Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 13, 2020	2019_752627_0023 (A2)	016259-19, 017882-19, 018049-19, 019992-19	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Oak Terrace
291 Mississaga Street West ORILLIA ON L3V 3B9

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

Amended by RYAN GOODMURPHY (638) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The amendment has been granted to allow the home to achieve sustainable compliance.

Issued on this 13th day of January, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Amended by RYAN GOODMURPHY (638) - (A2)

Amended 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): November 18-22, 25-26, 2019.

The following intakes were inspected during this Critical Incident System inspection:

- Three Critical Incident System (CIS) reports related to falls; and,

- One CIS report related to resident to resident abuse.

A Follow Up inspection, #2019_752627_0024, was completed concurrently with this Critical Incident System inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (E.D.), Director of Care (DOC), Regional Manager of Education (R.E.), Business Manager (B.M.), Environmental Service Manager (E.M.), Staff Educator (S.E.), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Activity Aide (A.A.), residents and families.

The Inspectors also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents, policies and procedures.

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

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

6 WN(s)
2 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted to the Director regarding resident #004’s fall, which resulted in an injury that caused a significant change in the resident's health status.

Inspector #687 reviewed the CIS report, which identified that two staff members had assisted resident #004 with an activity of daily living (ADL), without providing them with the specific type of equipment.

Inspector #687 reviewed resident #004’s care plan in effect at that time of the incident. The care plan indicated that the resident required a specific type of equipment when completing a certain ADL.

Inspector #687 reviewed the home’s policy titled “Resident Assessment and Plan of Care”, last modified April 30, 2019, which indicated the interdisciplinary team was to ensure that the plan of care was accurate and reflective of [the resident's] current status".

Inspector #687 interviewed Personal Support Worker (PSW) #120, who stated that they had assisted resident #004 with the specific ADL and that they had not provided the resident with the specific type of equipment.

Inspector #687 interviewed Registered Practical Nurse (RPN) #106, who stated that when resident #004 fell, the resident had not had the specific type of equipment. The RPN further stated that the staff were supposed to encourage the resident to use the specific type of equipment when completing a specific ADL, as was indicated in the resident's care plan.

Inspector #687 interviewed the Director of Care (DOC), who stated that the resident's specific type of equipment was not provided to the resident at the time of the resident's fall. The DOC further stated that the staff members should have provided care to resident #004 according to the resident's care plan. [s. 6. (7)]

2. A CIS report was submitted to the Director regarding resident #005's fall, which caused a significant change to the the resident's health status.

Inspector #687 reviewed resident #005's care plan in effect at that time of the incident, for the focus of "significant risk factors for a fall". The care plan indicated that a specific type of equipment was to be used when the resident completed a specific ADL.

Inspector #687 reviewed the home's policy titled "Resident Assessment and Plan of Care", last modified April 30, 2019, which indicated that the interdisciplinary team was to ensure that the plan of care was accurate and reflective of [the resident's] current status".

Inspector #687 interviewed PSW #109, who stated that when they had responded to the resident's fall, they had noted that the resident had not had the specific type of equipment

Inspector #687 interviewed RPN #130, who stated that they had not observed the specific type of equipment when they responded to the resident.

Inspector #687 interviewed the DOC who stated that resident #005's "Post Fall Assessment" had not indicated the specific type of equipment and that staff should have ensured that the specific type of equipment was available to resident #005.

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer

necessary.

A CIS report was submitted to the Director regarding resident #003's fall which caused a significant change to their health status.

Inspector #687 reviewed the resident #003's current care plan for the focus of "significant risk factors for a fall". The care plan indicated that the resident had a specific intervention in place.

On two specific dates, Inspector #687 observed resident #003 without the specific intervention in place.

Inspector #687 reviewed the home's policy titled, "Resident Assessment and Plan of Care", last modified April 30, 2019, which indicated that the interdisciplinary team would ensure that the plan of care was accurate and reflective of the resident's current status.

Inspector #687 interviewed with PSW #115, RPN #106 and RPN #114 who verified that resident #003 no longer required the specific intervention.

Inspector #687 interviewed the DOC who stated that resident #003 no longer required the specific intervention and that the care plan should have been updated by the registered staff to reflect the change. [s. 6. (10) (b)]

4. A CIS report was submitted to the Director regarding resident #004's fall which caused a significant change to their health status. Please see WN #1, item #1 for details.

Inspector #687 reviewed resident #004's current care plan for the focus of "significant risk factors for a fall". The care plan indicated that the resident required specific interventions.

Inspector #687 observed resident #004 with a different intervention in place. The following day, the resident was observed without the specific interventions.

Inspector #687 reviewed the home's policy titled, "Resident Assessment and Plan of Care", last modified April 30, 2019, which indicated that the interdisciplinary team would ensure that the plan of care was accurate and reflective of the resident's current status.

Inspector #687 interviewed PSW #124, PSW#125 and the Physiotherapist (PT). They verified that resident #004 no longer had the specific intervention; they now had a different intervention.

Inspector #687 interviewed the DOC who verified that the resident no longer had the specific intervention; they had a different intervention. The DOC further stated that resident #004's care plan should have been updated by registered staff to reflect the change. [s. 6. (10) (b)]

5. A CIS report was submitted to the Director regarding resident #005's fall that resulted in an injury to the resident which caused a significant change to their health status. Please see WN #1, item #2 for details.

Inspector #687 reviewed resident #005's care plan in effect at that time of the inspection, for the focus of "significant risk factors for a fall". The care plan indicated that the resident required a specific intervention.

On three separate occasions, Inspector #687 observed resident #005 without the specific intervention.

Inspector #687 reviewed the home's policy titled, "Resident Assessment and Plan of Care", last modified April 30, 2019, which indicated that the interdisciplinary team would ensure that the plan of care was accurate and reflective of the resident's current status.

Inspector #687 interviewed PSW #109 and Registered Nurse (RN) #134 who stated that resident #005 no longer had the specific intervention.

Inspector #687 interviewed the Executive Director (E.D.) who stated that resident #005 no longer had the specific intervention, and that the resident's care plan should have been updated to reflect the resident's current fall prevention interventions. [s. 6. (10) (b)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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 the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan of care is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents including;
a) Identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and,
b) Identifying and implementing interventions.

A CIS report was submitted to the Director regarding an episode of responsive behaviours between residents #001 and #002.

Inspector #627 reviewed the progress notes for resident #001 in Point Click Care (PCC), for a specific period of time and identified multiple other instances whereby resident #001 had exhibited responsive behaviours.

Inspector #627 reviewed resident #001's current care plan and could not identify a focus of responsive behaviours.

Inspector #627 reviewed a flow chart titled "Responsive Behaviour Care Pathways"(undated), which was included in the home's policy titled "Dementia Care- Responsive Behaviour Procedure", last modified March 31, 2019. The Responsive Behaviour Care Pathways identified the actions to be taken when a resident exhibited responsive behaviours. The document indicated that staff were to "implement individualized care plans and ensure updates were communicated to all team members".

Inspector #627 interviewed PSW #111 who stated that resident #001 exhibited responsive behaviours and that there should have been a focus in the resident's care plan for the responsive behaviour they exhibited, as well as triggers and interventions that were effective.

Inspector #627 interviewed PSW #110 who stated that resident #001 exhibited responsive behaviours. PSW #110 stated that to the best of their knowledge, resident #001's responsive behaviours, triggers and interventions were not identified in the resident's care plan.

Inspector #627 interviewed PSW #109 who stated that resident #001 exhibited a lot responsive behaviours.

Inspector #627 interviewed RPN #105 who stated that when a resident exhibited a specific type of behaviour, an assessment intervention would be started and staff would be notified during the shift and at report. RPN #105 stated that the assessment intervention had not been completed at the time of the incident and that assessment intervention was one of "our problem" as there was no time to follow up on the assessment intervention charting and complete an associated intervention and update the resident's care plan. RPN #105 stated this was why

staff were not motivated to complete the assessment intervention as "nothing gets done with them".

Inspector #627 interviewed RPN #116 who stated that resident #001 exhibited responsive behaviours. Upon review of resident #001's care plan, with the Inspector, the RPN acknowledged that the resident's responsive behaviours were not identified in the care plan.

Inspector #627 interviewed RN #120 who stated that resident #001 exhibited responsive behaviours. Upon review of resident #001's care plan, RN #120 stated that resident #001's care plan had not included responsive behaviours which shocked and disappointed them.

Inspector #627 interviewed the Staff Educator (S.E), who was lead for the Responsive Behaviour Program. They stated that when residents exhibited responsive behaviours, an assessment intervention was completed regardless of the frequency of the responsive behaviour. The DOS would be analyzed for patterns and the care plan updated accordingly with triggers, interventions and goals. The S.E reviewed resident #001's care plan and stated that they did not understand why the resident's behaviours, triggers and goal were not identified in resident #001's care plan. [s. 54.]

Additional Required Actions:

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

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 where the Long-Term Care Homes Act (LTCHA) or Ontario Regulation (O. Reg) 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, system, policy, protocol, procedure, strategy or system was complied with.

In accordance with O. Reg 79/10, s. 53 (1) 2, the licensee shall ensure that the following are developed to meet the needs of residents with responsive behaviours: Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

Specifically, staff did not comply with the home's strategies for residents with responsive behaviours as found in the policy titled "Dementia Care- Responsive Behaviour Procedure", last modified March 31, 2019.

A CIS report was submitted to the Director regarding residents #001 exhibiting responsive behaviours toward resident #002.

1) Inspector #627 reviewed the home's policy titled "Dementia Care- Responsive Behaviour Procedure, Responsive", last modified March 31, 2019, which instructed staff to complete an interdisciplinary "responsvie behaviour huddle", clearly documenting the details and ensure they were added to weekly "responsive behaviour rounds" and initiate a behaviour tracking tool for resident offender.

Inspector #627 interviewed RPN #116 who stated that when a resident exhibited a specific type of responsive behaviour, a huddle would be held immediately after

the incident and an assessment intervention would be initiated to monitor the resident's behaviour. The RPN further stated that a huddle should have occurred and an assessment intervention should have been initiated when the responsive behaviour occurred.

Inspector #627 interviewed RPN #122 who stated that they were working on the evening of the incident. RPN #122 stated that they did not recall initiating an assessment intervention as it was a very busy night, and they may have forgotten.

Inspector #627 interviewed the Staff Educator (S.E.), who was lead for the home's responsive behaviour program. The S.A. indicated that a huddle should be held as soon as possible after an incident to identify triggers and intervention, and an assessment intervention should be initiated for a specified period of time, when a resident exhibits a responsive behaviour, regardless if it was an incident that required contacting the Ministry, or the police. The S.A. acknowledged that a huddle was not held and an assessment intervention was not initiated and completed.

2) Inspector #627 reviewed the home's binder where the assessment intervention forms were kept, and resident #001's paper chart. The Inspector identified two behaviour tracking tool.

Upon review of the forms, Inspector #627 noted that both of the behaviour tracking tool had not been completed entirely on 80 percent of the days for which it should have been completed.

Inspector #627 reviewed the home's policy titled, "Dementia Care- Responsive Behaviour Procedure", last modified March 31, 2019, which instructed to "initiate [Behaviour Tracking Tool] for resident offender".

Inspector #627 interviewed RPN #116, #122 and RN #120 who stated that when an assessment intervention was initiated, the registered staff on the floor ensured that it was completed for the entirety of the shifts and for the duration of the observation.

Inspector #627 interviewed the S.E., who stated that an assessment intervention should be completed anytime a resident exhibited responsive behaviours, for every shift and for the duration of the observation period. Upon review of the two

behaviour tracking tools, the S.A. acknowledged that the assessment intervention charting was not completed on every shift during the observation periods. [s. 8. (1) (a)]

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 where the Long- Term Care Homes Act (LTCHA) or Ontario Regulation (O. Reg) 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, system, policy, protocol, procedure, strategy or system was complied with, to be implemented voluntarily.

WN #4: 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 required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A CIS report was submitted to the Director regarding resident #004's fall. Please see WN #1, item #1 for details.

A review of resident #004's progress notes for a specific date, indicated that RN #113 documented that they were called to respond as the resident was found on the floor. The progress notes indicated that the resident sustained injuries as a result of this fall incident.

Inspector #687 reviewed resident #004's Point Click Care (PCC) assessments, in the assessment tab, and failed to identify a Post-Fall Assessment, for the fall.

Inspector #687 reviewed the home's policy titled "Post-Fall Management", last reviewed March 31, 2019, which indicated that a Post-Fall Assessment was to be completed by the nurse immediately following the fall".

Inspector #687 interviewed RN #113 who stated that they had responded to resident #004's fall incident and they were aware that they were supposed to complete a Post-Fall Assessment; however, they had not.

Inspector #687 interviewed the DOC who stated that their expectation was for their registered staff members to complete a Post-Fall Assessment when a resident had fallen. The DOC verified that there was no Post-Fall Assessment completed for resident #004's fall.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to inform the Director within 10 days of becoming aware of the incident, a description of the individuals involved in the incident including the names of any staff members who were present at the incident.

A CIS report was submitted to the Director regarding resident #004's fall. Please see WN #1, item #1 for details.

Inspector #687 reviewed the CIS report which failed to identify the names of two staff members involved.

Inspector #687 reviewed a document provided by the home entitled "Critical Incident System Report Required Content" under Appendix C. The documented instructed to include, "a description of the individuals involved in the incident, including the name of the staff members who were present at or discovered the incident".

During an interview with Inspector #687, PSW #120 stated that there were two PSWs who had been present at the time of resident #004's fall.

Inspector #687 interviewed the DOC who verified that there were two staff members present at the time of the fall and that they had not included the names of the two staff members who were involved in the incident in the CIS report. [s. 107. (4) 2. ii.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 147. Powers on inspection

Specifically failed to comply with the following:

s. 147. (3.1) Every person shall give all reasonable assistance to an inspector in the exercise of the inspector's powers or the performance of the inspector's duties under this Act or the regulations. 2017, c. 25, Sched. 5, s. 30 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every person gave all reasonable assistance to an inspector in the exercise of the inspector's powers or the performance of the inspector's duties under this Act or the regulations.

The Long-Term Care Homes Act, 2007, Section (s) 28, indicated that "every person is guilty of an offence who attempts, by any means, to prevent another person from providing information to an inspector or the Director where the provision of the information is required or permitted by this Act or the Regulations".

A CIS report was submitted to the Director regarding a fall involving resident #005.

During an interview between Inspector #687 and PSW #111, the Inspector asked if resident #005 had a specific type of equipment to which the PSW had not responded immediately. The Inspector was not aware that the DOC was standing behind the Inspector. The DOC directed the staff to respond, "You say you don't remember!" The PSW looked at the DOC and looked at the Inspector and stated "I'm sorry; I don't remember".

Later the same day, during an interview between Inspector #687 and PSW #111, the PSW apologized to the Inspector for what had occurred in the morning between them, the DOC, and the Inspector. The PSW stated that they were trying to answer the questions of the Inspector but were directed by the DOC to respond, "You say, you don't remember".

At a later time, PSW #125 approached Inspector #687. The PSW stated that they were present when the DOC interrupted the conversation of the Inspector with PSW #111 earlier in the morning and that this was not the first time that this had occurred. [s. 147. (3.1)]

Issued on this 13th day of January, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by RYAN GOODMURPHY (638) - (A2)
Inspection No. / No de l'inspection :	2019_752627_0023 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	016259-19, 017882-19, 018049-19, 019992-19 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 13, 2020(A2)
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Oak Terrace 291 Mississaga Street West, ORILLIA, ON, L3V-3B9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Annette Schneider

Ontario

Ministry of Long-Term Care

Ministère 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 Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre: 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 section 6 (7), of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must ensure that the care set out in the plan of care is provided to residents #004, #005 and all residents as specified in their plan.

Grounds / Motifs :

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

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

A Critical Incident System (CIS) report was submitted to the Director regarding resident #004's fall, which resulted in an injury that caused a significant change in the resident's health status.

Inspector #687 reviewed the CIS report, which identified that two staff members had assisted resident #004 with an activity of daily living (ADL), without providing them with the specific type of equipment.

Inspector #687 reviewed resident #004's care plan in effect at that time of the incident. The care plan indicated that the resident required a specific type of equipment when completing a certain ADL.

Inspector #687 reviewed the home's policy titled "Resident Assessment and Plan of Care", last modified April 30, 2019, which indicated the interdisciplinary team was to ensure that the plan of care was accurate and reflective of [the resident's] current status".

Inspector #687 interviewed Personal Support Worker (PSW) #120, who stated that they had assisted resident #004 with the specific ADL and that they had not provided the resident with the specific type of equipment.

Inspector #687 interviewed Registered Practical Nurse (RPN) #106, who stated that when resident #004 fell, the resident had not had the specific type of equipment. The RPN further stated that the staff were supposed to encourage the resident to use the specific type of equipment when completing a specific ADL, as was indicated in the resident's care plan.

Inspector #687 interviewed the Director of Care (DOC), who stated that the resident's specific type of equipment was not provided to the resident at the time of the resident's fall. The DOC further stated that the staff members should have provided care to resident #004 according to the resident's care plan. (687)

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

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2. A CIS report was submitted to the Director regarding resident #005's fall, which caused a significant change to the the resident's health status.

Inspector #687 reviewed resident #005's care plan in effect at that time of the incident, for the focus of "significant risk factors for a fall". The care plan indicated that a specific type of equipment was to be used when the resident completed a specific ADL.

Inspector #687 reviewed the home's policy titled "Resident Assessment and Plan of Care", last modified April 30, 2019, which indicated that the interdisciplinary team was to ensure that the plan of care was accurate and reflective of [the resident's] current status".

Inspector #687 interviewed PSW #109, who stated that when they had responded to the resident's fall, they had noted that the resident had not had the specific type of equipment

Inspector #687 interviewed RPN #130, who stated that they had not observed the specific type of equipment when they responded to the resident.

Inspector #687 interviewed the DOC who stated that resident #005's "Post Fall Assessment" had not indicated the specific type of equipment and that staff should have ensured that the specific type of equipment was available to resident #005.

The severity of the issue was determined to be a level three, as there was actual harm to the resident. The scope of the issue was a level two, which indicated a pattern. The home had a level three compliance history, which indicated previous non-compliance to the same subsection:

- Voluntary plan of correction (VPC), served on April 21, 2017, in report #2017_535557_0003. (687)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 21, 2020(A2)

Ontario

Ministry of Long-Term Care

Ministère 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

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Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee must be compliant with section 54, of the Ontario Regulation 79/10, of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must ensure that steps are taken to minimize the risk of altercations between and amongst residents, including:

a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observations, that could potentially trigger such altercations; and,
b) identifying and implementing interventions; and,
c) Update the care plans of all residents who exhibit verbal and physical responsive behaviours with triggers, goals and interventions.
d) Review resident #001 and other residents' plan of care to ensure the care plan addresses any responsive behaviour, specifically that resulted in altercations or trends of potential altercations between and amongst residents.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents

including;
a) Identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and,
b) Identifying and implementing interventions.

A CIS report was submitted to the Director regarding an episode of responsive behaviours between residents #001 and #002.

Inspector #627 reviewed the progress notes for resident #001 in Point Click Care (PCC), for a specific period of time and identified multiple other instances whereby resident #001 had exhibited responsive behaviours.

Inspector #627 reviewed resident #001's current care plan and could not identify a focus of responsive behaviours.

Inspector #627 reviewed a flow chart titled "Responsive Behaviour Care Pathways"(undated), which was included in the home's policy titled "Dementia Care-Responsive Behaviour Procedure", last modified March 31, 2019. The Responsive Behaviour Care Pathways identified the actions to be taken when a resident exhibited responsive behaviours. The document indicated that staff were to "implement individualized care plans and ensure updates were communicated to all team members".

Inspector #627 interviewed PSW #111 who stated that resident #001 exhibited responsive behaviours and that there should have been a focus in the resident's care plan for the responsive behaviour they exhibited, as well as triggers and interventions that were effective.

Inspector #627 interviewed PSW #110 who stated that resident #001 exhibited responsive behaviours. PSW #110 stated that to the best of their knowledge, resident #001's responsive behaviours, triggers and interventions were not identified in the resident's care plan.

Inspector #627 interviewed PSW #109 who stated that resident #001 exhibited a lot responsive behaviours.

Inspector #627 interviewed RPN #105 who stated that when a resident exhibited a specific type of behaviour, an assessment intervention would be started and staff would be notified during the shift and at report. RPN #105 stated that the assessment intervention had not been completed at the time of the incident and that assessment intervention was one of "our problem" as there was no time to follow up on the assessment intervention charting and complete an associated intervention and update the resident's care plan. RPN #105 stated this was why staff were not motivated to complete the assessment intervention as "nothing gets done with them".

Inspector #627 interviewed RPN #116 who stated that resident #001 exhibited responsive behaviours. Upon review of resident #001's care plan, with the Inspector, the RPN acknowledged that the resident's responsive behaviours were not identified in the care plan.

Inspector #627 interviewed RN #120 who stated that resident #001 exhibited responsive behaviours. Upon review of resident #001's care plan, RN #120 stated that resident #001's care plan had not included responsive behaviours which shocked and disappointed them.

Inspector #627 interviewed the Staff Educator (S.E), who was lead for the Responsive Behaviour Program. They stated that when residents exhibited responsive behaviours, an assessment intervention was completed regardless of the frequency of the responsive behaviour. The DOS would be analyzed for patterns and the care plan updated accordingly with triggers, interventions and goals. The S.E reviewed resident #001's care plan and stated that they did not understand why the resident's behaviours, triggers and goal were not identified in resident #001's care plan. [s. 54.]

The severity of the issue was determined to be a level three, as there was actual risk of harm to the resident. The scope of the issue was a level one, which indicated an isolated event. The home had a level three compliance history, which indicated previous non-compliance to the same section:

- VPC issued on January 9, 2019, in report 2019_565647_0002. [687]

(627)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Feb 21, 2020

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

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 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:

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

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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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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 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 13th day of January, 2020 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by RYAN GOODMURPHY (638) - (A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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