face meeting with the complainant. The ED provided additional notes concerning the complaint investigation and actions taken, and acknowledged that the CCF was not completed for this written complaint, and that it should have been as per the home's policy. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 that the written procedures for initiating complaints to the licensee and for how the licensee deals with complaints are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written complaint received by the long-term care home concerning the care of resident #006 was immediately forwarded to the Director.

a. The following evidence related to resident #014 was found under inspection report 2019_767643_0019.

A letter of complaint by e-mail was sent from resident #014's SDM, related to resident #014's care and services provided in the home was forwarded by the home to the Director on an identified date. Review of the e-mail showed it had been addressed to the social worker and the ED on an identified date 27 days prior, and the social worker had responded to the SDM by email on the same day it was sent.

Interview with the ED indicated that they had become aware of resident #014's SDM's concerns on the above mentioned identified date, but was not aware that the written letter of complaint needed to be immediately submitted to the Director, and did not forward the written complaint to the Director until 27 days following receipt of the written complaint. (646)

b. A written letter of complaint from resident #006's SDM, related to resident care in the home, was forwarded to the Director by the home on an identified date. March 6, 2019.

During an interview with Inspector #722, the ED indicated that the written letter of complaint was received by the home 12 days before the above identified date in a face-to-face meeting with resident #006's SDM. The ED confirmed that they forwarded the written complaint to the Director 12 calendar days after the complaint was originally received. The ED indicated that they were not aware that the written letter of complaint needed to be immediately submitted to the Director. (722)

c. To expand the scope, Inspector #722 randomly selected one additional complaint from 2019 for review. A Client Concern Form (CCF) was identified, from an identified date documenting a written letter of complaint that was submitted to the home related to the care of resident #022. Inspector #722 reviewed the written complaint letter, which was written by resident #022's SDM and was not dated.

The ED indicated during an interview with Inspector #722 that the complaint letter from resident #022's SDM was received by the home on the above identified date, via email, and acknowledged that the letter was not forwarded to the Director, as the family had requested that the letter not be submitted to the Ministry of Health and Long-Term Care (MOHLTC).

Inspector #722 reviewed the home's policy titled Management of Complaints, Policy #1.1.24, revised June 2018, which indicated that for written complaints, the ED or designate was responsible for forwarding a copy of the complaint, including the documented response and actions taken to resolve the complaint, to the MOHLTC if appropriate.

During the interview with Inspector #722, the ED acknowledged that the written letters of complaint described above were not submitted to the Director as required by the legislation. [s. 22. (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 with ensuring that any written complaint concerning the care of a resident or the operation of the long-term care home is immediately forwarded to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident had occurred immediately reported the suspicion and the information upon which it was based to the Director.

On September 5, 2018, the Director informed licensees via a memo regarding Amendments to the reporting requirements memo of July 5, 2018. The memo highlighted that the licensee must submit a report to the Director Monday to Friday, 8:30 a.m. to 4:30 p.m. by immediately initiating and submitting an on-line CIS report. At all other times the licensee must call the after-hours reporting line and submit a CIS report first thing the

following business day.

A CIS report was submitted to the Director for alleged staff to resident physical abuse on an identified date, for an incident that occurred three days earlier. The CIS report identified that resident #011 reported to RPN #117 that a PSW was rough with them while providing care.

Inspector #690 reviewed reports made to the after-hours reporting line by the licensee and was unable to locate one related to the above mentioned incident.

Inspector #690 reviewed electronic progress notes for resident #011 and identified a progress note documented by RN #122 that indicated that resident #011 reported to RPN #117 that a staff member had been rough with the resident while providing care and showed RPN #117 a mark on an identified part of their body. The progress note further indicated that the incident was reported to the DOC by RN #122.

Inspector #690 reviewed the home's policy titled "Unusual Occurrances: The Critical Incident System (CIS)", policy #6.1.1, last revised November 2017, which indicated that any abuse of a resident by anyone or neglect of a resident by the facility or staff that resulted in harm or a risk of harm to the resident required immediate and mandatory reporting using the Critical Incident System.

In an interview with Inspector #690, RN #122 indicated that they were working on an identified shift the date of the incident, when RPN #117 reported the allegation of abuse to them. RN #122 indicated that they had called the DOC right away.

In an interview with Inspector #690, the DOC indicated that any allegation of abuse is to be reported to the Director immediately by submitting a CIS report or calling the after-hours reporting line. The DOC further indicated that they did not immediately report the allegation of abuse reported by resident #011 and that they should have. [s. 24. (1)]

2. The licensee has failed to ensure that, any person who had reasonable grounds to suspect that unlawful conduct that resulted in harm or risk of harm to a resident, immediately reported the suspicion and information upon which it was based to the Director.

A CIS report for unlawful conduct that resulted in harm or risk of harm to a resident was submitted to the Director on an identified date for an incident that occurred 23 days

earlier. The CIS report indicated that PSW #132 was observed to be attempting to transfer resident #010 with specified transfer equipment by themselves. The CIS report further indicated that resident #010 required assistance with a different type of transfer equipment.

In an interview with Inspector #690, the DOC indicated that they had submitted the CIS report for the above mentioned incident because there would have been a significant risk of harm to resident #010 if PSW #132 had transferred resident #010 by themselves as the resident required assistance from two staff for all transfers. The DOC indicated that they had wanted to ensure that they had all the information about the incident to include in the CIS report prior to submitting the report and that they should have submitted the report immediately when they became aware of the incident on October 15, 2018. [s. 24. (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 with ensuring that any person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident;
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident;
3. Unlawful conduct that resulted in harm or a risk of harm to a resident;
4. Misuse or misappropriation of a resident's money; and
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006, 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 has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #010.

A CIS report was submitted to the Director on an identified date for an incident which occurred 23 days earlier. The CIS report indicated that PSW #132 was observed to be attempting to transfer resident #010 with specified transfer equipment by themselves. The CIS report further indicated that resident #010 required assistance with a different type of transfer equipment.

During an observation of resident #010's room, Inspector #690 identified two transfer logos on the wall by the resident's bed. One logo indicated that the resident required a specified transfer technique assisted by two staff. The second logo indicated that resident #010 required two staff to assist them using specified transfer equipment if unable to bear weight.

A review of resident #010's electronic care plan by Inspector #690 identified a focus for transferring that indicated that resident #010 required assistance for transferring from one position to another. The care plan further indicated that staff were to assist the resident with two staff using a specified technique, or to provide two person assistance using the above specified transfer equipment if the resident was unable to weight bear.

Inspector #690 reviewed resident #010's health records and identified a document titled "Daily Care Record as per Resident Care Plan" (DCR). The inspector reviewed the documentation on the DCR for transfers and identified that over an identified three month period, the resident was transferred 76 times by one staff member on a specified shift.

A review of the home's policy titled "Mechanical Lifts", policy #06.18, last revised July 2017, indicated that staff will complete lifts and transfers according to the resident plan of care and transfer logo located at the bedside.

In an interview with Inspector #690, PSW #128 indicated that they would utilize the care plan to find information on how to transfer a resident. PSW #128 indicated that resident #010 at times required two staff to transfer them using the above specified technique, or required use of the above specified transfer equipment if they could not bear weight. PSW #128 further indicated that they would transfer resident #010 by themselves on their shift as they were familiar with resident #010 and were able to do it.

In an interview with Inspector #690, RPN #102 indicated that resident #010 at times required two staff to transfer them using the above specified technique, or required use of the above specified transfer equipment if they could not bear weight. RPN #102 further indicated that some staff had been able to transfer resident #010 by themselves lately as the resident had been able to. Together, Inspector #690 and RPN #102 reviewed resident #010's electronic care plan. RPN #102 indicated that according to resident #010's care plan, resident #010 was to have two staff present for all transfers and that staff should be providing safe transfers as per the direction in the care plan.

In an interview with the PT, they indicated to Inspector #690 that resident #010 required the assistance of two staff for a side by side transfer if they were cooperating or required a full mechanical lift for transfers if they were unable to bear weight. The PT identified that resident #010 should not be transferred by only one staff as it was not safe, even if the staff member was familiar with the resident. The PT indicated to the Inspector that they were asked by RPN #102 to re-assess resident #010 on June 21, 2019, to assess if resident #010's transfer status could be changed to a one person assist. The Physiotherapist indicated that the outcome of the assessment was that it was unsafe to transfer resident #010 with only one staff member and that resident #010 required the presence of two staff for all transfers.

In an interview with Inspector #690, the DOC indicated that staff would access the electronic care plan or a printed copy of the care plan to identify how to transfer a resident and that staff should provide care as specified in the care plan. Together, Inspector #690 and the DOC reviewed the daily care records and the electronic care plan for resident #010 and the DOC identified that PSW #128 had documented they had been transferring resident #010 by themselves. The DOC further identified that the transfer with one staff was unsafe for resident #010 and that it was the expectation that staff provide safe transfer assistance. [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 with ensuring 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for residents who demonstrated responsive behaviours, when actions were taken to respond to the needs of the residents, including assessments, reassessments and interventions, that the resident's responses to interventions were documented.

A CIS report was submitted to the Director for an altercation involving resident #008 toward resident #018, that occurred on an identified date. Two CIS reports were submitted to the Director on a subsequent identified date, for an altercation between resident #008 and #009.

Inspector #722 reviewed the progress notes for resident #008, which provided a description of the incidents that occurred on the above identified dates. Three days

following the first altercation a progress note was identified that indicated "Dementia Observation System (DOS) charting started today." Several other entries in the progress notes by registered staff were identified that indicated that DOS monitoring had been completed.

Resident #008's health record was reviewed by Inspector #722, and a physician's order written five days after the first identified altercation indicated: "DOS charting x 1 week". Inspector #722 reviewed the DOS tool in resident #008's health record a specified seven day period, which showed that entries at 30-minute intervals were blank for an identified shift on six identified dates. Entries were also blank on two additional shifts during the seven day period. Inspector #722 did not identify a DOS record for the last two dates corresponding to the above physician's order.

Inspector #722 reviewed DOS monitoring records for residents #002 and #009, to determine the scope of the issue. Resident #002 had a physician's order from an identified date, which indicated "DOS charting x 2 weeks." Inspector #722 reviewed the DOS Flow Sheet for resident #002, and identified that the DOS documentation from an identified two week period was incomplete for at least eight hours on 10 of the 14 days when the monitoring was in place.

Inspector #722 identified that resident #009 had a physician's order from an identified date, which indicated: "DOS Charting for 2 weeks." Inspector #722 reviewed the DOS Flow Sheet for resident #009, and identified that the DOS documentation from an identified two week period was incomplete for an entire shift (8 hours) on five identified dates; and was incomplete for two entire shifts (16 hours) on four other identified dates.

Inspector #722 interviewed PSW #124 who confirmed that they were assigned to provide care to resident #008 on five of the seven above identified dates, and indicated that they don't recall why the DOS flow sheet was not completed for the resident on their shift. They indicated that they may have forgotten and acknowledged that it should have been completed.

RPN #113, the BSO lead in the home, was interviewed by Inspector #722, and indicated that registered staff or the physician may initiate the DOS monitoring for a resident, to identify patterns in responsive behaviours.

RPN #113 indicated that the DOS tool should be completed every 30 minutes by the PSW who was assigned to the resident, and the appropriate behaviour code entered in

the flow sheet. RPN #113 indicated that the DOS flow sheet should have been completed for resident #008 for a specified seven day period according to their directions and the physician's order. The RPN confirmed that none of the 30-minute fields should be blank while DOS monitoring was being completed for a resident.

Inspector #722 reviewed the home's policy, "Flow Sheets Documentation", Policy #7.9, Revision: November 2018, which indicated the following:
- Under Statement of Policy: 2. The PSW assigned to the resident is responsible for completion of the Flow Sheet for the shift; and 3. The RN/RPN on each shift is responsible for monitoring the completion of the Flow Sheet.
- Under Application of Policy: The PSW assigned to the resident: 1. Initials the completion of each component of care in the appropriate date column for their shift on the flow sheet.

Inspector #722 interviewed the DOC, who acknowledged that DOS monitoring was required for residents #002, #008, and #009 for the periods specified above, related to the residents' responsive behaviours. The DOC confirmed that the PSWs were expected to complete the tool according to the home's "Flow Sheets Documentation" policy. The DOC acknowledged that the DOS documentation for all three residents was not completed appropriately. [s. 53. (4) (c)]

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 with ensuring that for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of incidents in which injury to a resident resulted in a significant change in the residents' health condition and for which the residents were taken to a hospital.

a. A CIS report was submitted to the Director regarding a fall on an identified date which resulted in resident #004 being transferred to hospital and subsequently returned to the home with a significant change in their health condition. The CIS report was submitted to the Director 10 days following the incident.

A review of the home's policy titled "Unusual Occurrances: The Critical Incident System (CIS)", policy #6.1.1, last revised November 2017, indicated that any injury of a resident that resulted in a transfer to hospital must be immediately reported to the Executive Director and/or the DOC or designate and reported to the Director using the CIS with one business day after the occurrence with a full report submitted within 10 days.

Inspector #749 reviewed resident #004's progress notes documented the day following the fall incident which described a phone call from the hospital informing the home that resident #004 had sustained an identified injury, was admitted to the hospital. A progress note from five days following the fall incident which indicated the resident had a surgical intervention performed in hospital.

Inspector #749 interviewed DOC#101, who indicated it was their responsibility for reporting critical incidents to the Director. When asked if resident #004's fall on the above identified date resulted in a significant change in status DOC #101 replied "yes". When asked what the time-frame was for reporting this critical incident DOC# 101 indicated that they do a full investigation prior to submitting the critical incident to the Director.

b. A CIS report was submitted to the Director regarding a fall on an identified date, which resulted in resident #003 being transferred to hospital and returned to the with a significant change in their health status. The CIS report was submitted to the Director 18 days following the incident.

Inspector #749 reviewed resident #003's progress notes documented on the date of the incident which described a phone call from the home to the hospital informing the home that resident #003 had sustained a specified injury, and would potentially require treatment in hospital. A progress note from five days following the fall incident indicated resident #003 underwent a procedure in hospital three days earlier.

In an interview with DOC #101, when asked if resident #003's fall on the above identified date resulted in a significant change in status DOC #101 replied "yes". When asked to verify the reporting time frame for this incident was not within the correct time frame DOC #101 replied "yes".

c. A CIS report was submitted to the Director on an identified date for an incident that occurred 10 days prior, that caused an injury to a resident for which the resident was taken to the hospital and which resulted in a significant change in the resident's health condition. The CIS report indicated that resident #001 was transferred to the hospital and returned to the home the day after the incident with a specified treatment intervention in place.

In an interview with RN #122, they indicated to Inspector #690 that they became aware

of resident 001's injury on the date of the incident, and that would have reported the injury to the DOC as soon as they became aware of it.

In an interview with Inspector #690, the DOC indicated that anytime a resident sustained an injury that required a transfer to hospital, staff were to notify the DOC immediately. The DOC could not recall when they became aware of resident #001's injury, and that they thought they had 10 days to submit the CI report. The DOC indicated that according to the LTCHA and the home's policy, that they should have submitted the CI report within one business day of becoming aware of the injury which resulted in a significant change in resident #001's health status and resident #001's transfer to hospital. [s. 107. (3)]

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 with ensuring that the Director is informed, no later than one business day after the occurrence of the incident, of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, to be implemented voluntarily.

Issued on this 23rd day of July, 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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ADAM DICKEY (643), AMY PAGE (749), COREY GREEN (722), IVY LAM (646), TRACY MUCHMAKER (690)
Inspection No. / No de l'inspection :	2019_767643_0020
Log No. / No de registre :	025790-17, 002630-18, 005500-18, 009483-18, 011021-18, 012217-18, 012247-18, 022850-18, 026260-18, 026262-18, 029977-18, 005279-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 19, 2019
Licensee / Titulaire de permis :	The Governing Council of the Salvation Army in Canada 2 Overlea Blvd, TORONTO, ON, M4H-1P4
LTC Home / Foyer de SLD :	Isabel and Arthur Meighen Manor 155 Millwood Road, TORONTO, ON, M4S-1J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Julie Wong

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 The Governing Council of the Salvation Army in Canada, 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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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, s. 8 (1).

Specifically the licensee shall:
1) Ensure that registered staff are provided training on the home's falls prevention and management policy and the application of head injury routine assessments;
2) Develop and implement an auditing system to ensure that registered staff carry out and document head injury routine assessments as per the home's policy;
3) Maintain a written record of audits conducted in the home. The written record must include the date of the audit, the resident's name, the name of the person completing the audit and the outcome of the audit.

Grounds / Motifs :

1. The licensee failed to ensure that, where the Act or 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, the plan, policy, protocol, procedure, strategy or system was complied with.

As required by the Regulation (O. Reg. 79/10, s. 48 (1). 1) the licensee was required to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home. As required by the Regulation (O. Reg. 79/10, s. 30 (1). 1) a written

description of the program was required that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Review of the home's policy titled Fall Prevention Program, policy #06.24, last revised October 2018, showed that when a resident had fallen, the Registered Staff were to complete a thorough assessment of the resident, including a Head Injury Report if a head injury was suspected or if the fall was un-witnessed and there was evidence of head trauma; e.g. redness, swelling or bruising.

The home's Head Injury Routine (HIR) tool was reviewed by Inspector #749 which showed the frequency of checks to be documented:
- every 15 minutes for the first hour (four checks),
- every half hour for the second hour (two checks),
- every hour for the next two hours (two checks),
- every two hours for four hours (two checks),
- every four hours (three checks), then
- every shift for five shifts (total of 72 hours).

a. CIS report #C603-000001-18 was submitted to the Director regarding a fall incident on an identified date which resulted in resident #004 being transferred to hospital for assessment. Review of the CIS report showed that the resident was noted to have an identified injury.

Review of resident #004's progress notes showed the resident was found to have fallen un-witnessed on the above identified date and had complained of pain. The resident was sunsequently transferred to hospital for treatment.

Inspector #749 reviewed resident #004's HIR monitoring document from the above mentioned fall incident. The first documented assessment was completed 10 minutes after discovering the resident had fallen, 25 minutes following the first assessment, then every hour for the next three hours, then it indicated the resident was transferred to hospital.

In an interview with RPN #115, they stated the frequency listed on the bottom of the head injury routine tool is what the staff are to follow. Together, Inspector

#749 and RPN #115 reviewed the head injury routine tool for resident #004, for the fall on the above identified date, specific to documented assessment frequency. RPN #115 verified staff did not follow the required frequency of checks.

In an interview with the DOC #101, when asked about the frequency of HIR checks and when it is to be documented, the DOC indicated what is at the bottom of the HIR tool is the correct frequency. When asked if staff received training on the head injury routine tool as part of fall prevention, DOC #101 indicated it is part of the documentation training. Together, Inspector #749 and DOC # 101 reviewed the head injury routine tool for resident #004, for the fall on the above identified date, specific to documented assessment frequency. DOC #101 verified that the frequency was not followed by staff.

b. CIS report #C603-000010-18 was submitted to the Director regarding a fall incident on an identified date, which resulted in resident #003 being transferred to hospital for assessment.

Inspector #749 reviewed resident #003's HIR monitoring document from the above identified date, for a fall that took place at a specified time. The first documented assessment was completed at the next three half-hour intervals, then one hour later, then it indicated the resident was sent to hospital.

In an interview with RN #114, they stated the frequency of a HIR assessment should be completed every 15 minutes for an hour, every 30 for an hour, then every hour after that. Together, Inspector #749 and RN #114 reviewed the head injury routine tool for resident #003, for the fall on the above identified date, specific to documented assessment frequency. RN #114 verified staff did not follow the frequency of checks.

Together, Inspector #749 and DOC # 101 reviewed the head injury routine tool for resident #003, for the fall on the above identified date, specific to documented assessment frequency. DOC #101 verified that the assessment frequency was not followed by staff.

c. Due to identified noncompliance, the sample of residents reviewed was expanded to include resident #002.

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

Inspector #749 reviewed resident #002's HIR monitoring document from an identified date, for a fall that took place at a specified time. The documented assessments were completed at the time of the fall incident, one hour and 15 minutes later, two hours after the fall, two and one-half hours after the fall, three and one-half hours after the fall and eight and one-half hours following the fall. The HIR documentation showed "sleeping" four hours after the last mentioned assessment time, and four and seven hours after that "refused" was documented. An assessment was documented an additional four hours later, hour then "sleeping" was documented for two additional four hour periods.

Together, Inspector #749 and DOC # 101 reviewed the head injury routine tool for resident #002, for the above mentioned fall incident, specific to documented assessment frequency. DOC #101 verified that the frequency was not followed by staff. The DOC acknowledged that the staff had not documented the HIR for required frequency for residents #004, #003 and #002.

The severity of this issue was determined to be a level 2 as there was minimal risk to residents #002, #003 and #004. The scope of the issue was a level 3 as it related to three out of four residents reviewed. The home had a level 3 compliance history as there was one previous noncompliance to the same subsection issued in the last 36 months which included:
- A WN and VPC issued July 18, 2018, under inspection report #2018_370649_0008. (749)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 29, 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 19th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Adam Dickey

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