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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 12, 2017	2017_535557_0005	010196-17	Critical Incident System

Licensee/Titulaire de permis

HUNTSVILLE LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

MUSKOKA LANDING
65 ROGERS COVE DRIVE HUNTSVILLE ON P1H 2L9

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

VALERIE PIMENTEL (557)

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): May 29, 30, 31, June 1 and 2, 2017.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Unit Coordinator/RAI/MDS Coordinator (UN/RAIC), Restorative Care Coordinator, Environmental Service Manager (ESM), Housekeeping Supervisor, Registered Practical Nurse (RPN), Personal Support Workers (PSW).

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, reviewed clinical health records: progress notes, MDS, RAPS, medications, eMAR's, assessments, referrals, care plan, staffing schedules/assignments, minutes of relevant committee meetings, relevant policy and procedures and previous inspection notes.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

The home submitted a critical incident (CI), to the Ministry of Health and Long Term Care (MOHLTC) reporting that an identified resident had an unwitnessed fall on a specific day

in 2016. The resident was found lying on the floor outside of his/her room without adaptive devices on. The identified resident ambulated to the nursing station with the assistance of two staff members.

Record review of the plan of care for the identified resident revealed he/she was sent to the hospital the following day in 2016, for further assessment. He/she was diagnosed with an identified injury and returned to the home the same day. An identified number of days later, the resident passed away, the coroner identified the cause of death as a complication of the identified injury related to a fall.

A review of the progress notes on an identified day in 2016, at the time of the reported fall, the resident was found on the floor lying in an identified area. The resident did not verbalize pain at the time. The floor in the identified resident's room and the hallway had been mopped a few minutes prior to the fall. The floor had remained in an identified manner and the resident attempted to walk into his/her room, the area was identified to be in a specified condition related to humidity affecting the surface area of the floor.

A late entry progress note on the same identified date in 2016, at an identified time, by an identified registered staff member revealed the following: before the identified fall the resident was ambulating from his/her room to nursing desk. The resident was then provided an identified care measure and was brought back to the nursing station. The resident's bedroom and bathroom required an identified care measure.

The written care plan identified the resident was at high risk for falls characterized by history of falls. The goal was identified as resident will have no injuries from falls and interventions were implemented by the home.

The resident had five falls in the previous seven months prior to the fall on the identified date in 2016.

An interview with PSW #100 confirmed that he/she was a casual worker at the time of the identified resident's fall that occurred on an identified day in 2016, and had not worked many shifts on the identified home area and was not familiar with the residents. He/she had little recall of the incident however, he/she did remember the shift and that the identified resident required a additional care after the incident.

An interview with PSW #102 confirmed the identified resident came to the nursing station and that PSW #100 and PSW #103 gave the resident additional care. An identified

registered staff member and PSW #102 performed an identified measure to the resident's room and hallway. PSW #102 further indicated that he/she retrieved identified items to provide an identified measure to the floor and indicated that the area of the home was humid at the time. He/she confirmed the fans in the hallway and the resident's room were on to help assist in keeping the surface area safer. Next, the identified registered staff member called for assistance as he/she found the resident on the floor outside of his/her room and recalls locating a lift in order to assist with getting the resident up. When asked if the floor was in an identified condition at the time of the fall, PSW #102 confirmed the floor was in the above mentioned identified condition.

An interview with the identified registered staff member confirmed that he/she had found the identified resident on the floor at an identified time outside of his/her room on an identified day in 2016. The registered staff member indicated that the resident was without adaptive devices on at the time of the fall and the floor was in an identified manner. The registered staff member further indicated that the floor area was unsafe due to the environmental conditions of the home at the identified time.

PSW #102 was asked to describe the identified resident's behavior during the identified shift, he/she stated the resident always exhibited an identified responsive behaviour. PSW #102 further clarified the resident had visual apparatus but never used them, he/she could maneuver around his/her room and hallway without the visual apparatus.

An interview with the Unit Coordinator/Rai/MDS Coordinator (UNRAIC) confirmed the identified resident was a high risk for falls and may not have been wearing appropriate adaptive devices and the fall was related to the identified condition of the floor.

PSW #100, #102, and UNRAIC confirmed that staff cannot see down the hallways on either resident wing related to the lay out of the home areas and confirmed this is not safe. They confirmed the only way you can see down these two areas is to physically walk to them and look and because they could not see down the hall, they were unsure of the resident's whereabouts and if he/she was entering the identified area mentioned above. The home does not have concave mirrors or a camera monitoring system to observe these areas.

An interview with the housekeeping supervisor confirmed he/she is the person that maintains the floors on a daily basis with the machine. He/She further confirmed that the floor surfaces are better maintained within an identified humidity level and that at the time of the fall the levels were at an identified percentage.

An interview with the director of care (DOC) confirmed the resident was found on the floor on an identified day in 2016, at an identified time. He/she confirmed that at the time of the fall the resident was without adaptive devices on when found on the floor. He/she confirmed the floor was in an identified manner at the time of the fall and the staff had placed identified markers in the area. The DOC confirmed the home failed to ensure that the environment was safe for the identified resident.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual harm. The identified resident was admitted to home on an identified day and was deemed at high risk for falls and was to have in place adaptive devices when up and dressed. At the time of the fall on the identified day in 2016, at an identified time, the resident was found with no adaptive devices on and the floor had been identified in a specified condition, known to the staff working at the time. The resident sustained an identified injury and passed away, an identified number of days later on an identified day in 2016, for reason identified by the coroner as complications of an identified injury due to a fall.
The scope of the non-compliance is related to the identified resident.
The home has no previously history of non-compliance in this area. [s. 5.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

The home submitted a CI to the MOHLTC reporting on an identified day in 2016, that an identified resident had an unwitnessed fall. The resident was found lying on the floor outside of his/her room without adaptive devices on. The identified resident ambulated to the nursing station with the assistance of two staff members. The identified resident was sent to the hospital the following day, for further assessment. He/she was diagnosed with an identified injury and returned to the home the same day he/she was sent to the hospital.

The resident had five falls in the previous seven months prior to the fall on the identified day in 2016. After the last fall on an identified day in 2016, the following day, the resident was sent to hospital for an assessment and was diagnosed with an identified injury.

Record review of the written plan of care identified the resident at a high risk for falls and had identified interventions. Review of Resident Assessment Protocols (RAPs) on an identified day in 2016, revealed that some of the interventions identified were unsuccessful and that the care plan was to be revised.

PSW #100, #102 and #103 when asked where they would obtain information about the residents, indicated from the kardex and if they had time from the written care plan. The identified staff members further indicated that the resident would ambulate throughout their shift and if put to bed would only stay for a short period of time. PSW #100 and #103 indicated they were relatively new to the home and confirmed the kardex did not identify the resident was to use adaptive devices after a specific intervention was provided to the resident and further confirmed there were no entries in this specific section of the plan of care.

UN/RAIC confirmed the information in the written care plan and RAP's were conflicting. He/she further identified that the information from the care plan would be transferred into the kardex when the "K" showed in the intervention section of the care plan. This would be done when the registered staff wrote an intervention in the care plan.

An interview with the DOC confirmed there was not a specific focus in the care plan in regards to the use of adaptive devices at specific times during different shifts. He/she further stated that the staff are supposed to read all the sections in the kardex as interventions may be found in other areas such as the fall focus in this case the special interventions to prevent falls were identified as wearing of assistive devices when up for the day.

An interview with the DOC confirmed the plan of care did not provide clear direction to direct care providers in regards to adaptive devices to the identified resident in the two specific sections of the kardex. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective.

The home submitted a CI to the MOHLTC reporting on an identified day in 2016, that an identified resident had an unwitnessed fall on a specific day in 2016. The resident was found lying on the floor outside of his/her room without his/her adaptive devices. The identified resident ambulated to the nursing station with the assistance of two staff members. The identified resident was sent to the hospital the following day, for further assessment. He/she was diagnosed with an identified injury and returned to the home the same day he/she was sent to the hospital.

The records indicated that the identified resident in the previous identified months had

five falls. The falls occurred on two dates in an identified month in 2015, and on three occasions in three different identified months in 2016, after the last fall on a fourth identified date in 2016, the following day, the identified resident was sent to hospital for an assessment.

Record review of the plan of care identified focuses, goals and interventions which required to be reviewed and or revised for the identified resident.

An interview with the UN/RAIC and the Restorative Care coordinator confirmed that the identified focuses, goals and interventions in the written care plan were not effective as the resident continued to fall.

An interview with the DOC confirmed that the identified resident should have been reassessed and the plan of care reviewed and revised after the identified falls when the care set out in the plan had not been effective. [s. 6. (10) (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise is in compliance with and is implemented in accordance with all applicable requirements under the Act.

S. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Falls prevention and management
S. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Record review of the home's policy titled "Resident Rights, Care and Services -Required Programs - Falls Prevention and Management Program", Revised Date: 2016-05-27, does not identify or provide for strategies to reduce or mitigate falls.

On an identified day in 2017, at an identified time, the inspector, the Administrator and DOC reviewed the above noted policy. The Administrator looked at other corporate policies to see if there were other policies that identified strategies to reduce or mitigate

falls and could not find strategies identified.

An interview with the Administrator and DOC confirmed that the home's policy, "Resident Rights, Care and Services - Required Programs - Falls Prevention and Management Program", Revised Date: 2016-05-27, does not identify or provide for strategies to reduce or mitigate falls.

The Administrator and DOC acknowledged that the home's policy did not meet the legislative requirements under the Act. [s. 8. (1) (a)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with.

General requirements
S. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Falls prevention and management
S. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Record review of the home's policy titled "Resident Rights, Care and Services - Required Programs - Falls Prevention and Management Program", Revised Date: 2016-05-27, identified that all unwitnessed falls will result in head injury routines being initiated unless resident is capable of communicating they did not hit their head. The policy further states that there will be post fall follow up progress notes for a minimum of three consecutive shifts following the incident.

On an identified day in 2017, at an identified time, the inspector #557 and an identified registered staff member, reviewed the progress notes for two identified days in 2016,

following the fall at an identified time on an identified day in 2016, for an identified resident. On an identified day in 2016, a progress note indicated that the resident was lying quietly awake in his/her bed at the time of observation. He/she indicated the resident was in pain and documented an identified assessment. The nurse documented that he/she will monitor closely. The next shift, shift #2 did not document at all in the progress notes. Shift #3 did document the administration of a medication, transfer to hospital and the identified injury.

An interview with the DOC confirmed that the home's expectation was for registered staff to document for three consecutive shifts following the incident of a fall. He/she confirmed that the registered staff did not document on the identified shift #2 on the identified day in 2016, for the identified resident.

The DOC acknowledged that the home's policy for Falls Prevention and Management was not complied with. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise is in compliance with and is implemented in accordance with all applicable requirements under the Act, and to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with, to be implemented voluntarily.

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) :	VALERIE PIMENTEL (557)
Inspection No. / No de l'inspection :	2017_535557_0005
Log No. / Registre no:	010196-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 12, 2017
Licensee / Titulaire de permis :	HUNTSVILLE LONG TERM CARE CENTRE INC. 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	MUSKOKA LANDING 65 ROGERS COVE DRIVE, HUNTSVILLE, ON, P1H-2L9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carrie Acton

To HUNTSVILLE LONG TERM CARE CENTRE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

1. Within one week of receipt of this order, identify all residents in the home at high risk of falls.

2. Review each of the resident's plan of care as identified in task 1 with direct care staff to ensure that the fall prevention interventions are provided to the residents as specified in the plan.

3. Develop and implement a quality improvement process to ensure that all residents assessed at high risk of falls receive the fall prevention intervention(s) as specified in the plan of care.

The licensee shall prepare, submit and implement a plan that includes tasks 1-3 and the person(s) responsible for completing the tasks. The plan is to be submitted to valerie.johnston@ontario.ca by June 24, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

The home submitted a critical incident (CI), to the Ministry of Health and Long Term Care (MOHLTC) reporting that an identified resident had an unwitnessed fall on a specific day in 2016. The resident was found lying on the floor outside of his/her room without adaptive devices on. The identified resident ambulated to the nursing station with the assistance of two staff members.

Record review of the plan of care for the identified resident revealed he/she was sent to the hospital the following day in 2016, for further assessment. He/she

was diagnosed with an identified injury and returned to the home the same day. An identified number of days later, the resident passed away, the coroner identified the cause of death as a complication of the identified injury related to a fall.

A review of the progress notes on an identified day in 2016, at the time of the reported fall, the resident was found on the floor lying in an identified area. The resident did not verbalize pain at the time. The floor in the identified resident's room and the hallway had been mopped a few minutes prior to the fall. The floor had remained in an identified manner and the resident attempted to walk into his/her room, the area was identified to be in a specified condition related to humidity affecting the surface area of the floor.

A late entry progress note on the same identified date in 2016, at an identified time, by an identified registered staff member revealed the following: before the identified fall the resident was ambulating from his/her room to nursing desk. The resident was then provided an identified care measure and was brought back to the nursing station. The resident's bedroom and bathroom required an identified care measure.

The written care plan identified the resident was at high risk for falls characterized by history of falls. The goal was identified as resident will have no injuries from falls and interventions were implemented by the home.

The resident had five falls in the previous seven months prior to the fall on the identified date in 2016.

An interview with PSW #100 confirmed that he/she was a casual worker at the time of the identified resident's fall that occurred on an identified day in 2016, and had not worked many shifts on the identified home area and was not familiar with the residents. He/she had little recall of the incident however, he/she did remember the shift and that the identified resident required a additional care after the incident.

An interview with PSW #102 confirmed the identified resident came to the nursing station and that PSW #100 and PSW #103 gave the resident additional care. An identified registered staff member and PSW #102 performed an identified measure to the resident's room and hallway. PSW #102 further indicated that he/she retrieved identified items to provide an identified measure

to the floor and indicated that the area of the home was humid at the time. He/she confirmed the fans in the hallway and the resident's room were on to help assist in keeping the surface area safer. Next, the identified registered staff member called for assistance as he/she found the resident on the floor outside of his/her room and recalls locating a lift in order to assist with getting the resident up. When asked if the floor was in an identified condition at the time of the fall, PSW #102 confirmed the floor was in the above mentioned identified condition.

An interview with the identified registered staff member confirmed that he/she had found the identified resident on the floor at an identified time outside of his/her room on an identified day in 2016. The registered staff member indicated that the resident was without adaptive devices on at the time of the fall and the floor was in an identified manner. The registered staff member further indicated that the floor area was unsafe due to the environmental conditions of the home at the identified time.

PSW #102 was asked to describe the identified resident's behavior during the identified shift, he/she stated the resident always exhibited an identified responsive behaviour. PSW #102 further clarified the resident had visual apparatus but never used them, he/she could maneuver around his/her room and hallway without the visual apparatus.

An interview with the Unit Coordinator/Rai/MDS Coordinator (UNRAIC) confirmed the identified resident was a high risk for falls and may not have been wearing appropriate adaptive devices and the fall was related to the identified condition of the floor.

PSW #100, #102, and UNRAIC confirmed that staff cannot see down the hallways on either resident wing related to the lay out of the home areas and confirmed this is not safe. They confirmed the only way you can see down these two areas is to physically walk to them and look and because they could not see down the hall, they were unsure of the resident's whereabouts and if he/she was entering the identified area mentioned above. The home does not have concave mirrors or a camera monitoring system to observe these areas.

An interview with the housekeeping supervisor confirmed he/she is the person that maintains the floors on a daily basis with the machine. He/She further confirmed that the floor surfaces are better maintained within an identified

humidity level and that at the time of the fall the levels were at an identified percentage.

An interview with the director of care (DOC) confirmed the resident was found on the floor on an identified day in 2016, at an identified time. He/she confirmed that at the time of the fall the resident was without adaptive devices on when found on the floor. He/she confirmed the floor was in an identified manner at the time of the fall and the staff had placed identified markers in the area. The DOC confirmed the home failed to ensure that the environment was safe for the identified resident.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual harm. The identified resident was admitted to home on an identified day and was deemed at high risk for falls and was to have in place adaptive devices when up and dressed. At the time of the fall on the identified day in 2016, at an identified time, the resident was found with no adaptive devices on and the floor had been identified in a specified condition, known to the staff working at the time. The resident sustained an identified injury and passed away, an identified number of days later on an identified day in 2016, for reason identified by the coroner as complications of an identified injury due to a fall.
The scope of the non-compliance is related to the identified resident.
The home has no previously history of non-compliance in this area. [s. 5.] (557)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 24, 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
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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 12th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Pimentel

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