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

Hamilton Service Area Office
119 King Street West 11th Floor
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Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
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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
Dec 3, 2018; Feb 6, 2019	2018_543561_0017	016406-18	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Fox Ridge Care Community
389 West Street BRANTFORD ON N3R 3V9

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

DARIA TRZOS (561)

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): September 24, 25, 26, 27, 28, and October 1, 2, 3, 2018.

This Critical Incident System (CIS) inspection was completed concurrently with the Resident Quality Inspection (RQI) number 2018_543561_0016 / 023251-18.

Non compliance related to LTCHA, s. 6(7) identified during a complaint inspection log # 005152-18, conducted concurrently with the RQI log # 023251-18 was issued in this report as a Compliance Order (CO).
Non compliance related to LTCHA, s. 6(7) identified during a complaint inspection log #019697-17, conducted concurrently with the RQI log #023251-18 was issued in this report as a CO.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Director of Environmental Services, Registered staff, and Personal Support Workers (PSWs).

During the course of the inspection, the inspector observed provision of care, reviewed relevant documentation including clinical records, investigation notes, and policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
2 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).

Findings/Faits saillants :

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

A) A Critical Incident System (CIS), was submitted to the Director on an identified date in 2018, related to a fall of resident #014, whereby the resident sustained an injury and was transferred to hospital.

Clinical care records were reviewed and the written plan of care indicated that the resident was at an identified risk for falls and required specific interventions in place to prevent falls and injuries.

PSW #144 who provided direct care to the resident was interviewed and stated that they had transferred resident #014 to bed with the assistance of another PSW. Before leaving the room, PSW #144 forgot to initiate one of the interventions and resident #014 fell and sustained an injury.
Registered staff #135 was interviewed and stated that on the day of the incident, PSW #144 reported to them that resident #014 had fallen. When they entered the resident's room, the resident was on the floor, and sustained an injury. Registered staff #135 assessed the resident and two PSWs assisted to transfer resident #014 back to bed with a device. The registered staff stated that when they walked into the room, one of the interventions was not in place.

The home's investigation notes were reviewed and indicated that PSW #144 and registered staff #135 were interviewed by the DOC after the incident. The home's investigation notes indicated that one of the interventions for falls was not implemented by the PSW. Resident #014 fell and sustained injuries.

The DOC was interviewed during this inspection and stated that resident #014 had a plan of care indicating that they were at an identified risk for falls and required identified interventions in place to prevent falls. The DOC acknowledged that PSW #144 forgot to initiate one of the interventions and resident #014 fell and sustained an injury.

The licensee failed to ensure that the care set out in the plan of care related to the falls interventions was provided to the resident as per the plan of care.

This area of non-compliance was identified during a CIS Inspection, log #016406-18.

B) A Complaint was submitted to the Ministry of Health and Long Term Care, related to concerns that staff were not providing care to resident #020 as set out in the plan.

The plan of care revealed that resident #020 had recurrent altered skin integrity, and directed staff to provide an intervention. The resident was observed on an identified date while PSWs #124 and #150 transferred the resident using a device. The resident's intervention was observed during the transfer and the Inspector observed it was not applied as per the plan of care. Interview with PSW #150 confirmed that there was a specific intervention in place. Interview with PSW #150 after the transfer was completed, confirmed that the intervention to protect the resident was not applied as required in the resident's plan of care. (528)

This area of non compliance was identified during a Complaint Inspection log #011543-17, conducted concurrently with the RQI log #023251-18, and was issued in this report.

C) A review of Complaint intake submitted on an identified date in 2017, identified a concern related to the licensee's management of falls for resident #031.

Review of the Physiotherapist post fall assessment recommended the resident have a number of interventions in place to decrease further risk of fall and injuries.
According to the clinical health record, the resident had a number of falls over an identified specified period. On an identified date in 2017, one of the falls resulted in an injury.

In an interview with the DOC and the ADOC they both verified that one of the interventions recommended was not provided to the resident.

The care was not provided to resident #031 related to falls prevention interventions. (581)

This area of non compliance was identified during a Complaint Inspection log #019697-17, conducted concurrently with the RQI log #023251-18. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A CIS was submitted to the Director on an identified date in 2018, related to a fall of resident #014, whereby the resident sustained an injury and was transferred to hospital.

The home's investigation notes were reviewed and indicated that a family member observed the resident to have identified injuries.

Interview with the PSW #144 identified that the resident fell and there was evidence of injuries.
In an interview with the registered staff #135, they stated that they documented the assessment on paper and later documented in PCC.
Clinical records were reviewed and no documentation could be found of the specified injury. The registered staff failed to identify all areas of injury in their records on paper and later in PCC due to an identified issue in the home.

The DOC was interviewed and acknowledged that the assessment documented by registered staff did not contain documentation of the specified injury.

The licensee failed to ensure that the full assessment of resident's injuries after the fall was documented.

This area of non-compliance was identified during a CIS Inspection, log # 016406-18 [s. 30. (2)]

Issued on this 7th day of February, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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) :	DARIA TRZOS (561)
Inspection No. / No de l'inspection :	2018_543561_0017
Log No. / No de registre :	016406-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 3, 2018; Feb 6, 2019
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Fox Ridge Care Community 389 West Street, BRANTFORD, ON, N3R-3V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sandy Croley

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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:
1. Ensure that all residents in the home that are at risk for falls are provided with falls interventions as specified in the plan of care.
2. Ensure that the annual falls prevention training includes a scenario explaining the importance of following the plan of care for residents that use fall prevention interventions and the consequences of not following the plan of care.
2. Ensure that resident #020 and any other resident in the home are provided with treatment for their altered skin integrity as specified in the plan of care.

Grounds / Motifs :

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

A) A Critical Incident System (CIS), was submitted to the Director on an identified date in 2018, related to a fall of resident #014, whereby the resident sustained an injury and was transferred to hospital.

Clinical care records were reviewed and the written plan of care indicated that the resident was at an identified risk for falls and required specific interventions in place to prevent falls and injuries.

PSW #144 who provided direct care to the resident was interviewed and stated that they had transferred resident #014 to bed with the assistance of another PSW. Before leaving the room, PSW #144 forgot to initiate one of the interventions and resident #014 fell and sustained an injury.

Registered staff #135 was interviewed and stated that on the day of the incident, PSW #144 reported to them that resident #014 had fallen. When they entered the resident's room, the resident was on the floor, and sustained an injury. Registered staff #135 assessed the resident and two PSWs assisted to transfer resident #014 back to bed with a device. The registered staff stated that when they walked into the room, one of the interventions was not in place.

The home's investigation notes were reviewed and indicated that PSW #144 and registered staff #135 were interviewed by the DOC after the incident. The home's investigation notes indicated that one of the interventions for falls was not implemented by the PSW. Resident #014 fell and sustained injuries.

The DOC was interviewed during this inspection and stated that resident #014 had a plan of care indicating that they were at an identified risk for falls and required identified interventions in place to prevent falls. The DOC acknowledged that PSW #144 forgot to initiate one of the interventions and resident #014 fell and sustained an injury.

The licensee failed to ensure that the care set out in the plan of care related to the falls interventions was provided to the resident as per the plan of care.

This area of non-compliance was identified during a CIS Inspection, log #016406-18.

B) A Complaint was submitted to the Ministry of Health and Long Term Care, related to concerns that staff were not providing care to resident #020 as set out in the plan.

The plan of care revealed that resident #020 had recurrent altered skin integrity, and directed staff to provide an intervention. The resident was observed on an identified date while PSWs #124 and #150 transferred the resident using a device. The resident's intervention was observed during the transfer and the Inspector observed it was not applied as per the plan of care. Interview with PSW #150 confirmed that there was a specific intervention in place. Interview with PSW #150 after the transfer was completed, confirmed that the intervention to protect the resident was not applied as required in the resident's plan of care. (528)

This area of non compliance was identified during a Complaint Inspection log #011543-17, conducted concurrently with the RQI log #023251-18, and was issued in this report.

C) A review of Complaint intake submitted on an identified date in 2017, identified a concern related to the licensee's management of falls for resident #031.

Review of the Physiotherapist post fall assessment recommended the resident have a number of interventions in place to decrease further risk of fall and injuries.
According to the clinical health record, the resident had a number of falls over an identified specified period. On an identified date in 2017, one of the falls resulted in an injury.

In an interview with the DOC and the ADOC they both verified that one of the interventions recommended was not provided to the resident.

The care was not provided to resident #031 related to falls prevention interventions. (581)

This area of non compliance was identified during a Complaint Inspection log #019697-17, conducted concurrently with the RQI log #023251-18.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 2 as it related to three resident out of six residents reviewed. The home had a level 4 history as they had multiple NC with a Voluntary Plan of Correction (VPC) to the current area of concern issued under this section on April 25, 2017 (2017_556168_0010), on April 19, 2016 (2016_337581_0003), and on November 30, 2015 (2015_188168_0026). (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 04, 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 3rd day of December, 2018

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Daria Trzos

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