Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 14, 2020	2019_769646_0018	013451-19, 015015-19, 018282-19, 020527-19, 020958-19, 021053-19	Critical Incident System

Licensee/Titulaire de permis

The Kensington Health Centre
25 Brunswick Avenue TORONTO ON M5S 2L9

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

The Kensington Gardens
25 Brunswick Avenue TORONTO ON M5S 2L9

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

IVY LAM (646), MATTHEW CHIU (565), NAZILA AFGHANI (764)

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): December 9, 10, 11, 13, 16, 17, and 18, 2019.

The following intakes were inspected in this critical incident inspection:
- Logs #013451-19, #018282-19, #020527-19 related to falls,
- Log #020958-19 related to fracture of unknown cause,
- Log #015015-19 related to improper medication administration, and
- Log #021053-19 related to unexpected death.

During the course of the inspection, the inspector(s) spoke with the Directors of Care (DOCs), Assistant Directors of Care (ADOCs), Registered Dietitian (RD), Food and Nutrition Manager (FNM), Dietary Aide, Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Clinical Practice Educator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs)/Personal Care Attendants (PCAs), and Residents.

During the course of the inspection, the inspector observed staff to resident interactions, provision of resident care, medication administration, reviewed residents' health care records, investigation notes, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 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 has failed to ensure that the care in resident #002's plan of care was provided to the resident as specified in the plan.

Critical Incident System (CIS) report showed that on an identified date, resident #002 had an unwitnessed fall and was found on the floor. The resident was later found with an identified injury resulting from the fall.

Review of resident #002's falls risk assessment and progress notes indicated that resident #002 was at risk of falls and had a history of falls prior to the above-mentioned fall incident.

Review of resident #002's plan of care prior to the fall indicated that staff were to ensure resident was provided with an identified falls prevention intervention. Review of plan of care revisions showed that the identified intervention for resident #002 had been in place for an identified period and the intervention also appeared on the recent care plan revisions for resident #002 after the abovementioned fall. Review of resident #002's progress notes indicated that the date of the fall, the resident did not have their identified falls prevention intervention.

Interview with Personal Care Attendant (PCA) #104 indicated that on the day of the incident, they were unable to find the falls prevention intervention. They further stated that the falls prevention intervention had been in resident #002's plan of care for an identified period.

Interview with PCA #105 stated that on the day of the fall, after getting resident #002 up from bed, they noticed resident did not have their identified falls prevention intervention.

In an interview, Registered Practical Nurse (RPN) #102 stated that at the time of the fall, resident #002 did not have their identified falls prevention intervention, and it had not been available for the resident since the day prior to the incident.

Interview with Director of Care (DOC) #100 stated that, despite clear directions in resident #002's plan of care, the resident was not provided with their falls prevention intervention at the time of incident as per the resident's in the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in resident #001's plan of care was provided to the resident as specified in the plan.

a. The home submitted a CIS report related to resident #001's fall that occurred on an identified date. The resident was taken to the hospital and diagnosed with an identified injury.

Review of resident #001's RAI-MDS assessment and plan of care indicated that the resident had both cognitive and physical impairments at the time of the above-mentioned fall. The plan of care stated the resident was at risk for falls and had interventions implemented for falls prevention. One of the interventions, created on an identified date, stated that the resident was to have an identified falls prevention intervention provided at all times, but the resident may refuse them for identified reasons.

Separate interviews with resident #001's primary PCAs, PCAs #107 and #109 indicated that after the resident's recovery from the above-mentioned injury, their physical functioning had improved and was able to ambulate using an identified assistive device. The resident was at an identified level of risk for falls and contributing factors to falls risk was identified. During the above interviews, PCAs #107 and #109 stated they did not provide resident #001 the identified falls prevention intervention on their shifts. The PCA #107 further stated that since the resident did not like to use the identified falls prevention interventions and may refuse the intervention, and the staff had stopped providing the identified falls prevention intervention on their own.

b. The home submitted a CIS report on another identified date related to resident #004, who had sustained an identified injury with unknown cause.

Review of resident #004's RAI-MDS assessment and plan of care indicated the resident had both cognitive and physical impairments at the time of the above-mentioned date. The plan of care stated the resident was at risk for falls and had interventions implemented for falls prevention. One of the interventions indicated that the resident was to have an identified falls prevention provided, but the resident refused to use it.

Interviews with resident #004's primary PCAs #107 and #109 indicated that resident #004 was at risk for falls. The staff stated they did not provide the identified falls prevention intervention to the resident during their shifts on the identified dates above. PCA #109 further stated that the resident had previously refused to use the identified falls prevention intervention on several occasions.

Further, review of resident #001 and #004's progress notes and Point Click Care's Point of Care records did not indicate any records related to the use of the identified falls prevention intervention, or whether the resident had refused to use them or whether the residents had refused to use them on the two identified dates above.

Interview with Registered Nurse (RN) #108 stated that resident #001 and #004's plans of care directed staff to provide the identified falls prevention intervention for the residents. If they refused, staff should report it to the unit nurse and the nurse would document the refusal. RN #108 stated they were aware that residents #001 and #004 did not have their falls prevention interventions. RN #109 stated during the interview that they had not received any reports indicating the residents had refused to use their identified falls prevention intervention on their shift.

Interview with Assistant Director of Care (ADOC) #112 indicated that staff should have followed resident #001 and #004's plans of care to apply the identified falls prevention interventions for the identified residents on all shifts. If the residents had refused, it should be reported to the nurse and the refusal should be documented. ADOC #112 acknowledged that the use of the identified falls prevention interventions set out in resident #001's and #004's plans of care were not provided to the residents as specified in their plans. [s. 6. (7)]

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

A CIS report was submitted to the Ministry of Long-Term Care (MLTC) on an identified date related to an incident of unexpected death. At an identified time on the date of the incident, the private caregiver notified RPN #119 that resident #005 was coughing. RPN #119 went to get treatment and monitoring equipment while PSW #120 stayed with the resident and the caregiver. Upon return, the RPN saw that the resident required emergency treatment and provided identified emergency techniques and the resident responded to the emergency techniques. Further treatment was provided for the resident by the RN. Upon rechecking the resident, the RN was unable to obtain blood pressure or apical pulse from resident #005. The SDM of resident #005, the physician and coroner were called, and the coroner identified the cause of death for the resident. The CIS report further stated that the resident was provided an identified modified food texture.

Review of resident #005's care plan in place at the time of the incident showed that the resident was to receive another identified modified food texture different than what was on the CIS report. Review of the physician's order for the resident on the date of the incident showed the same information as the resident's care plan, which had a different modified food texture than was stated on the CIS report.

Review of the resident's care plan and diet on the physician's order showed that a revision was made on the day after the resident passed away, and the food texture was changed to be the same as what was stated on the CIS report.

Interview with dietary aide #124 who worked on the date of the incident stated that they would have provided the diet as specified on the dietary Kardex in the servery, and that the Food and Nutrition Manager (FNM) would update the dietary Kardex if any changes were made for the resident. However, the dietary aide could not recall what diet texture was provided for resident #005 that day.

Interview with FNM #123 stated that the Registered Dietitian (RD) is in charge of updating the care plan, but the FNM or dietary supervisors would update the dietary Kardex used by the dietary staff. The RD would write on the RD communication tool the specific dietary changes for a resident, and the FNM or dietary supervisors would update the dietary Kardex. Review of the RD communication tool by FNM #123 showed that there was a note in the month prior to the incident to further modify the resident's fluid consistency. However, there were no directions from RD #122 since that day to the time of the incident regarding directions to change resident #005's diet for food texture modification to the texture identified on the CIS. FNM #123 stated that they would not have changed the resident's diet texture on the dietary Kardex unless the RD had

instructed them to do so.

Interview with PSW #120 who had responded to the incident that date stated that by the time they arrived, resident #005's private caregiver had already taken the food to resident #005. The PSW further stated that they had seen the private caregiver provide identified eating assistance to the resident, and that the resident was seated upright. PSW #120 stated that they had first gone to collect resident #005's meal tray, they had observed that a portion of the resident's modified texture food was consumed. The texture of the food mentioned by the PSW was the same as identified on the CIS report. The PSW stated that the resident had finished the identified food and had eaten well that day. At that point, while the dish was being collected, the PSW stated the resident began to have an identified action, and they called for the registered staff.

Interview with RPN #119 who had responded to the resident stated that the resident had received an identified modified food texture and had been eating that identified texture food every time the RPN had seen them. This texture was the same as identified on the CIS report. The RPN stated that they had not reviewed the resident's care plan for their diet but had always thought the resident was ordered the modified texture that they had observed, that is, the modified texture identified on the CIS report. The RPN further stated that it would be the RD who would update the diet for the resident.

The home did not have the contact information of resident #005's private caregiver, and they could not be interviewed in this inspection.

Interview with RD #122 stated that they had assessed resident #005 on an identified date about one month prior to the incident, and again on the date of the incident, related to identified dietary issues for the resident. The RD stated that the resident had required an identified modified texture as specified on the CIS report on the identified date about one month prior to the incident. The RD stated that during the dates of their assessment, the resident had been provided with modified food texture as identified on the CIS. The RD stated that they had not checked the dietary Kardex, care plan, or physician's orders on the dates where they had assessed the resident and had thought the resident was already receiving the identified modified food texture. The RD further stated that they had made the revision on the date after the resident passed away, as there was originally a scheduled meeting with the family that day, and the RD noticed that the changes to the resident's food texture had not been made. The RD further stated that they were not aware the resident had passed away the day prior, until after they had made the changes on the computer and reviewed the resident's progress notes on PCC.

In separate interviews, RD #122 and DOC #121 both stated that resident #005's diet texture should have been changed to the modified food texture identified on the CIS when the resident's nutritional care needs changed about one month prior to the incident and it was not done. [s. 6. (10) (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 to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A CIS report was submitted to the MLTC related to a medication incident on an identified date where resident #007's medications were administered to resident #006 by RPN #113. Resident #006 showed identified symptoms and was transferred to the hospital.

Review of the home's medication incident report showed that RPN #113 was to administer 13 identified medications to resident #007, but had instead administered them to the incorrect resident, resident #006.

Review of resident #006's eMAR the date of the incident showed that resident #006's own medications at that identified time were not provided for the resident because of the incident above and were put on hold.

Interviews with residents #006 and #007, indicated that on the date of the incident, a new nurse had come to the room, and stated they were here to give the medication, and provided the medications to resident #006. Resident #006 stated the nurse neither called the resident's name, nor checked their wristband prior to providing their medication. Resident #007 stated that the nurse did not give resident #007 their medication, and they asked the nurse for their medication, to which the nurse apologized and stated they thought resident #007 was a visitor.

Interview with RPN #113 stated that they had checked the room number and the medication but had not checked the resident's face on the computer's eMAR prior to providing the medication. Upon entering the room, the RPN saw a person seated in a chair, and another person seated in the bed. The RPN stated they had thought the person in the chair was a visitor, and went to the resident in the bed, and stated they were here to provide the resident's medication. The RPN stated they did not call out the resident's name or check the resident's wrist band but had provided the resident in the bed with their medication and had left the room.

RPN #113 stated that several minutes later, the person seated in the chair came to the RPN and asked the RPN for their medication, and the RPN realized that they had made an error in the medication administration. The RPN called RN #118 for assistance, and resident #006 was sent to the hospital. RPN #113 stated that RN #118 later gave resident #007 their medication.

Interview with RN #118 stated that RPN #113 had informed the RN of the medication error, where the RPN had given resident #007's medications to resident #006. The RN contacted the physician, who ordered all of resident #006's medication at the identified time to be on hold and to closely monitor the resident. The RN monitored the resident and noticed that the resident displayed identified signs of changes in health status. The

physician was called and resident #006 was sent to the hospital to be further monitored. Resident #006 returned to the home and continued to be closely monitored by staff. RN #118 stated that to prevent this incident, RPN #113 should have followed the home's process to check if it was the right resident by calling the resident's name, checking the photo on the medication cart computer, and checking the resident's ID band on their wrist.

Interview with DOC #121 stated that it is the home's expectation to verify that the right resident is receiving the medication by visual confirmation with the photograph in the medication record and the resident's ID bracelet. The DOC further stated that the RPN #113 did not verify that it was the right resident, and the wrong medications that had not been prescribed for resident #006 were administered to the resident. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #009 was inspected as part of the sample expansion when a finding of non-compliance was identified for resident #006 related to medication administration.

Review of the home's identified medication administration policy showed that the registered staff was to remain with the resident until oral drugs have been swallowed, and was not to leave medication at the bedside or dining table.

Review of resident #009's physician's order showed that the resident was prescribed an identified medication at an identified time.

During the observation of the medication pass by Inspectors #646 and #764 on an identified date, the inspectors observed RPN #116 provide resident #009 with the identified medication at the dining table and returned to their medication cart after giving the identified medication to resident #009. As RPN walked away from the resident, the inspectors observed resident #009 dispose of some of the identified medication in a beverage cup on the table. Resident #009 was then observed to leave the dining room without completing their prescribed amount the identified medication. The inspectors observed that the amount of medication left was more than half of the initial amount offered to the resident, and the resident had taken less than half of their prescribed identified medication.

The inspectors continued medication pass observation with RPN #116 and did not

observe the RPN return to resident #009 or the dining room to see if the resident had completed the identified medication. Upon return to the dining room, the dining tables were observed to be cleared, and resident #009 had not been administered the full dose of their identified medication as prescribed.

Review of the eMAR for the identified medication at the identified time for resident #009 on the identified date, showed that the staff had documented that resident #009 had taken the full dosage of their identified medication.

Interview with DOC #121 stated that, when administering medication to a resident, it was the home's expectation for the registered staff to remain with the resident until the drugs have been swallowed by the resident. The DOC stated it was not done in this incident with resident #009 and their identified medication, and the staff did not ensure that the full dosage of the identified medication was administered to resident #009 as prescribed. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, and
- drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to inform the Director immediately, in as much detail as is possible in the circumstances of an unexpected or sudden death for resident #005.

A CIS report was submitted to the MLTC on an identified date, related to an incident of unexpected death on two days prior to the date the CIS was submitted.

Interview with DOC #121 stated that this was an incident of unexpected death of resident #005, and the MLTC Director should have been informed immediately, but no after-hours line was called, and the CIS report was submitted two days after the incident of resident #005's unexpected death. [s. 107. (1)]

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 23rd day of January, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	IVY LAM (646), MATTHEW CHIU (565), NAZILA AFGHANI (764)
Inspection No. / No de l’inspection :	2019_769646_0018
Log No. / No de registre :	013451-19, 015015-19, 018282-19, 020527-19, 020958-19, 021053-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 14, 2020
Licensee / Titulaire de permis :	The Kensington Health Centre 25 Brunswick Avenue, TORONTO, ON, M5S-2L9
LTC Home / Foyer de SLD :	The Kensington Gardens 25 Brunswick Avenue, TORONTO, ON, M5S-2L9
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	William O'Neill

Ontario

Ministry of Long-Term Care

Ministère 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 Kensington Health Centre, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 001

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 the LTCHA, 2007.

Specifically, the licensee shall ensure that:
a. Residents #001, #002, #004, and all residents, whose care plans indicate they require an identified intervention, are provided the intervention as specified in their plan.
b. Staff on each shift to document the provision of the intervention, and to indicate a reason when it was not provided to the residents.

Grounds / Motifs :

1. The licensee has failed to ensure that the care in resident #002's plan of care was provided to the resident as specified in the plan.

Critical Incident System (CIS) report showed that on an identified date, resident #002 had an unwitnessed fall and was found on the floor. The resident was later found with an identified injury resulting from the fall.

Review of resident #002's falls risk assessment and progress notes indicated that resident #002 was at risk of falls and had a history of falls prior to the above-mentioned fall incident.

Review of resident #002's plan of care prior to the fall indicated that staff were to ensure resident was provided with an identified falls prevention intervention. Review of plan of care revisions showed that the identified intervention for resident #002 had been in place for an identified period and the intervention also appeared on the recent care plan revisions for resident #002 after the abovementioned fall. Review of resident #002's progress notes indicated that

the date of the fall, the resident did not have their identified falls prevention intervention.

Interview with Personal Care Attendant (PCA) #104 indicated that on the day of the incident, they were unable to find the falls prevention intervention. They further stated that the falls prevention intervention had been in resident #002's plan of care for an identified period.

Interview with PCA #105 stated that on the day of the fall, after getting resident #002 up from bed, they noticed resident did not have their identified falls prevention intervention.

In an interview, Registered Practical Nurse (RPN) #102 stated that at the time of the fall, resident #002 did not have their identified falls prevention intervention, and it had not been available for the resident since the day prior to the incident.

Interview with Director of Care (DOC) #100 stated that, despite clear directions in resident #002's plan of care, the resident was not provided with their falls prevention intervention at the time of incident as per the resident's in the plan of care. (764)

2. The licensee has failed to ensure that the care set out in resident #001's plan of care was provided to the resident as specified in the plan.

a. The home submitted a CIS report related to resident #001's fall that occurred on an identified date. The resident was taken to the hospital and diagnosed with an identified injury.

Review of resident #001's RAI-MDS assessment and plan of care indicated that the resident had both cognitive and physical impairments at the time of the above-mentioned fall. The plan of care stated the resident was at risk for falls and had interventions implemented for falls prevention. One of the interventions, created on an identified date, stated that the resident was to have an identified falls prevention intervention provided at all times, but the resident may refuse them for identified reasons.

Separate interviews with resident #001's primary PCAs, PCAs #107 and #109

indicated that after the resident's recovery from the above-mentioned injury, their physical functioning had improved and was able to ambulate using an identified assistive device. The resident was at an identified level of risk for falls and contributing factors to falls risk was identified. During the above interviews, PCAs #107 and #109 stated they did not provide resident #001 the identified falls prevention intervention on their shifts. The PCA #107 further stated that since the resident did not like to use the identified falls prevention interventions and may refuse the intervention, and the staff had stopped providing the identified falls prevention intervention on their own.

b. The home submitted a CIS report on another identified date related to resident #004, who had sustained an identified injury with unknown cause.

Review of resident #004's RAI-MDS assessment and plan of care indicated the resident had both cognitive and physical impairments at the time of the above-mentioned date. The plan of care stated the resident was at risk for falls and had interventions implemented for falls prevention. One of the interventions indicated that the resident was to have an identified falls prevention provided, but the resident refused to use it.

Interviews with resident #004's primary PCAs #107 and #109 indicated that resident #004 was at risk for falls. The staff stated they did not provide the identified falls prevention intervention to the resident during their shifts on the identified dates above. PCA #109 further stated that the resident had previously refused to use the identified falls prevention intervention on several occasions.

Further, review of resident #001 and #004's progress notes and Point Click Care's Point of Care records did not indicate any records related to the use of the identified falls prevention intervention, or whether the resident had refused to use them or whether the residents had refused to use them on the two identified dates above.

Interview with Registered Nurse (RN) #108 stated that resident #001 and #004's plans of care directed staff to provide the identified falls prevention intervention for the residents. If they refused, staff should report it to the unit nurse and the nurse would document the refusal. RN #108 stated they were aware that residents #001 and #004 did not have their falls prevention interventions. RN

#109 stated during the interview that they had not received any reports indicating the residents had refused to use their identified falls prevention intervention on their shift.

Interview with Assistant Director of Care (ADOC) #112 indicated that staff should have followed resident #001 and #004's plans of care to apply the identified falls prevention interventions for the identified residents on all shifts. If the residents had refused, it should be reported to the nurse and the refusal should be documented. ADOC #112 acknowledged that the use of the identified falls prevention interventions set out in resident #001's and #004's plans of care were not provided to the residents as specified in their plans.

The severity of this non-compliance was identified as minimal harm or risk, and the scope was identified as widespread as it related to three out of four residents reviewed. Review of the home's compliance history revealed a previous complied order to the same subsection LTCHA, 2007 S.O. 2007, c.8 s. 6. (7). under inspection report #2019_616722_0016 issued July 30, 2019. Due to the scope being widespread and previous non-compliance, a compliance order is warranted. (565)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 09, 2020

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 Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

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

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 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 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 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 14th day of January, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ivy Lam

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