Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 16, 2019	2019_745690_0024	015407-19	Critical Incident System

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Muskoka Shores Care Community
200 Kelly Drive GRAVENHURST ON P1P 1P3

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

TRACY MUCHMAKER (690)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 3-6, 2019.

The following intake was inspected upon during this Critical Incident System Inspection:

-One log, which was related to a critical incident report that the home submitted to the Director for a fall that resulted in a transfer to hospital.

Follow Up inspection #2019_745690_0023 was conducted concurrently during this Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Managers (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Care Support Workers (CSW) and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed health care records, internal investigation notes, as well as licensee policies, procedures and programs.

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

During the course of this inspection, Non-Compliances were issued.
- **1 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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident (CI) report was submitted to the Director on an identified date, related to a fall with injury. The CI report indicated that resident #001 had an unwitnessed fall on an identified date, was sent to the hospital and was diagnosed with an identified injury. A further review of the CI report indicated that resident #001 had sustained a fall on the previous day, had exhibited an identified symptom and was placed on a specific type of monitoring.

A review of the electronic progress notes described how resident #001 was found on an identified date at a specified time. The progress notes indicated that the resident had an identified injury from a previous incident, and that a specific type of monitoring was initiated. A further review of progress notes identified documentation that the resident had settled approximately four hours after the first documented fall and that the specified type of monitoring continued. The progress notes further identified that resident #001 was found approximately five hours after the first documented fall, had exhibited identified symptoms and was transferred to the hospital.

Inspector #690 conducted a review of assessments on Point Click Care (PCC) and identified an assessment related to a fall that occurred on an identified date. The Inspector could not locate any other assessments related to falls on the identified date. During a review of the assessment for the fall that occurred on the identified date, the Inspector identified that the assessment was not fully completed as a section of the assessment to document what interventions were put in place to prevent further falls was blank. During a review of the assessment for the fall that occurred the following day, the Inspector identified that the assessment was not fully completed as a section of the assessment to document what interventions were put in place to prevent further falls was blank.

A review of the home's internal investigation notes identified a document that indicated that Nurse Manager (NM) #102 had spoken with Registered Practical Nurse (RPN) #112. The document indicated that NM #102 reviewed the identified assessments with RPN #112 and explained the importance of filling out all the information in a thorough and

diligent manner, and to include implementing fall prevention interventions as soon as possible after a fall to prevent further falls. The investigation notes also included a statement from Care Support Worker (CSW) #113, that indicated that Personal Support Worker (PSW) #110 had been working on the unit with them had told them that the resident had a fall earlier prior to the fall that was documented by RPN #112.

In an interview with PSW #110, they indicated that they had been working on an identified date and had witnessed resident #001 fall at a specified time in a specified location. PSW #110 indicated that they had reported the fall to RPN #112. PSW #110 further indicated that CSW #113 had came to them and PSW #104 and told them that resident #001 had fallen. PSW #110 described how they found resident #001 and that the resident was in a different specified location than the first fall that they had witnessed.

In an interview with CSW #113, they indicated that they were working on the identified date and had heard a loud bang. CSW #113 described how they found resident #001 and that they had called for help. CSW #113 indicated that PSW #110 arrived at the scene and had told CSW #113 and PSW #104 that they had witnessed the resident fall earlier when CSW #113 and PSW #104 were off the unit.

In an interview with the Inspector, Registered Nurse (RN) #108 indicated that they were called by RPN #112 to assess resident #001 after the fall on the identified date. RN #108 indicated that they were not made aware that resident #001 had a fall earlier on the same date, but that they had been made aware that the resident had been exhibiting specified symptoms. RN #108 indicated that if a resident was witnessed to fall, there was to be a specified assessment completed after every fall. RN #108 further indicated that the assessments for all three of the falls should have included implementing interventions to prevent another fall.

In an interview with NM #102, they indicated that they had conducted an investigation into two of the falls that resident #001 had sustained. NM #112 indicated that they did not speak to PSW #110 or PSW #104 however was aware that CSW #113 had indicated to them that there had been a previous fall on the same day as the first fall that was documented by RPN #112. NM #112 indicated that they followed up with RPN #112 regarding the identified assessments that were completed for the two documented falls. NM #112 indicated that they had reminded RPN #112 about the importance of completing the assessments fully, including implementing interventions to prevent further falls. NM #112 indicated that there should have been a post fall assessment completed

for all three falls and that the two post fall assessments that were done did not include interventions to prevent further falls and that they should have.

In an interview with Inspector #690, the DOC indicated that the identified assessment was to be completed for all falls and that the assessment should include implementing interventions to prevent a further fall. Together the DOC and Inspector #690 reviewed the post fall assessments for resident #001 for both falls, and the DOC indicated that there should have been an assessment conducted for the first fall that occurred and that the two assessments that were documented by RPN #112 did not include interventions to prevent a recurrence and that they should have. [s. 49. (2)]

2. A CI report was submitted to the Director related to a fall with injury. The CI report indicated that resident #001 had fallen on an identified date, and was transferred to hospital.

Please see WN #1, finding #1 for details

A) A review of the electronic progress notes documented by RPN #112 described how resident #001 was found at a specified time. The progress notes indicated that the resident had an identified injury from a previous incident. A specific type of monitoring was initiated as the fall was unwitnessed. A further review of progress notes identified documentation that the resident had settled approximately four hours later and that the specified monitoring continued. The progress notes further described how resident #001 was found approximately five hours after the first documented fall, had identified symptoms and was transferred to the hospital.

A review of resident #001's health records, identified a specified monitoring document for resident #001, that indicated that the specified monitoring was initiated on the identified date, for a fall that occurred at a specified time. The specified type of monitoring document included instructions on the form that indicated that staff were to monitor the resident every 15 minutes for an hour, every 30 minutes for two hours, every hour for three hours, every two hours for eight hours and every four hours for 12 hours. The Inspector identified that the documentation on the specified type of monitoring document was initiated at the time of the fall and that documentation that was to be done between two hours and four hours after the first documented fall indicated that the resident was sleeping and there was no record of any assessment of the resident during that time period. The documentation for six hours following the first documented fall indicated that resident #001 was at the hospital.

B) A review of electronic progress notes indicated that resident #001 sustained an unwitnessed fall on an identified date after resident #001's return from hospital and that a specified type of monitoring was initiated.

A review of the documentation for the specified type of monitoring, identified the specified type of monitoring was initiated at a specified time. The documentation for the specified type of monitoring on two occasions indicated that the resident was "sleeping". The documentation for the specified type of monitoring for four occasions had the following documented, "data gap".

C) During a record review of resident #002's progress notes, it was identified that the resident had an unwitnessed fall on an identified date. The progress notes indicated that a specified type of monitoring was to be initiated.

A review of the documentation for the specified type of monitoring for resident #002's fall on the identified date indicated that the specified type of monitoring was to be done at the following times; every 30 minutes for one hour, every hour for four hours, and every eight hours for 56 hours or until staff were directed by the physician to cease the monitoring. The documentation for the specified type of monitoring for resident #002 was initiated at a specified time. The documentation for the specified type of monitoring for two of the identified time intervals indicated that the assessment of the resident was partially completed as there were no vital signs documented. The documentation for two of the identified time intervals indicated "data gap". The documentation for one of the identified time intervals, indicated that the resident was sleeping.

A review of the home's policy titled "Falls Prevention and Management-VII-G-30.10", last revised April 2019, identified under the heading "Post Falls Assessment", that the nurse will initiate a head injury routine if a head injury is suspected, or if the resident's fall was unwitnessed. The policy further identified that the nurse will monitor for head injury as per the schedule on the post-fall form for signs of neurological changes.

A review of the home's policy titled "Head Injury Routine-VII-G-30.20", last revised April 2019, indicated that staff were to ensure that head injury routine would be initiated on any resident who had sustained or was suspected of sustaining a head injury, and any unwitnessed resident fall. The policy further indicated that the HIR was to be completed as per the schedule outlined or as ordered by the physician.

In an interview with Inspector #690, RPN #111 indicated that a specified type of monitoring was to be initiated after any unwitnessed fall, and for any resident that had been witnessed to injure a specified area of their body. RPN #111 indicated that the schedule to complete the specified type of monitoring was outlined on the monitoring form and that it was to be fully completed unless otherwise directed by a physician. RPN #111 indicated that the schedule for completing the specified type of monitoring had been changed and the new forms had the new schedule on them for staff to follow. RPN #111 further indicated that if staff document "data gap" on the form it was usually because the staff were too busy to do the assessment. Together, RPN #111 and Inspector #690 reviewed the documentation for the specified type of monitoring for resident #002. RPN #111 indicated that they had checked on the resident #002 at two of the identified time intervals but did not complete the entire assessment as they did not check the residents vital signs and that they should have. RPN #111 identified that the specified type of monitoring was only completed three times on resident #002 in the 24 hour time period following the fall and that the assessment should have been completed according to the schedule outlined on the form.

During an interview with the Inspector, RN #108 indicated that the specified type of monitoring was to be initiated on any unwitnessed fall, and for any resident that had been witnessed to injure a specified part of their body. RN #108 indicated that staff were to complete a specified type of monitoring on the resident according to the schedule that is outlined on the form. RN #108 indicated that the specified type of monitoring for resident #001 and #002 were not fully completed and that they should have been.

In an interview with the DOC, they indicated that it was the home's expectation that staff would initiate and fully complete the specified type of monitoring as per the schedule outlined on the form after any unwitnessed fall, or any fall in which a resident was known to injure a specified part of their body. The DOC further indicated that it was unacceptable for staff to document "data gap" in place of an assessment and that if a resident was sleeping, that staff should have woken the resident up and assessed them. The DOC indicated that the specified type of monitoring assessments for resident #001 and #002 were not completed and that they should have been. [s. 49. (2)]

Additional Required Actions:

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

Issued on this 20th day of September, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TRACY MUCHMAKER (690)
Inspection No. / No de l'inspection :	2019_745690_0024
Log No. / No de registre :	015407-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 16, 2019
Licensee / Titulaire de permis :	2063412 Ontario Limited as General Partner of 2063412 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Muskoka Shores Care Community 200 Kelly Drive, GRAVENHURST, ON, P1P-1P3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angela Coutts

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To 2063412 Ontario Limited as General Partner of 2063412 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee must be compliant with s. 49 (2) of the O. Reg.
Specifically the licensee must ensure that when any resident has fallen, the resident is assessed and when their condition requires, a post-fall assessment is completed using a clinically appropriate assessment instrument specifically designed for falls.

Specifically the licensee must;

a) Develop, implement, and document an auditing process which ensures staff are conducting post fall assessments in entirety to include interventions to prevent further falls, and completing a specific assessment when required as per the home's Head Injury Routine policy.
b) The documentation of the auditing process shall include actions taken when deficiencies are identified.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident (CI) report was submitted to the Director on an identified date, related to a fall with injury. The CI report indicated that resident #001 had an unwitnessed fall on an identified date, was sent to the hospital and was diagnosed with an identified injury. A further review of the CI report indicated

resident #001 had sustained a fall on the previous day, had exhibited an identified symptom and was placed on a specific type of monitoring.

A review of the electronic progress notes described how resident #001 was found on an identified date at a specified time. The progress notes indicated that the resident had an identified injury from a previous incident, and that a specific type of monitoring was initiated. A further review of progress notes identified documentation that the resident had settled approximately four hours after the first documented fall and that the specified type of monitoring continued. The progress notes further identified that resident #001 was found approximately five hours after the first documented fall, had exhibited identified symptoms and was transferred to the hospital.

Inspector #690 conducted a review of assessments on Point Click Care (PCC) and identified an assessment related to a fall that occurred on an identified date. The Inspector could not locate any other assessments related to falls on the identified date. During a review of the assessment for the fall that occurred on the identified date, the Inspector identified that the assessment was not fully completed as a section of the assessment to document what interventions were put in place to prevent further falls was blank. During a review of the assessment for the fall that occurred the following day, the Inspector identified that the assessment was not fully completed as a section of the assessment to document what interventions were put in place to prevent further falls was blank.

A review of the home's internal investigation notes identified a document that indicated that Nurse Manager (NM) #102 had spoken with Registered Practical Nurse (RPN) #112. The document indicated that NM #102 reviewed the identified assessments with RPN #112 and explained the importance of filling out all the information in a thorough and diligent manner, and to include implementing fall prevention interventions as soon as possible after a fall to prevent further falls. The investigation notes also included a statement from Care Support Worker (CSW) #113, that indicated that Personal Support Worker (PSW) #110 had been working on the unit with them had told them that the resident had a fall earlier prior to the fall that was documented by RPN #112.

In an interview with PSW #110, they indicated that they had been working on an

identified date and had witnessed resident #001 fall at a specified time in a specified location. PSW #110 indicated that they had reported the fall to RPN #112. PSW #110 further indicated that CSW #113 had came to them and PSW #104 and told them that resident #001 had fallen. PSW #110 described how they found resident #001 and that the resident was in a different specified location than the first fall that they had witnessed.

In an interview with CSW #113, they indicated that they were working on the identified date and had heard a loud bang. CSW #113 described how they found resident #001 and that they had called for help. CSW #113 indicated that PSW #110 arrived at the scene and had told CSW #113 and PSW #104 that they had witnessed the resident fall earlier when CSW #113 and PSW #104 were off the unit.

In an interview with the Inspector, Registered Nurse (RN) #108 indicated that they were called by RPN #112 to assess resident #001 after the fall on the identified date. RN #108 indicated that they were not made aware that resident #001 had a fall earlier on the same date, but that they had been made aware that the resident had been exhibiting specified symptoms. RN #108 indicated that if a resident was witnessed to fall, there was to be a specified assessment completed after every fall. RN #108 further indicated that the assessments for all three of the falls should have included implementing interventions to prevent another fall.

In an interview with NM #102, they indicated that they had conducted an investigation into two of the falls that resident #001 had sustained. NM #112 indicated that they did not speak to PSW #110 or PSW #104 however was aware that CSW #113 had indicated to them that there had been a previous fall on the same day as the first fall that was documented by RPN #112. NM #112 indicated that they followed up with RPN #112 regarding the identified assessments that were completed for the two documented falls. NM #112 indicated that they had reminded RPN #112 about the importance of completing the assessments fully, including implementing interventions to prevent further falls. NM #112 indicated that there should have been a post fall assessment completed for all three falls and that the two post fall assessments that were done did not include interventions to prevent further falls and that they should have.

In an interview with Inspector #690, the DOC indicated that the identified assessment was to be completed for all falls and that the assessment should include implementing interventions to prevent a further fall. Together the DOC and Inspector #690 reviewed the post fall assessments for resident #001 for both falls, and the DOC indicated that there should have been an assessment conducted for the first fall that occurred and that the two assessments that were documented by RPN #112 did not include interventions to prevent a recurrence and that they should have. [s. 49. (2)]

(690)

2. A CI report was submitted to the Director related to a fall with injury. The CI report indicated that resident #001 had fallen on an identified date, and was transferred to hospital.

Please see WN #1, finding #1 for details

A) A review of the electronic progress notes documented by RPN #112 described how resident #001 was found at a specified time. The progress notes indicated that the resident had an identified injury from a previous incident. A specific type of monitoring was initiated as the fall was unwitnessed. A further review of progress notes identified documentation that the resident had settled approximately four hours later and that the specified monitoring continued. The progress notes further described how resident #001 was found approximately five hours after the first documented fall, had identified symptoms and was transferred to the hospital.

A review of resident #001's health records, identified a specified monitoring document for resident #001, that indicated that the specified monitoring was initiated on the identified date, for a fall that occurred at a specified time. The specified type of monitoring document included instructions on the form that indicated that staff were to monitor the resident every 15 minutes for an hour, every 30 minutes for two hours, every hour for three hours, every two hours for eight hours and every four hours for 12 hours. The Inspector identified that the documentation on the specified type of monitoring document was initiated at the time of the fall and that documentation that was to be done between two hours

and four hours after the first documented fall indicated that the resident was sleeping and there was no record of any assessment of the resident during that time period. The documentation for six hours following the first documented fall indicated that resident #001 was at the hospital.

B) A review of electronic progress notes indicated that resident #001 sustained an unwitnessed fall on an identified date after resident #001's return from hospital and that a specified type of monitoring was initiated.

A review of the documentation for the specified type of monitoring, identified the specified type of monitoring was initiated at a specified time. The documentation for the specified type of monitoring on two occasions indicated that the resident was "sleeping". The documentation for the specified type of monitoring for four occasions had the following documented, "data gap".

C) During a record review of resident #002's progress notes, it was identified that the resident had an unwitnessed fall on an identified date. The progress notes indicated that a specified type of monitoring was to be initiated.

A review of the documentation for the specified type of monitoring for resident #002's fall on the identified date indicated that the specified type of monitoring was to be done at the following times; every 30 minutes for one hour, every hour for four hours, and every eight hours for 56 hours or until staff were directed by the physician to cease the monitoring. The documentation for the specified type of monitoring for resident #002 was initiated at a specified time. The documentation for the specified type of monitoring for two of the identified time intervals indicated that the assessment of the resident was partially completed as there were no vital signs documented. The documentation for two of the identified time intervals indicated "data gap". The documentation for one of the identified time intervals, indicated that the resident was sleeping.

A review of the home's policy titled "Falls Prevention and Management-VII-G-30.10", last revised April 2019, identified under the heading "Post Falls Assessment", that the nurse will initiate a head injury routine if a head injury is suspected, or if the resident's fall was unwitnessed. The policy further identified that the nurse will monitor for head injury as per the schedule on the post-fall form for signs of neurological changes.

A review of the home's policy titled "Head Injury Routine-VII-G-30.20", last revised April 2019, indicated that staff were to ensure that head injury routine would be initiated on any resident who had sustained or was suspected of sustaining a head injury, and any unwitnessed resident fall. The policy further indicated that the HIR was to be completed as per the schedule outlined or as ordered by the physician.

In an interview with Inspector #690, RPN #111 indicated that a specified type of monitoring was to be initiated after any unwitnessed fall, and for any resident that had been witnessed to injure a specified area of their body. RPN #111 indicated that the schedule to complete the specified type of monitoring was outlined on the monitoring form and that it was to be fully completed unless otherwise directed by a physician. RPN #111 indicated that the schedule for completing the specified type of monitoring had been changed and the new forms had the new schedule on them for staff to follow. RPN #111 further indicated that if staff document "data gap" on the form it was usually because the staff were too busy to do the assessment. Together, RPN#111 and Inspector #690 reviewed the documentation for the specified type of monitoring for resident #002. RPN #111 indicated that they had checked on the resident #002 at two of the identified time intervals but did not complete the entire assessment as they did not check the residents vital signs and that they should have. RPN #111 identified that the specified type of monitoring was only completed three times on resident #002 in the 24 hour time period following the fall and that the assessment should have been completed according to the schedule outlined on the form.

During an interview with the Inspector, RN #108 indicated that the specified type of monitoring was to be initiated on any unwitnessed fall, and for any resident that had been witnessed to injure a specified part of their body. RN #108 indicated that staff were to complete a specified type of monitoring on the resident according to the schedule that is outlined on the form. RN #108 indicated that the specified type of monitoring for resident #001 and #002 were not fully completed and that they should have been.

In an interview with the DOC, they indicated that it was the home's expectation that staff would initiate and fully complete the specified type of monitoring as per

the schedule outlined on the form after any unwitnessed fall, or any fall in which a resident was known to injure a specified part of their body. The DOC further indicated that it was unacceptable for staff to document "data gap" in place of an assessment and that if a resident was sleeping, that staff should have woken the resident up and assessed them. The DOC indicated that the specified type of monitoring assessments for resident #001 and #002 were not completed and that they should have been. [s. 49. (2)]

The severity of this issue was determined to be a level three, as there was actual harm/actual risk. The scope of the issue was a level two, which indicated a pattern. The home has a level three compliance history with related non-compliance in the last 36 months with this section of the Ontario Regulation 79/10.
-Voluntary Plan of Correction (VPC) issued October 9, 2018 (2018_669642_0019). (690)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 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 16th day of September, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tracy Muchmaker

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