Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 18, 2019	2019_641665_0004	030986-18, 031105-18	Complaint

Licensee/Titulaire de permis

Kristus Darzs Latvian Home
11290 Pine Valley Drive Woodbridge ON L4L 1A6

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

Kristus Darzs Latvian Home
11290 Pine Valley Drive Woodbridge ON L4L 1A6

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

JOY IERACI (665)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 22, 25, 28, March 1, 5, 6, 7, 8 and 11, 2019. Off site March 12 and 13, 2019.

The following intakes were inspected:
- Log #030986-18 related to skin and wound, abuse and falls
- Log #031105-18 related to skin and wound

PLEASE NOTE: A Compliance Order #001 related to LTCHA, 2007, c.8, s. 6 (7), identified in a concurrent CIS inspection #2019_641665_0005 dated March 18, 2019, was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Quality Lead (QL), Resident Support Manager (RSM), Nurse Practitioner (NP), Facilities Manager (FM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Substitute Decision Maker (SDM) and residents.

During the course of the inspection, the inspector observed staff and resident interactions, reviewed clinical health records, training records, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
0 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 set out in the plan of care was provided to the resident as specified in the plan.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint through the ACTIONline on an identified date from resident #001's SDM, related to care concerns of the resident. One of the care concerns was related to an area of altered skin integrity that was observed by the SDM on a specified date.

In an interview, the SDM indicated on their visit on the specified date, they observed two areas of altered skin integrity on resident #001, with one area bigger than the other and had looked like it had been there for days. The SDM indicated the staff were not aware of the areas of altered skin integrity until they brought it to the attention of RN #109.

A review of the progress notes made by RN #109 on the specified date above, indicated their assessment of the two areas of altered skin integrity and their measurements. RN #109 informed the SDM that the areas of altered skin integrity appeared old, not new.

A review of the written plan of care at the time of the incident, indicated an intervention for the PSWs to document on the flow sheet if skin is intact and of any areas of altered skin integrity. The PSWs were directed to report any new areas of altered skin integrity to the registered staff.

The home's skin and wound program policy with a last reviewed date of May 18, 2018, indicated that the roles and responsibilities of the PSW was to screen for and document

electronically in point of care (POC) and immediately verbally report to the registered nursing staff any abnormal or unusual skin conditions, for example red or open areas, blisters, bruises, tears, scratches.

In an interview, PSW #104 indicated they had initially observed the altered skin integrity nine days prior to the SDM's observation, and reported it to registered staff. In another interview, PSW #110, indicated they had observed the altered skin integrity one day prior to the SDM's observation, but did not report the altered skin integrity to the registered staff.

A review of the documentation survey reports for a specified two month period indicated the following:
- PSW #104 did not document the resident's skin condition and altered skin integrity on five identified dates.
- PSW #110 did not document the resident's skin condition and altered skin integrity on an identified date

A review of the progress notes and assessments did not locate documentation of the altered skin integrity to resident #001 prior to the SDM's observation.

In interviews, PSWs #104 and #110 indicated that when a resident has altered skin integrity, it is the home's process to report the altered skin integrity to the registered staff and document the altered skin integrity in POC. PSW #104 reviewed the documentation survey reports for the identified two month period and indicated that they did not follow resident #001's plan of care in documenting the area of altered skin integrity on five identified dates. The PSW indicated that they did not document resident #001's skin condition correctly on one identified date in POC.

In the interview, PSW #110 indicated it was their mistake for not reporting the areas of altered skin integrity to the registered staff and for not documenting on the areas of altered skin integrity the day before the SDM's observation. The PSW indicated that they did not follow the plan of care for resident #001 related to documentation and reporting altered skin integrity.

In an interview, the DOC indicated it is the home's process for the PSW staff to report to the registered staff and document in POC any altered skin integrity observed on residents. The DOC acknowledged that PSWs #104 and #110 did not follow resident #001's plan of care related to reporting and documenting the altered skin integrity. [s. 6.

(7)]

2. The MOHLTC received a complaint through the ACTIONline on an identified date, from resident #001's SDM, related to care concerns of the resident. One of the care concerns was related to the number of falls the resident had which caused injury.

In an interview, the SDM indicated that resident #001 had a two falls which caused injury. The SDM stated that one fall, resulted in the resident having an identified injury, and three months later, the resident sustained another injury which required an identified treatment in hospital.

A review of the clinical records indicated that resident #001 had a history of falls. The falls risk assessments on four identified dates over a five month period, indicated that the resident was at high risk for falls.

A further review of the clinical records indicated the resident had four falls over a specified period of four months which included injury to resident #001 noted above.

A review of the written plan of care indicated a falls intervention of a specified safety device.

In interviews, RPNs #103 and #108 and PSW #104 indicated the safety device was in the resident's plan of care as a falls intervention when the resident's mobility status changed on an identified month and year.

A review of the MOHLTC's Critical Incident System (CIS) reports indicated resident #001's fall which resulted in the identified injury. The CIS report indicated that the intervention for staff to ensure that the specified safety device was on and working, was in place prior to the fall.

In an interview, PSW #113 indicated that resident #001 was sitting on their mobility aide in a specified common area, and while the PSW was transporting residents out of the main dining room to an identified resident home area, they found the resident lying on the floor in the specified common area. The PSW stated that they did not hear the safety device at the time of the fall and did not observe the safety device on the resident. PSW #113 further indicated that if the safety device was on and working, they would have heard the safety device, but didn't.

In an interview, RPN #114 indicated that they assessed the resident after the fall. The RPN indicated that the resident had a history of falls and had the specified safety device at the time of the fall, as an intervention to manage falls. The RPN stated that they observed the safety device attached to the resident's mobility aide but not on the resident.

In an interview, the DOC indicated it is the home's process for the plan of care to be followed as specified in the plan. The DOC acknowledged that the staff did not follow the plan of care for resident #001 as the staff did not ensure that the specified safety device was on and working. [s. 6. (7)]

3. Resident #003 was randomly selected to expand the sample for non-compliance identified for resident #002 in a concurrent CIS inspection #2019_641665_0005.

A review of the progress note by RPN #103 on an identified date, indicated that PSW #119 reported resident #003's altered skin integrity.

A review of the written plan of care at the time of the incident, indicated an intervention for the PSWs to document on the flow sheet if skin is intact and of any areas of altered skin integrity. The PSWs were directed to report any new areas of altered skin integrity to the registered staff.

A review of the documentation by PSW #119 on an identified date, in POC, under skin condition, did not locate any documentation of the altered skin integrity of resident #003.

In an interview, PSW #119 indicated that they had reported the altered skin integrity of resident #003 to RPN #103 prior to care on the identified date. The PSW stated that it is the home's process for any altered skin integrity to be documented in POC under skin condition and be reported to the nurse. The PSW reviewed resident #003's POC documentation on the identified date, and acknowledged that they did not follow the plan of care regarding documentation of the resident's altered skin integrity.

In an interview, the DOC indicated it is expected for the staff to follow the plan of care of the residents. The DOC acknowledged that PSW #119 did not follow the plan of care regarding documentation of resident #003's altered skin integrity. [s. 6. (7)]

4. 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, care set

out in the plan had not been effective.

This non-compliance is further evidence to support compliance order (CO) #001 that was issued on January 25, 2019, during a CIS inspection #2018_766500_0021 to be complied April 30, 2019.

In an interview, the SDM indicated that resident #001 had a two falls which caused injury. The SDM stated that one fall, resulted in the resident having an identified injury, and three months later, the resident had another fall and sustained another injury which required an identified treatment in hospital. In the interview, the SDM indicated they were concerned that the falls occurred when the resident was alone in a specified common area and unsupervised, and had made recommendations to the staff not to leave the resident alone in the specified common area after the fall that caused injury three months later as noted above.

A record review indicated that the SDM had made a written complaint to the ED and DOC on an identified date, regarding the two falls the resident had with injury. A review of the complaint indicated that the SDM met with the ED on the same day the written complaint was made, and had requested that the resident not to be left alone. A review of the progress note six days later indicated that the SDM attended a meeting with the home and did not want the resident to spend time in the specified common area alone.

Further review of the clinical records indicated the resident had three falls in the specified common area over a period of three months which resulted in injury noted above.

A review of the clinical records and falls risk assessments indicated that resident #001 had a history of falls and was a high risk for falls.

In interviews, RPNs #103 and #108 and the FM (RN #105) indicated that the resident also had a history of responsive behaviours towards staff and other residents, which made managing the resident's falls and responsive behaviours challenging.

A review of the written plan of care at the time of the falls, indicated the resident had seven identified falls interventions. In addition, the written plan of care had interventions to bring the resident to another identified common area to engage in a particular activity to manage the resident's responsive behaviours, and when the resident exhibited responsive behaviour, bring the resident to their room or another quiet location.

In interviews, RPNs #103, #108 and #114 and PSWs #104 and #116 indicated that the resident was monitored by placing them in the other identified common area to manage the resident's falls. However, the RPNs and PSW #104 stated that the staff would leave the resident in the specified common area engaged in the specified activity when the resident exhibited responsive behaviours. In the interviews, the RPNs and PSW #104 indicated that when the resident was in the specified common area, staff would monitor the resident as staff walked by.

The interviews with RPNs #103, #108 and #114 indicated that the intervention to leave the resident in the specified common area alone was not effective in managing the resident's falls, as the resident had falls while in this area and sustained injury. The RPNs indicated that the plan of care was changed for the resident not to be left alone in the specified common area after the SDM had a meeting in the home after the last fall with injury.

A review of the written plan of care after the last fall with injury, indicated new interventions to manage the resident's falls, which included, monitor closely to ensure safety, resident is not to be left alone in the specified common area and bring the resident to the other identified common area for close monitoring.

In interviews, Facility Manager RN #105 and the DOC indicated that the intervention to leave resident #001 in the specified common area engaged in the specified activity was not effective in managing the resident's falls, but was effective in managing the resident's responsive behaviours. The DOC stated that the plan of care was reassessed and revised after the SDM made a complaint and recommended that resident #001 not to be left alone in the specified common area.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 has failed to ensure that a written complaint concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

1) A review of the home's complaint form and documentation of the complaint indicated that the home received the written complaint from the SDM through email on an identified date.

A review of the written complaint the MOHLTC received from the home indicated that the complaint was forwarded to the Director eight days after the home received the written complaint.

In interviews, the DOC and ED indicated that the written complaint was not forwarded to the Director immediately.

2) In an interview, the SDM of resident #001 indicated they sent a written complaint to the DOC and ED regarding the number of falls the resident had with injury. The SDM indicated they had sent the complaint through email after the resident's fall on an identified date.

A review of the home's complaints binder located the written complaint the SDM forwarded to the home on an identified date and time. The home's complaint form did not have documentation that the written complaint was forwarded to the Director.

In interviews, the DOC and ED acknowledged that the written complaint was not forwarded to the Director as required.

The sample was expanded as a result of the non-compliance identified.

A review of the home's complaints binder indicated two written complaints from family

members of residents #005 and #006.

3) A review of the home's complaint form and documentation for resident #005, indicated that a family member emailed the DOC and Quality Lead on an identified date and time regarding care concerns of an incident that occurred with resident #005. The complaint documentation did not indicate that the written complaint was forwarded to the Director.

4) The home received a handwritten letter from a family member of resident #006 on an identified date. The complaint form indicated that the family member had identified care concerns of the resident. The complaint documentation did not indicate that the written complaint was forwarded to the Director.

In interviews, the DOC and ED indicated that the written complaints related to residents #005 and #006 were not forwarded to the Director as per legislative requirements. [s. 22. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The home has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1) The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

The MOHLTC received a complaint through the ACTIONline on an identified date, from resident #001's SDM, related to care concerns of the resident. The home forwarded a written complaint from the SDM on an identified date, to the MOHLTC, related to areas of altered skin integrity the SDM observed on resident #001 on an identified date.

A review of the home's investigation by the DOC indicated the following:
- The DOC had staff meetings with the resident home area's staff
- PCC documentation indicated the resident did not have a fall and there were no incident report related to inappropriate staff care.
- Staff stated resident #001 had identified responsive behaviours.

- Staff stated that resident always have the identified altered skin integrity due to the resident's responsive behaviour.

A further review of the investigation notes did not locate documentation on the questions that were asked by the DOC to the staff, the staff that were present in the staff meetings and the PCC documentation that was reviewed by the DOC.

In an interview, the DOC indicated they conducted an investigation through staff meetings with the permanent staff on two identified shifts and that the staff indicated there were no concerns or inappropriate treatment of the resident. The DOC stated that they did not have documentation as to the questions they asked the staff, who attended the staff meetings and did not interview staff who cared for the resident individually. The DOC indicated they were not aware that PSWs #104 and #110 observed the area of altered skin integrity prior to the SDM's observation, until it was brought up to their attention by the inspector.

In an interview, the ED indicated they would expect the investigation to resident #001's area of altered skin integrity to include individual interviews with the staff who provided care to the resident and a complete review of the documentation in PCC by both the registered staff and PSWs. The ED reviewed the investigation that was conducted by the DOC and acknowledged it was not a sufficient and complete investigation, especially when the inspector was informed by PSWs #104 and #110 that they had observed the altered skin integrity prior to the SDM's observation on the identified date. [s. 101. (1) 1.]

2. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 3) A response shall be made to the person who made the complaint, indicating, i) what the licensee has done to resolve the complaint.

In an interview, the SDM of resident #001 indicated that they did not receive a response from the home related to their written complaint on an identified date related to the resident's altered skin integrity, and was still waiting for the outcome of the home's investigation.

A review of the home's complaint form indicated that the complaint was unresolved and did not have documentation whether a response to the complainant was provided.

In an interview, the DOC indicated that the home offered the complainant to come and

meet with the team and management on three identified dates, but was not able to meet with the complainant. The DOC stated the resident was transferred to an identified facility on an identified date, few days later, and did not return to the home. In the interview, the DOC acknowledged that a response to the complainant was not provided as required.

In an interview, the ED acknowledged that a response to the complainant was not provided. The ED indicated that a response letter was sent to the complainant and to the MOHLTC at the time of this inspection, after the inspector brought it to the home's attention. [s. 101. (1) 3.]

Issued on this 27th day of March, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOY IERACI (665)
Inspection No. / No de l'inspection :	2019_641665_0004
Log No. / No de registre :	030986-18, 031105-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 18, 2019
Licensee / Titulaire de permis :	Kristus Darzs Latvian Home 11290 Pine Valley Drive, Woodbridge, ON, L4L-1A6
LTC Home / Foyer de SLD :	Kristus Darzs Latvian Home 11290 Pine Valley Drive, Woodbridge, ON, L4L-1A6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lauma Stikuts

To Kristus Darzs Latvian Home, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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 must:

a) Ensure that any resident that is provided with an identified safety device is attached to the resident and their mobility aide as per the plan of care and is working. In addition, any resident that is provided with another identified type of the safety device as per the plan of care is applied to the resident's mobility aide and is working.

b) Develop an on-going auditing process to ensure that the identified safety device used for any resident are applied and working, and include who will be responsible for doing the audits and evaluating the results. The home is required to maintain a documentation record of the audits, the dates the audits were conducted, who performed the audits and an evaluation of the results.

Grounds / Motifs :

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

The Ministry of Health and Long Term Care (MOHLTC) received a complaint through the ACTIONline on an identified date from resident #001's SDM, related to care concerns of the resident. One of the care concerns was related to an area of altered skin integrity that was observed by the SDM on a specified date.

In an interview, the SDM indicated on their visit on the specified date, they

observed two areas of altered skin integrity on resident #001, with one area bigger than the other and had looked like it had been there for days. The SDM indicated the staff were not aware of the areas of altered skin integrity until they brought it to the attention of RN #109.

A review of the progress notes made by RN #109 on the specified date above, indicated their assessment of the two areas of altered skin integrity and their measurements. RN #109 informed the SDM that the areas of altered skin integrity appeared old, not new.

A review of the written plan of care at the time of the incident, indicated an intervention for the PSWs to document on the flow sheet if skin is intact and of any areas of altered skin integrity. The PSWs were directed to report any new areas of altered skin integrity to the registered staff.

The home's skin and wound program policy with a last reviewed date of May 18, 2018, indicated that the roles and responsibilities of the PSW was to screen for and document electronically in point of care (POC) and immediately verbally report to the registered nursing staff any abnormal or unusual skin conditions, for example red or open areas, blisters, bruises, tears, scratches.

In an interview, PSW #104 indicated they had initially observed the altered skin integrity nine days prior to the SDM's observation, and reported it to registered staff. In another interview, PSW #110, indicated they had observed the altered skin integrity one day prior to the SDM's observation, but did not report the altered skin integrity to the registered staff.

A review of the documentation survey reports for a specified two month period indicated the following:
- PSW #104 did not document the resident's skin condition and altered skin integrity on five identified dates.
- PSW #110 did not document the resident's skin condition and altered skin integrity on an identified date

A review of the progress notes and assessments did not locate documentation of the altered skin integrity to resident #001 prior to the SDM's observation.

In interviews, PSWs #104 and #110 indicated that when a resident has altered skin integrity, it is the home's process to report the altered skin integrity to the registered staff and document the altered skin integrity in POC. PSW #104 reviewed the documentation survey reports for the identified two month period and indicated that they did not follow resident #001's plan of care in documenting the area of altered skin integrity on five identified dates. The PSW indicated that they did not document resident #001's skin condition correctly on one identified date in POC.

In the interview, PSW #110 indicated it was their mistake for not reporting the areas of altered skin integrity to the registered staff and for not documenting on the areas of altered skin integrity the day before the SDM's observation. The PSW indicated that they did not follow the plan of care for resident #001 related to documentation and reporting altered skin integrity.

In an interview, the DOC indicated it is the home's process for the PSW staff to report to the registered staff and document in POC any altered skin integrity observed on residents. The DOC acknowledged that PSWs #104 and #110 did not follow resident #001's plan of care related to reporting and documenting the altered skin integrity.
(665)

2. The MOHLTC received a complaint through the ACTIONline on an identified date, from resident #001's SDM, related to care concerns of the resident. One of the care concerns was related to the number of falls the resident had which caused injury.

In an interview, the SDM indicated that resident #001 had a two falls which caused injury. The SDM stated that one fall, resulted in the resident having an identified injury, and three months later, the resident sustained another injury which required an identified treatment in hospital.

A review of the clinical records indicated that resident #001 had a history of falls. The falls risk assessments on four identified dates over a five month period, indicated that the resident was at high risk for falls.

A further review of the clinical records indicated the resident had four falls over a

specified period of four months which included injury to resident #001 noted above.

A review of the written plan of care indicated a falls intervention of a specified safety device.

In interviews, RPNs #103 and #108 and PSW #104 indicated the safety device was in the resident's plan of care as a falls intervention when the resident's mobility status changed on an identified month and year.

A review of the MOHLTC's Critical Incident System (CIS) reports indicated resident #001's fall which resulted in the identified injury. The CIS report indicated that the intervention for staff to ensure that the specified safety device was on and working, was in place prior to the fall.

In an interview, PSW #113 indicated that resident #001 was sitting on their mobility aide in a specified common area, and while the PSW was transporting residents out of the main dining room to an identified resident home area, they found the resident lying on the floor in the specified common area. The PSW stated that they did not hear the safety device at the time of the fall and did not observe the safety device on the resident. PSW #113 further indicated that if the safety device was on and working, they would have heard the safety device, but didn't.

In an interview, RPN #114 indicated that they assessed the resident after the fall. The RPN indicated that the resident had a history of falls and had the specified safety device at the time of the fall, as an intervention to manage falls. The RPN stated that they observed the safety device attached to the resident's mobility aide but not on the resident.

In an interview, the DOC indicated it is the home's process for the plan of care to be followed as specified in the plan. The DOC acknowledged that the staff did not follow the plan of care for resident #001 as the staff did not ensure that the specified safety device was on and working.

The severity of this issue was determined to be a level three as there was actual harm as resident #001 sustained an injury. The scope of this issue was a

pattern, as it involved two out of three residents that were reviewed. The home had a level four compliance history with the same area of non-compliance that included:
- a Voluntary Plan of Correction (VPC) at inspection #2018_766500_0021 issued January 25,
2019 (665)

3. Resident #003 was randomly selected to expand the sample for non-compliance identified for resident #002 in a concurrent CIS inspection #2019_641665_0005.

A review of the progress note by RPN #103 on an identified date, indicated that PSW #119 reported resident #003's altered skin integrity.

A review of the written plan of care at the time of the incident, indicated an intervention for the PSWs to document on the flow sheet if skin is intact and of any areas of altered skin integrity. The PSWs were directed to report any new areas of altered skin integrity to the registered staff.

A review of the documentation by PSW #119 on an identified date, in POC, under skin condition, did not locate any documentation of the altered skin integrity of resident #003.

In an interview, PSW #119 indicated that they had reported the altered skin integrity of resident #003 to RPN #103 prior to care on the identified date. The PSW stated that it is the home's process for any altered skin integrity to be documented in POC under skin condition and be reported to the nurse. The PSW reviewed resident #003's POC documentation on the identified date, and acknowledged that they did not follow the plan of care regarding documentation of the resident's altered skin integrity.

In an interview, the DOC indicated it is expected for the staff to follow the plan of care of the residents. The DOC acknowledged that PSW #119 did not follow the plan of care regarding documentation of resident #003's altered skin integrity.

(665)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 19, 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 18th day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joy Ieraci

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