Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 25, 2017	2017_556168_0006	032841-16, 004249-17, 004516-17	Complaint

Licensee/Titulaire de permis

PARK LANE TERRACE LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

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

PARK LANE TERRACE
295 GRAND RIVER STREET NORTH PARIS ON N3L 2N9

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

LISA VINK (168), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 24, 27, 28, 2017 and March 1, 2, 3, 7, 8, 2017.

This Complaint inspection was conducted concurrently with Critical Incident inspection number 2017-555506-0009, for log numbers 013139-16, 018611-16, 024957-16, 033046-16 and 001646-17.

Finding of non compliance from this Complaint inspection are included in Critical Incident inspection report number 2017-555506-0009.

This Complaint inspection report contains findings of non compliance from Critical Incident inspection report number 2017-555506-0009.

This Complaint inspection was completed for complaint logs as identified below:
032841-16 - related to falls prevention and management
004249-17 - related to social work and social services work qualifications
004516-17 - related to social work and social services work qualifications.

The following Critical Incident Reports were inspected during this inspection:
2779-000019-16 - incident that caused an injury to a resident for which the resident was taken to the hospital and which caused a significant change the the resident's health status
2779-000027-16 - incident that caused an injury to a resident for which the resident was taken to the hospital and which caused a significant change the the resident's health status
2779-000004-17 - incident that caused an injury to a resident for which the resident was taken to the hospital and which caused a significant change the the resident's health status.

During the course of the inspection, the inspector(s) spoke with the former Administrator, the Director of Care, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), restorative care staff, staff educator, physiotherapist (PT), physiotherapist assistant (PTA), former staff who worked in the position of Social Service Worker, Ontario College of Social Workers and Social Service Workers, office manager, admissions coordinator and residents.

During the course of this inspection, the inspectors: observed the provision of care and services, reviewed relevant records including but not limited to: policies and procedures, training records, employee files and clinical health files.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Training and Orientation

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

- **4 WN(s)**
- **1 VPC(s)**
- **3 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when they assisted residents.

Resident #052 was assessed in 2016, which identified that they required a mechanical lift for all transfers.
In 2017, the resident had been unwell for a few days.
According to the clinical record, on a specified day in 2017, the resident had a change in condition.
Registered staff documented that they would monitor the resident and contact the physician to visit the resident.
Later that morning the resident was transferred to the toilet with the use of the lift.
PSW #105, attempted to transfer the resident off of the toilet with the lift; however, without the assistance of a second staff member.
During this transfer the resident became weak and slid to the floor.
The resident was assessed by RN #106 following the incident and was transported to the hospital where they were diagnosed with an injury.
Interview with RN #106 identified that they were informed, later in the shift, that the resident was transferred by one staff only, PSW #105. The RN reported that they spoke with PSW #105 who verified the allegation.
Interview with PSW #105, verified that they were aware of the need to use two staff at all times with a mechanical lift and that at the time of the incident this was not completed.
Interview with restorative care staff #108 verified that the home had a process in place which included that staff were to conduct a "mobility review prior to handling" to ensure that there was no change in the resident's status and that staff had been trained that they may always increase the level of assistance with transfers if the condition of the resident required increased assistance.
Interview with the DOC and restorative care staff verified the expectation that two staff were to be present at all times when they operated a mechanical lift for safety.
The resident was not transferred safely.

This finding of non compliance was identified during Critical Incident Inspection 2779-000004-17. [s. 36.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure that when a resident had fallen, they were assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A. Resident #021 sustained a fall in 2016.
The resident was assessed by RN #109 following the fall and was transported to the hospital where they were diagnosed with an injury. A review of the clinical record did not include a post fall assessment following the fall as confirmed by nursing management staff #107. Interview with RN #109 verified the requirement to complete a post fall assessment; however, could not recall if the assessment was completed as required. Interview with RN #100 verified the expectation that a post fall assessment be completed following each fall and recorded in the progress notes.

This finding of non compliance was identified during Critical Incident Inspection 2779-000019-16.

B. Resident #052 sustained a fall in 2017, while they were transferred.
The resident was assessed post fall, transferred to the hospital and diagnosed with an injury.
A review of the clinical record did not include the completion of a post-fall assessment, following this incident, using a clinically appropriate assessment instrument that was specifically designed for falls.
Interview with the DOC, following a review of portions of the clinical record, verified that the incident would be considered a fall and that a post fall assessment was not completed as required.

This finding of non compliance was identified during Critical Incident Inspection 2779-000004-17.

C. Resident #051 was identified to be at moderate risk for falls when admitted to the home, based on the Fall Risk Assessment completed the day after admission.
According to the clinical record the resident sustained seven falls during a three week period of time, following their admission.
Post fall assessments, using clinically appropriate assessment instruments, that were specifically designed for falls, were not completed for five of the seven falls, as verified by the DOC, following a review of the clinical record.

This finding of non compliance was identified during Critical Incident Inspection 2779-000027-16.

The home's policy and procedure PCC Assessments, with an effective date of July 2015, indicated that a "post fall audit tool" was to be completed "following each resident fall incident with or without injury", to "assess completeness of current assessment, documentation and interventions of individualized resident fall prevention program".

When the residents had fallen they did not have a post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

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 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. (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 failed the ensure that the written plan of care for each resident set out the planned care for the resident.

Resident #051 was admitted to the home in 2016.
A review of the clinical record, including Point of Care (POC) entries and progress notes, identified that the resident displayed a number of responsive behaviours which required interventions of staff.
A review of the initial care plan identified a focus statement and interventions/tasks for wandering displayed by the resident; however the plan did not include focus statements or interventions/tasks for the other behaviours displayed.
Approximately three months after the resident was admitted to the home the plan was revised to include other behaviours which the resident displayed.
Interview with the DOC, following a review of progress notes and POC records, acknowledged that the records identified behaviours which included resistance to care, agitation and rummaging and that the plan of care did not include focus statements related to these interventions until approximately three months after admission to the home.

The plan of care did not set out the planned care for the resident.

This finding of non compliance was identified during Critical Incident Inspection 2779-000027-16. [s. 6. (1) (a)]

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

A. Resident #055 had a plan of care that informed staff that the resident did not like something specific and directed staff not to invade the resident's personal space.
On an identified date in 2016, PSW #114 conducted the specific activity that the resident did not like and this upset the resident.
PSW #114 acknowledged that they did not follow the plan of care when they conducted the specific activity.

This finding of non compliance was identified during Critical Incident Inspection # 2779-000015-16.

B. Resident #053 had a plan of care in place which identified them to conduct a specific activity and included two specific interventions in an effort to ensure their safety.
The resident was observed on March 2, 2017, returning into the home, following this activity.
The resident utilizing one of the two interventions for safety as identified on their plan of care.
The resident showed the Inspector some supplies to complete the activity which were not in an area as directed in the plan of care.
Interview with RN #100 verified that the identified interventions were included in the plan of care; however, that that these interventions were often not followed by the resident.
Interview with the DOC confirmed the expectation that the interventions be followed and acknowledged that the staff were not following the resident's plan of care.

This finding of non compliance was identified during Critical Incident Inspection # 2779-000028-16. [s. 6. (7)]

3. The licensee 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. In 2016, resident #021 sustained an injury as a result of a fall.
The resident was hospitalized where they received treatment and returned to the home ten days later.
According to the clinical record, when the resident returned from the hospital they had a new diagnosis, additional areas of altered skin integrity and reported pain when the identified area was touched.
A review of information provided by the hospital, at the time of the transfer back to the home, included that the resident required the use of an intervention.
Progress notes recorded five days after the resident returned from the hospital identified the resident had a device in their room, which would have been used as an intervention for the injury.
A review of the plan of care did not include the changes in the resident's care needs, specifically related to the new diagnosis, altered skin integrity, pain or the use of the device as acknowledged by nursing management staff #107.
RPN #101, who worked the day the resident returned from the hospital, reviewed the plan of care and verified it was not updated to reflect changes in the resident's care needs.
There was no documentation located in the clinical record to support that the resident was assessed for the use of the intervention or that the intervention was implemented on the residents return from hospital.
The resident was not reassessed nor was the plan of care reviewed and revised with changes in their care needs.

This finding of non compliance was identified during Critical Incident Inspection 2779-000019-16.

B. A review of the SALT (safe, ambulation, lift and transfer) logo posted in resident #054's room identified that they required two staff, side by side assistance and an aid for all transfers.
The resident was transferred from the toilet to the wheelchair by two staff only and not with the assistance of the aid, as acknowledged by RPN #119 and PSW #123, who completed the transfer.
When interviewed separately both staff reported that the aid was not used during the transfer as it caused the resident to become agitated and unsafe.
RPN #119 stated that they were not aware if this information had been previously recorded in the resident's clinical record, although the change in needs were known to staff.
Interview with restorative staff #108 identified that they had received an email from RPN

#119, dated the day of the transfer, regarding this change in need, and were not previously aware of the need and their plans to reassess the resident.
The plan of care was not reviewed with changes in care needs.

C. The plan of care for resident #051 was not reviewed or revised with changes in their care needs.
The resident had a number of changes in their care needs during their stay at the home.

i. The resident was observed to be toileted with the assistance of one staff member. A review of the plan of care included a focus statement for the level of assistance required to complete the activity of daily living (ADL) of toileting. Interventions/tasks for toileting included direction to "report to registered staff any decrease in ability to toilet self hygienically, safely and appropriately" and that the resident required "two person: extensive to total assistance for the entire process, take to the bathroom, transfer on/off toilet, ensure safety, provide pericare/product, adjust clothing, wash hands".
Interview with RPN #121 verified that the current level of assistance for toileting was one staff member and acknowledged that the plan of care was not reviewed or revised with changes in care needs.
ii. The resident was observed to be transferred by one staff member to the upright position from a seated position with the assistance of a walker. A review of the plan of care included a focus statement for the level of assistance required to complete the ADL of transferring. Interventions/tasks for transferring included direction to "report to registered staff any decrease in ability to transfer self, for example decrease in judgement or unsteady gait".
Interview with RPN #121 verified that the current level of assistance for transferring was one staff member at all times, which was consistent with the directions posted in the resident's room and acknowledged that the plan of care was not reviewed or revised with changes in care needs.
iii. The resident was observed to walk with the PTA pushing a walker, using an aid, with a second person following behind pushing a wheelchair. The resident was then observed to be walked to and from the dining room with the assistance of one staff member and a walker. A review of the plan of care included a focus statement for mobility.
Interventions/tasks for mobility included direction for PSW to walk resident in and out of bathroom for all toileting and in and out of dining room for each meal, with a different type of walker and the assistance of one staff.
Interview with RPN #121 verified that the current level of mobility was one staff member with the walker, which was located in the resident's room and stated that the aid would be used if directed on the SALT assessment. A review of the SALT assessment, posted

in the resident's room did not include the use of the aid.
Interview with restorative care staff #108 acknowledged that the resident currently used the walker in use on the date of the observation, no longer the other type of walker, and that the resident should be walked with the aid at all times due to unsteady gait and verified that the plan of care was not reviewed or revised with changes in care needs.
iv. A review of the plan of care included a focus statement for risk of falls which identified the resident to be at moderate risk. The plan also included a focus statement for the use/application of an external device for prevention of injury to self or others which identified the resident was at high risk for injury/falls.
A review of the most recent Fall Risk Assessment, completed January 2017, identified that the resident was at moderate risk for falls.
The DOC reviewed the resident's plan of care for the areas identified above and confirmed that the plan of care was not reviewed or revised with changes in the care needs in the areas of toileting, transferring, mobility and related to risk of falls.

This finding of non compliance was identified during Critical Incident Inspection 2779-000027-16.

D. The home submitted a Critical Incident Report to the Director in 2016, which indicated that resident #053 sustained an injury and was transported to the hospital.
A review of the clinical record identified that the resident demonstrated a behaviour prior to this incident, dating back to their admission.
A review of the plan of care did not include a focus statement related to this need or interventions until following the incident.
The plan of care was not reviewed and revised to include the behaviour as acknowledged during an interview with the DOC on March 1, 2017.

This finding of non compliance was identified during Critical Incident Inspection # 2779-000028-16 [s. 6. (10) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 written plan of care for each resident sets out the planned care for the resident and that the care set out in the plan of care is provided to residents as specified in their plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 63. Every licensee of a long-term care home shall ensure that social workers or social service workers who provide services in the home are registered under the Social Work and Social Service Work Act, 1998. O. Reg. 79/10, s. 63.

Findings/Faits saillants :

1. The licensee failed to ensure that social workers or social services workers who provide services in the home was registered under the Social Work and Social Service Work Act, 1998.

In 2016, the home hired employee #117, to the position of temporary, full time, Social Service Worker, who had previously graduated, from an approved college, with a diploma in Social Service Worker.
In 2017, it was discovered that they were not registered under the Social Work and Social Service Work Act, 1998.
The employee did not work at the home at the time of this inspection
Interview with former employee #117 verified that they were not registered under the Social Work and Social Service Work Act, 1998, during their time of employment at the home.
Information received from the Deputy Registrar with the Ontario College of Social Workers and Social Service Workers, verified on March 2, 2017, that the former employee did not appear on the Register.
A review of the job description for Social Service Worker, section 3-26, effective date July 2016, did not include under background/qualifications that the employee must be registered under the Social Work and Social Service Work Act, 1998, which was acknowledged by the DOC. [s. 63.]

Issued on this 12th 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) :	LISA VINK (168), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2017_556168_0006
Log No. / Registre no:	032841-16, 004249-17, 004516-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 25, 2017
Licensee / Titulaire de permis :	PARK LANE TERRACE LIMITED 284 CENTRAL AVENUE, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	PARK LANE TERRACE 295 GRAND RIVER STREET NORTH, PARIS, ON, N3L-2N9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Catherine Donahue

To PARK LANE TERRACE LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall ensure that all staff use safe transferring and positioning devices or techniques when assisting residents, including two staff to use mechanical lifts.

The licensee shall ensure that all nursing staff receive training on safe lifts and transfers, including the use of the mechanical lifts with two staff, on initial orientation and on a yearly basis.

The home shall ensure that there is a system place for random audits, at a frequency to be determined by the home, to ensure that staff complete lifts and transfers safely and that action is taken immediately when staff to do complete safe lifts or transfers.

Grounds / Motifs :

1. This Order was based upon three factors: severity, scope and history of non-compliance in keeping with section 299(1) of Ont. Regulation 79/10. The severity was 3 (actual harm/risk), the scope was 1 (isolated) and the compliance history was 4 (ongoing non compliance).

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when they assisted residents.

Resident #052 was assessed in 2016, which identified that they required a mechanical lift for all transfers.
In 2017, the resident had been unwell for a few days.
According to the clinical record, on a specified day in 2017, the resident had a change in condition.

Registered staff documented that they would monitor the resident and contact the physician to visit the resident.
Later that morning the resident was transferred to the toilet with the use of the lift.
PSW #105, attempted to transfer the resident off of the toilet with the lift; however, without the assistance of a second staff member.
During this transfer the resident became weak and slid to the floor.
The resident was assessed by RN #106 following the incident and was transported to the hospital where they were diagnosed with an injury.
Interview with RN #106 identified that they were informed, later in the shift, that the resident was transferred by one staff only, PSW #105. The RN reported that they spoke with PSW #105 who verified the allegation.
Interview with PSW #105, verified that they were aware of the need to use two staff at all times with a mechanical lift and that at the time of the incident this was not completed.
Interview with restorative care staff #108 verified that the home had a process in place which included that staff were to conduct a "mobility review prior to handling" to ensure that there was no change in the resident's status and that staff had been trained that they may always increase the level of assistance with transfers if the condition of the resident required increased assistance.
Interview with the DOC and restorative care staff verified the expectation that two staff were to be present at all times when they operated a mechanical lift for safety.
The resident was not transferred safely.

This finding of non compliance was identified during Critical Incident Inspection 2779-000004-17. [s. 36.] (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2017

Order # / Ordre no : 002

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 shall ensure that when a resident falls, 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.

Registered nursing staff shall be provided education and direction on when a clinically appropriate assessment instrument that is specifically designed for falls is to be completed, who is responsible to complete the assessment and the purpose of the assessment instrument.

The home shall implement an audit system, at times and frequencies as determined by the home, to ensure that staff complete a clinically appropriate assessment instrument that is specifically designed for falls, according to the home's procedure, when a resident has fallen, until staff consistently comply with the procedure.

Grounds / Motifs :

1. This Order was based upon three factors: severity, scope and history of non-compliance in keeping with section 299(1) of Ont. Regulation 79/10. The severity was 2 (minimal harm or potential for harm/risk), the scope was 3 (widespread) and the compliance history was 2 (previously unrelated non-compliance).

1. The licensee failed to ensure that when a resident had fallen, they were assessed and, if required, a post-fall assessment was conducted using a

clinically appropriate assessment instrument that was specifically designed for falls.

A. Resident #021 sustained a fall in 2016.
The resident was assessed by RN #109 following the fall and was transported to the hospital where they were diagnosed with an injury. A review of the clinical record did not include a post fall assessment following the fall as confirmed by nursing management staff #107. Interview with RN #109 verified the requirement to complete a post fall assessment; however, could not recall if the assessment was completed as required.
Interview with RN #100 verified the expectation that a post fall assessment be completed following each fall and recorded in the progress notes.

This finding of non compliance was identified during Critical Incident Inspection 2779-000019-16.

B. Resident #052 sustained a fall in 2017, while they were transferred.
The resident was assessed post fall, transferred to the hospital and diagnosed with an injury.
A review of the clinical record did not include the completion of a post-fall assessment, following this incident, using a clinically appropriate assessment instrument that was specifically designed for falls.
Interview with the DOC, following a review of portions of the clinical record, verified that the incident would be considered a fall and that a post fall assessment was not completed as required.

This finding of non compliance was identified during Critical Incident Inspection 2779-000004-17.

C. Resident #051 was identified to be at moderate risk for falls when admitted to the home, based on the Fall Risk Assessment completed the day after admission.
According to the clinical record the resident sustained seven falls during a three week period of time, following their admission.
Post fall assessments, using clinically appropriate assessment instruments, that were specifically designed for falls, were not completed for five of the seven falls, as verified by the DOC, following a review of the clinical record.

This finding of non compliance was identified during Critical Incident Inspection

2779-000027-16.

The home's policy and procedure PCC Assessments, with an effective date of July 2015, indicated that a "post fall audit tool" was to be completed "following each resident fall incident with or without injury", to "assess completeness of current assessment, documentation and interventions of individualized resident fall prevention program".

When the residents had fallen they did not have a post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)] (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that residents #051, #054, and #053 are reassessed and their plans of care are reviewed and revised, to reflect current needs and whenever there are changes in their care needs in the areas of falls prevention and management, activities of daily living, mobility and transfers and/or responsive behaviours.

The licensee shall ensure that all residents in the home are reassessed and their plans of care are reviewed and revised, when there are changes in their care needs in the areas of falls prevention and management, activities of daily living, mobility and transfers and/or responsive behaviours.

The home shall ensure that all staff who provide direct care to residents are aware of the current care needs of residents and communicate changes in needs to the appropriate person for reassessment.

The home shall provide education to all staff who are responsible for the reassessment of residents and revisions to plans to care, to emphasize the purpose of plans, staff responsibility to ensure that plans are up to date and reflective of care needs of residents and examples of situations which would require an amendment to a plan of care.

The home shall create and implement an auditing process to ensure that plans of care and reviewed and revised as needed at a frequency and duration as set out by the home.

Grounds / Motifs :

1. This Order was based upon three factors: severity, scope and history of non-compliance in keeping with section 299(1) of Ont. Regulation 79/10. The severity was 3 (actual harm/risk), the scope was 2 (pattern) and the compliance history was 4 (ongoing non-compliance).

The licensee 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. In 2016, resident #021 sustained an injury as a result of a fall.
The resident was hospitalized where they received treatment and returned to the home ten days later.

According to the clinical record, when the resident returned from the hospital they had a new diagnosis, additional areas of altered skin integrity and reported pain when the identified area was touched.
A review of information provided by the hospital, at the time of the transfer back to the home, included that the resident required the use of an intervention.
Progress notes recorded five days after the resident returned from the hospital identified the resident had a device in their room, which would have been used as an intervention for the injury.
A review of the plan of care did not include the changes in the resident's care needs, specifically related to the new diagnosis, altered skin integrity, pain or the use of the device as acknowledged by nursing management staff #107.
RPN #101, who worked the day the resident returned from the hospital, reviewed the plan of care and verified it was not updated to reflect changes in the resident's care needs.
There was no documentation located in the clinical record to support that the resident was assessed for the use of the intervention or that the intervention was implemented on the residents return from hospital.
The resident was not reassessed nor was the plan of care reviewed and revised with changes in their care needs.

This finding of non compliance was identified during Critical Incident Inspection 2779-000019-16.

B. A review of the SALT (safe, ambulation, lift and transfer) logo posted in resident #054's room identified that they required two staff, side by side assistance and an aid for all transfers.
The resident was transferred from the toilet to the wheelchair by two staff only and not with the assistance of the aid, as acknowledged by RPN #119 and PSW #123, who completed the transfer.
When interviewed separately both staff reported that the aid was not used during the transfer as it caused the resident to become agitated and unsafe.
RPN #119 stated that they were not aware if this information had been previously recorded in the resident's clinical record, although the change in needs were known to staff.
Interview with restorative staff #108 identified that they had received an email from RPN #119, dated the day of the transfer, regarding this change in need, and were not previously aware of the need and their plans to reassess the resident.
The plan of care was not reviewed with changes in care needs.

C. The plan of care for resident #051 was not reviewed or revised with changes in their care needs.
The resident had a number of changes in their care needs during their stay at the home.
i. The resident was observed to be toileted with the assistance of one staff member. A review of the plan of care included a focus statement for the level of assistance required to complete the activity of daily living (ADL) of toileting. Interventions/tasks for toileting included direction to "report to registered staff any decrease in ability to toilet self hygienically, safely and appropriately" and that the resident required "two person: extensive to total assistance for the entire process, take to the bathroom, transfer on/off toilet, ensure safety, provide pericare/product, adjust clothing, wash hands".
Interview with RPN #121 verified that the current level of assistance for toileting was one staff member and acknowledged that the plan of care was not reviewed or revised with changes in care needs.
ii. The resident was observed to be transferred by one staff member to the upright position from a seated position with the assistance of a walker. A review of the plan of care included a focus statement for the level of assistance required to complete the ADL of transferring. Interventions/tasks for transferring included direction to "report to registered staff any decrease in ability to transfer self, for example decrease in judgement or unsteady gait".
Interview with RPN #121 verified that the current level of assistance for transferring was one staff member at all times, which was consistent with the directions posted in the resident's room and acknowledged that the plan of care was not reviewed or revised with changes in care needs.
iii. The resident was observed to walk with the PTA pushing a walker, using an aid, with a second person following behind pushing a wheelchair. The resident was then observed to be walked to and from the dining room with the assistance of one staff member and a walker. A review of the plan of care included a focus statement for mobility. Interventions/tasks for mobility included direction for PSW to walk resident in and out of bathroom for all toileting and in and out of dining room for each meal, with a different type of walker and the assistance of one staff.
Interview with RPN #121 verified that the current level of mobility was one staff member with the walker, which was located in the resident's room and stated that the aid would be used if directed on the SALT assessment. A review of the SALT assessment, posted in the resident's room did not include the use of the aid.

Interview with restorative care staff #108 acknowledged that the resident currently used the walker in use on the date of the observation, no longer the other type of walker, and that the resident should be walked with the aid at all times due to unsteady gait and verified that the plan of care was not reviewed or revised with changes in care needs.
iv. A review of the plan of care included a focus statement for risk of falls which identified the resident to be at moderate risk. The plan also included a focus statement for the use/application of an external device for prevention of injury to self or others which identified the resident was at high risk for injury/falls.
A review of the most recent Fall Risk Assessment, completed January 2017, identified that the resident was at moderate risk for falls.
The DOC reviewed the resident's plan of care for the areas identified above and confirmed that the plan of care was not reviewed or revised with changes in the care needs in the areas of toileting, transferring, mobility and related to risk of falls.

This finding of non compliance was identified during Critical Incident Inspection 2779-000027-16.

D. The home submitted a Critical Incident Report to the Director in 2016, which indicated that resident #053 sustained an injury and was transported to the hospital.
A review of the clinical record identified that the resident demonstrated a behaviour prior to this incident, dating back to their admission.
A review of the plan of care did not include a focus statement related to this need or interventions until following the incident.
The plan of care was not reviewed and revised to include the behaviour as acknowledged during an interview with the DOC on March 1, 2017.

This finding of non compliance was identified during Critical Incident Inspection # 2779-000028-16 [s. 6. (10) (b)] (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 25th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

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