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 sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 6, 2017	2017_561583_0009	008507-17	Resident Quality Inspection

Licensee/Titulaire de permis

2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

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

Maple Grove Care Community
215 Sunny Meadow Blvd. BRAMPTON ON L6R 3B5

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

KELLY HAYES (583), NATASHA JONES (591), SAMANTHA DIPIERO (619)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 28, May 2, 3, 4, 5, 8 and 9, 2017.

The following inspections were completed concurrently with the Resident Quality Inspection (RQI):
Critical Incident Inspection log #035491-16 related to an unsafe transfer; log #034672-16 related to medications; log # 004067-17 related to falls; and log #000311 -17 related to alleged staff to resident abuse.
Complaint Inspection log #035086-16 related to resident care concerns; and log #002900-17 related to responsive behaviours.
Follow Up Inspection log #004067-17 related to s. 19. (1) duty to protect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered staff including Registered Nurses (RNs), and Registered Practical Nurses (RPNs), Physiotherapist (PT), Personal Support Workers (PSWs), Residents and family members.

During the course of the inspection, the inspectors toured the home, observed the provision of care, reviewed health care records, and reviewed relevant policies, procedures and practices.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **5 WN(s)**
- **3 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_267528_0023	583

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	Legendé 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments were integrated and consistent with and complemented each other.

Observations on an identified date in April 2017, revealed resident #004 had specified bed rails.

A review of an assessment for resident #004 in point click care (PCC) titled "Restraint/PASD assessment", documented on an identified date in 2017, indicated two bed rails were used for bed mobility and positioning, and the purpose of the device was to be used as a personal assistance safety device (PASD). A review of resident#004's

current written plan of care indicated two bed rails were applied when the resident was in bed for bed mobility, transfer and comfort as a PASD.

In interviews on identified dates in May 2017, PSW #121 and registered staff #123 confirmed specified bed rails were used for resident #004 for bed mobility and transfers as a PASD. In an interview on May 5, 2017, the DOC confirmed the above mentioned assessments were not integrated or consistent, and did not complement each other. [s. 6. (4) (a)]

2. The licensee failed to ensure that the resident was re-assessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan had not been effective.

Resident #011 had a history of responsive behaviours. On an identified date in 2016, the resident had a fall and obtained an identified injury and were transferred to hospital for assessment and treatment of the injury. A review of an identified assessment completed by the home indicated that the resident had identified injuries and that the resident experienced pain.

A review of the resident's written plan of care identified the resident had identified interventions in place but that the interventions were not effective due to the residents responsive behaviours.

This was confirmed in an interview with PSW #115. Interview with registered staff #114 indicated that the intervention was removed by the resident prior to the fall. Registered staff #114 further indicated that when a falls prevention intervention is not effective, including the intervention in place for resident #011, that registered staff can change the type of intervention used so that the intervention could be effective, and indicated that this was not completed. A review of the home's policy titled, "Falls Prevention", policy # VII-G-30.00, last revised January 2015, stated, "registered staff will monitor preventative interventions and evaluate effectiveness on an ongoing basis and with the quarterly review".

Interview with the DOC confirmed that the resident #011's specified intervention as part of the falls prevention intervention was ineffective, and that the plan of care was not revised.

Please note: This non-compliance was issued as a result of a Critical Incident (CI)

Inspection, which was conducted concurrently with the RQI Inspection. [s. 6. (10) (c)]

3. The licensee failed to ensure different approaches were considered in the revision of the plan of care when care set out in the plan had not been effective.

The resident was observed on identified dates in April and May 2017.

A review of the resident's current written plan of care indicated they were high risk for falls and identified interventions were in place. A review of the "Falls monthly meeting" notes on an identified dates in 2016 and 2017, indicated resident #014 had an identified pattern of multiple falls. It further indicated an identified number of incidents resulted in injuries and an identified number of incidents resulted in transfers to the hospital. Identified interventions were listed.

A review of resident #014's clinical health records indicated that prior to a fall they sustained on an identified date, specified interventions had been implemented, except for two interventions, which were initiated after the fall on later identified date.

In interviews with PSW's #121 and #122 and registered staff #123, they stated resident #014 was high risk for falls, and sustained multiple falls related to identified behaviours. They confirmed that since the implementation of a specific intervention, the resident has had a significant decrease in the number of falls; however, the resident continued to have falls.

In an interview on May 9, 2017, the ADOC stated other identified fall interventions undertaken by the home to prevent resident #014 from falling. The ADOC stated that due to the resident's identified behaviours and ambulatory status, other alternatives were not considered.

In an interview with the PT on May 10, 2017, they stated that the interventions were implemented late 2015, however; the resident continued to fall. They stated that since an identified intervention was implemented on an identified date in 2017, there had been a significant reduction in the number of falls; however, the resident still had falls. The PT further stated the resident was not assessed for other alternatives and that the home had a "restraint-free" policy.

The home did not ensure different approaches were considered in the revision of the plan of care when care set out in the plan had not been effective in relation to multiple

falls sustained by resident #014.

Please note: This non-compliance was issued as a result of a CI Inspection, which was conducted concurrently with the RQI Inspection. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified date in 2016, resident #002 was transferred by PSW #123 and PSW #124 using an identified type of lift. During the transfer resident #002 fell onto the floor. Assessments completed by registered staff after the fall identified that the resident had pain in an identified area, but no other identified injuries.

The home's investigation identified that the lift was not used correctly by PSW #123. In an interview with the DOC on May 4, 2017, it was confirmed safe transferring and positioning techniques were not used when assisting resident #002.

Please note: This non-compliance was issued as a result of a CI Inspection, which was conducted concurrently with the RQI Inspection. [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 to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: 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 each resident demonstrating responsive behaviours, where possible, the behavioural triggers for the resident were identified and strategies were developed and implemented to respond to these behaviours.

During the home's investigation of an alleged incident on an identified date in 2016, it was identified that resident #015 was responsive towards staff. A review of the resident's progress notes identified resident #015 was responsive towards staff on an identified dates in 2016 and an identified date in 2017. In an interview with registered staff #125 and #126 on an identified date in May 2017, it was confirmed that the resident occasionally demonstrated specified responsive behaviours towards staff. Staff shared identifed triggers for resident #015's behaviours.

During an interview with the DOC and review of resident #015's plan of care it was

identified that resident #015 did not have a responsive behaviour care plan to identify to direct care staff that the resident had identified responsive behaviours. On May 4, 2017, it was confirmed that the resident's behavioural triggers were not identified and strategies for staff to use to respond to the identified behaviours were not developed.

Please note: This non-compliance was issued as a result of a CI Inspection log #000311-17, which was conducted concurrently with the RQI Inspection. [s. 53. (4)]

2. The licensee failed to ensure that for each resident demonstrating responsive behaviours that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions.

Resident #011 had a history of identified responsive behaviours. On an identified date in 2017, resident #011 wandered into a co-resident's room. Interview with resident #014 indicated that there was a resident to resident altercation. Staff in the home became aware of the incident when resident #014 reported it to them the following day.

A review of the resident's written plan of care, identified staff were to monitor behaviour episodes and attempt to determine underlying cause. A review of the resident's clinical record indicated that from an identified date in 2016, to an identified date in 2017, the resident was exhibiting responsive behaviours frequently. Interview with PSW #114 indicated that this was an increase in the resident's usual behaviour pattern, and that behavioural issues are reported to registered staff for further assessment and intervention.

A review of the home's policy titled, "Responsive Behaviours – Management", policy #VII-F-10.20, stated, "the registered staff will complete behavioural assessments based on resident need, including but not limited to: Dementia Observation Screening (DOS), Behavioural Assessment Tools (BAT), and will complete an electronic Responsive Behaviour Referral to the internal BSO lead/Designate when there is a new, worsening, or change in responsive behaviours." Interview with registered staff #115 indicated that the resident's identified behaviours had increased and that no DOS monitoring, or referral to the Behavioural Support Ontario (BSO) nurse was initiated.

Interview with DOC confirmed that the resident's behaviours were not re-assessed and interventions in the plan of care were not revised when the residents responsive behaviours worsened.

Please note: This non-compliance was issued as a result of a Critical Incident (CI) Inspection and Complaint Inspection, which was conducted concurrently with the RQI Inspection. [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 to ensure that, for each resident demonstrating responsive behaviours, where possible, the behavioural triggers for the resident are identified, strategies are developed and implemented to respond to these behaviours and 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 #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that persons who had received training under subsection (2) received retraining in any areas mentioned in that subsection at times or intervals provided for in the regulations.

For the purpose of paragraph 11 of subsection 76(2) of the Act, s. 218 identified training was to be provided in the area of safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that were relevant to the staff member's responsibilities. For the purpose of subsection 76(4) of the Act, s. 219 identified the intervals for training were annual.

The 2016 training records for the area of safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids was provided by the DOC. In an interview with the DOC on May 4, 2017, it was confirmed that training in this area was relevant for direct care staff at the home. A review of the records identified that 69 out of 132 direct care staff completed annual training in this area in 2016. In an interview with the DOC on May 4, 2017, it was confirmed 63 staff did not complete annual retraining in the area of the safe and correct use of equipment.

Please note: This non-compliance was issued as a result of a CI Inspection, which was conducted concurrently with the RQI Inspection. [s. 76. (4)]

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 staff receive retraining in any areas mentioned in that subsection at times or intervals provided for in the regulations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin tears or wounds, was assessed by a registered dietician who is a member of the staff of the home.

Resident #011 returned to the home from hospital on an identified date in 2016, after a fall with injury. A skin and wound assessment documented on an identified date in 2016, noted that the resident obtained an alteration in skin during the fall, and obtained an additional alteration in skin during care when they returned from hospital.

A review of the resident's written plan of care, indicated that the resident had a diagnosis which made them at risk for poor wound healing. A review of the home's policy titled, "Skin & Wound Care Management Protocol", policy #VII-G-10.80, last revised April 2016, stated, "Registered staff will refer to the Registered Dietitian for assessment". A review of the resident's clinical record including progress notes, referrals, and assessments, did not indicate that the resident was referred to the home's Registered Dietitian (RD) for a nutritional assessment to promote wound healing.

Interview with RN #117 indicated that the resident did not receive a referral to the home's RD after returning from hospital with an alteration of skin integrity, and obtaining another on the same day in the home. Interview with the DOC confirmed that registered staff failed to refer the resident with altered skin integrity to the RD for an assessment.

Please note: This non-compliance was issued as a result of a Critical Incident (CI) Inspection and Complaint Inspection, which was conducted concurrently with the RQI Inspection. [s. 50. (2) (b) (iii)]

Issued on this 14th day of June, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY HAYES (583), NATASHA JONES (591), SAMANTHA DIPIERO (619)
Inspection No. / No de l'inspection :	2017_561583_0009
Log No. / Registre no:	008507-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 6, 2017
Licensee / Titulaire de permis :	2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP 302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Maple Grove Care Community 215 Sunny Meadow Blvd., BRAMPTON, ON, L6R-3B5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michele MacKenzie

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

To 2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall ensure that the all residents in the home who employ the use of alarms, including but not limited to door, seat, chair or clipped alarms, as part of their falls prevention strategy are reassessed and the plan of care reviewed and revised when the resident's care needs change or the safety alarm identified in the plan of care has not been effective to ensure the safety of residents in the home.

Grounds / Motifs :

1. 1. Judgment Matrix:
Noncompliance Severity: Actual Harm/Risk
Noncompliance Scope: Isolated
Compliance History: Previously issued as a VPC on October 27, 2016, and as a VPC on January 26, 2015.

The licensee failed to ensure that the resident was re-assessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan had not been effective.

Resident #011 had a history of responsive behaviours. On an identified date in 2016, the resident had a fall and obtained an identified injury and were transferred to hospital for assessment and treatment of the injury. A review of an identified assessment completed by the home indicated that the resident had

identified injuries and that the resident experienced pain.

A review of the resident's written plan of care identified the resident had identified interventions in place but that the interventions were not effective due to the residents responsive behaviours.

This was confirmed in an interview with PSW #115. Interview with registered staff #114 indicated that the intervention was removed by the resident prior to the fall. Registered staff #114 further indicated that when a falls prevention intervention is not effective, including the intervention in place for resident #011, that registered staff can change the type of intervention used so that the intervention could be effective, and indicated that this was not completed. A review of the home's policy titled, "Falls Prevention", policy # VII-G-30.00, last revised January 2015, stated, "registered staff will monitor preventative interventions and evaluate effectiveness on an ongoing basis and with the quarterly review".

Interview with the DOC confirmed that the resident #011's specified intervention as part of the falls prevention intervention was ineffective, and that the plan of care was not revised.

Please note: This non-compliance was issued as a result of a Critical Incident (CI) Inspection, which was conducted concurrently with the RQI Inspection. (619)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 28, 2017

Order # / Ordre no : 002

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee shall do the following:

i) Ensure when falls prevention interventions have not been effective, different approaches are considered using an interdisciplinary approach, including the resident or resident's substitute decision maker (SDM) and/or Power of Attorney (POA) as applicable, for all residents identified as at risk for falls.

ii) Ensure that when falls prevention strategies have been revised, they are documented in the residents' clinical health record, and updated appropriately in their written plan of care.

Grounds / Motifs :

1. 1. Judgement Matrix:
Severity of Harm - Actual Harm/Risk
Scope - Isolated
Compliance History – one or more related non-compliance in the last three (full) years

The resident was observed on identified dates in April and May 2017.

A review of the resident's current written plan of care indicated they were high risk for falls and identified interventions were in place. A review of the "Falls

monthly meeting" notes on an identified dates in 2016 and 2017, indicated resident #014 had an identified pattern of multiple falls. It further indicated an identified number of incidents resulted in injuries and an identified number of incidents resulted in transfers to the hospital. Identified interventions were listed.

A review of resident #014's clinical health records indicated that prior to a fall they sustained on an identified date, specified interventions had been implemented, except for two interventions, which were initiated after the fall on later identified date.

In interviews with PSW's #121 and #122 and registered staff #123, they stated resident #014 was high risk for falls, and sustained multiple falls related to identified behaviours. They confirmed that since the implementation of a specific intervention, the resident has had a significant decrease in the number of falls; however, the resident continued to have falls.

In an interview on May 9, 2017, the ADOC stated other identified fall interventions undertaken by the home to prevent resident #014 from falling. The ADOC stated that due to the resident's identified behaviours and ambulatory status, other alternatives were not considered.

In an interview with the PT on May 10, 2017, they stated that the interventions were implemented late 2015, however; the resident continued to fall. They stated that since an identified intervention was implemented on an identified date in 2017, there had been a significant reduction in the number of falls; however, the resident still had falls. The PT further stated the resident was not assessed for other alternatives and that the home had a "restraint-free" policy.

The home did not ensure different approaches were considered in the revision of the plan of care when care set out in the plan had not been effective in relation to multiple falls sustained by resident #014.

Please note: This non-compliance was issued as a result of a CI Inspection, which was conducted concurrently with the RQI Inspection. (591)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 28, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 6th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Hayes

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