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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 14, 2020	2020_824765_0002	023379-19, 023637-19, 000211-20, 000343-20	Critical Incident System

Licensee/Titulaire de permis

City of Greater Sudbury
200 Brady Street 4th Floor SUDBURY ON P3E 3L9

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

Pioneer Manor
960 Notre Dame Avenue SUDBURY ON P3A 2T4

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

HILARY ROCK (765), SYLVIE BYRNES (627)

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): January 20 - 24, 2020. Additional off-site activities were completed on January 27 and 28, 2020.

The following intakes were completed in this Critical Incident System Inspection:
One intake was related to alleged abuse,
and three intakes were related to falls.

During the course of the inspection, the inspector(s) spoke with the Director, Manager of Resident Care, Resident Care Coordinators (RCC), Manager of Therapeutic Services (MTS), Resident Assessment Instrument (RAI) Coordinator, Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The inspector(s) 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 this inspection, Non-Compliances were issued.
3 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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) required the licensee of a long-term care home to have, institute or otherwise put in place any policy and that the policy was complied with.

In accordance with Ontario Regulations (O.Reg.) section (s) 49(1), the licensee was required to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the licensee's policy titled "Falls and Fall related injuries: Assessment, Reduction and Management", last revised March 5, 2019.

a) A Critical Incident System (CIS) report was submitted to the Director related to resident #006 who had a fall which caused a significant change to the resident's health status.

Inspector #627 reviewed the home's policy titled "Falls and Fall related injuries: Assessment, Reduction and Management", last revised March 5, 2019, which indicated that when a resident fell, the responsible registered staff member was to complete the electronic incident report in Point Click Care (PCC) which included any predisposing factors that may have led to the fall. The policy also indicated that a post fall follow-up note was to be completed two days after the fall.

Inspector #627 interviewed Registered Practical Nurse (RPN) #104 who stated that once a resident had been assessed after falling, a "Fall Incident Report" would be completed. As well, a "fall follow up" was to be scheduled two days after the fall and would be added to the Treatment Administration Record (TAR). Upon review of the documentation for

events and a 48 hour fall risk assessment had not been documented in the “Fall Incident Report”.

Upon review of the documentation regarding resident #006, Registered Nurse (RN) #109 acknowledged to Inspector #627 that the post fall assessment had not been completed in it's entirety as the injuries and contributing factors were not documented, the scheduled event had not been entered, and a post falls follow up had not been completed.

The Resident Care Coordinator (RCC) acknowledged to Inspector #627 that the fall assessment had not been completed entirely as the causative factors and the two-day post follow up had not been completed; as well, a scheduled event had not been created.

b) A CIS report was submitted to the Director regarding a fall of resident #002, which caused a significant change to the resident’s health status.

Inspector #765 reviewed resident #002’s “Fall Incident Report” and noted that it had not been completed in it's entirety as it had not been updated with a post fall assessment. The “Fall Incident Report” was not updated to include that resident #002 was sent to the hospital, what injury they sustained, and the care plan review was not indicated as completed. There were also no post fall events created for this fall and the post fall follow up assessment had not been completed.

Upon review of the documentation for resident #002's fall, RPN #116 and RN #109 stated to inspector #765 in separate interviews that the post fall assessment was not done, the injuries were not documented, the scheduled event had not been entered, and a post falls follow up had not been completed.

Inspector #765 interviewed RCC #111 who acknowledged that the “Fall Incident Report” and post fall assessments were not completed as per policy for resident #002’s fall.

c) A CIS report was submitted to the Director regarding resident #001’s fall, which caused significant change to the resident’s health status.

Inspector #765 reviewed resident #001 "Fall Incident Report" and noticed that the injuries, contributing factors, and the resident being sent to the hospital had not been documented. Inspector #765 could not identify a scheduled event for follow up of this fall.

Inspector #765 reviewed resident #001's progress notes which indicated a previous fall on a different specified date, which was not indicated in the CIS report where the resident's history of falls had been documented. Inspector #765 failed to locate a "Fall Incident Report" for this fall. Inspector #765 reviewed resident #001's oneMAR from the month of the fall, and could not identify a scheduled post fall event for follow up of this fall.

Upon review of the documentation for resident #001's fall, RPN #108 stated to Inspector #765 that there had been no scheduled post fall follow up events added to TAR and the "Falls Incident Report" was not updated and should have been. RPN #108 stated that there were no contributing factors indicated and the injuries post incident were not filled out. RPN #108 also confirmed that there was no "Falls Incident Report" or post fall events for their fall on the specified date, and there should have been.

Upon review of the documentation regarding the "Fall Incident Report" for resident #001, RN #109 acknowledged to Inspector #765 that the post fall assessment for the fall indicated in the CIS had nothing in it; it was not completed and should have been. RN #109 stated that the injuries were not documented, the contributing factors were not filled out, the scheduled post fall event had not been entered, and a post falls follow up had not been completed. RN #109 also stated that there was no post fall completed and the "Risk Assessment" was not completed at time of fall. RN #109 said that the "Risk Assessment" was to be completed at the time of incident.

Inspector #765 interviewed RCC #111 who stated that the "Fall Incident Report" from the fall indicated in the CIS was not filled out accurately and it was not updated. RCC #111 acknowledged that the "Fall Incident Report" and post fall assessments were not completed as per policy for resident #001's falls. RCC #111 also stated they were now aware that the "Fall Incident Report" and post fall assessments were not completed for resident #001's fall on the different specified date.

2. In accordance with Ontario Regulations (O.Reg.) section (s) 49(1), the licensee was required to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the licensee's policy titled "Falls and Fall related injuries: Assessment, Reduction and Management", last revised March 5, 2019.

Inspector #765 interviewed Personal Support Worker (PSW) #107 who stated on a specified date, resident #001 had fallen while they were being assisted. PSW #107 described how the resident had fallen and that PSW #110 had assisted them to get resident #001 up off the floor and transferred back to bed as they had been unable to locate a nurse.

Inspector #765 interviewed PSW #110 who indicated the same as PSW #107 regarding the events of resident #001's fall. PSW #110 mentioned that resident #001 was trying to get up from the floor and they had assisted resident #001. PSW #110 stated that PSW #107 had notified the RPN of resident #001’s fall once the resident was in bed. PSW #110 confirmed that a registered staff member had not assessed resident #001 prior to them being transferred to bed after their fall.

Inspector #765 reviewed the home’s policy titled “Falls and Fall related injuries: Assessment, Reduction and Management,” last revised March 5, 2019, which indicated that if a resident experiences a fall, post fall procedures are to be followed. The processes for assessment included for the resident to be assessed by a registered nursing staff or the RN supervisor if deemed necessary. The resident was to remain where the fall occurred until assessed and once assessed, the resident was to be assisted off the floor using a mechanical device unless the resident was capable of getting up independently.

RPN #108 and RN #109 stated to Inspector #765 in separate interviews that PSWs were not to get residents up after a fall until a registered staff member had completed an assessment.

Inspector #765 interviewed RCC #111 who stated that when a resident fell, the PSW was to call registered staff to assess the resident and that after an assessment was complete an off the floor sling was to be utilized to transfer the resident. RCC #111 acknowledged that the resident should not have been transferred prior to being assessed by registered staff and they should not have been transferred by the PSW without registered staff assisting with the transfer off the floor with the off the floor sling. [s. 8. (1) (b)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

s. 6. (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 there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A CIS report was submitted to the Director regarding the fall of resident #001, which caused significant change to the resident’s health status.

Inspector #765 reviewed resident #001’s care plans that were in effect at the time of their fall and at the time of the inspection on PCC. The following areas of written care plan were noted:

a) At the time of resident #001’s fall, the falls section of their care plan identified that the resident was to have a specified continence intervention within the restorative section. However, the restorative section with the specified continence intervention had been

removed from the care plan six months prior to their fall.

Resident #001's care plan at the time of the inspection indicated they were using a specified device. Inspector #765 observed resident #001 every day throughout the week of the inspection and did not see any sign of the specified device.

Resident #001's care plan at the time of the inspection indicated a specified continence intervention was on hold. However, during observations, Inspector #765 noticed a sign in resident #001's room indicated they were still on the specified continence intervention.

PSW #107 described to Inspector #765 what specified continence intervention they used for resident #001 before their fall. PSW #107 indicated that the specified continence intervention should have been in the Kardex. PSW #107 stated that resident #001 did not have the specified continence intervention after their fall and was no longer using the specified device.

PSW #110 mentioned in an interview with Inspector #765 that they did not know resident #001's specified continence intervention but would look in the Kardex if they were providing care. In a separate interview with Inspector #765, PSW #103 stated that resident #001 did not have a specified continence intervention and that they always saw the specified continence intervention sign in resident #001's room which they indicated would be confusing to staff. PSW #103 further mentioned that if registered staff discontinued a specified continence intervention that they needed to take down the signs from resident rooms too. PSW #103 stated that the care plan should have been updated regarding the specified continence intervention and removal of the specified device. RPN #108 acknowledged that it was not clear direction for staff.

RN #109 mentioned that the falls section of the care plan regarding the specified continence intervention should have been updated when the specified continence intervention was resolved as it was not clear. RN #109 further stated that the specified device intervention in resident #001's care plan should have been removed from the care plan when it was discontinued. RN #109 acknowledged that this was not clear direction for staff as there were discrepancies especially with the sign in the resident's room indicating they were using the specified continence intervention.

Upon review of resident #001's care plan with Inspector #765, RCC #111 mentioned that the specified continence intervention was in the care plan under the restorative nursing section and then it was resolved six months prior. RCC #111 stated that staff were

required to look into the care plan to see what resident #001's specified requirements were and that the specified continence intervention did not exist. RCC #111 confirmed that when resident #001's specified device was removed that the care plan should have been updated to reflect that.

b) Resident #001's care plan and Kardex in place at time of the inspection indicated they required a specified transfer intervention, however another part of the care plan identified that the resident required a different transfer intervention.

RN #109 stated to Inspector #765, while trying to figure out the care plan, they noticed that under the falls section it indicated that the resident required a specified transfer intervention but in another section it identified a different transfer intervention. RN #109 continued to mention that there were definitely discrepancies throughout the care plan.

RCC #111 stated to Inspector #765 during an interview, that according to the fall section of the care plan it said that resident #001 required a specified transfer intervention but under the transfer section it indicated that resident #001 required a different specified transfer intervention. RCC #111 also indicated that the care plan was not correct if they were using a specified device as it was required to be completed by two staff.

c) Upon review of resident #001's plan of care, they were a specified falls risk. In contrast, Inspector #765 noticed that two other sections within resident #001's plan of care indicated they were a different specified falls risk.

PSW #107 mentioned to Inspector #765 that they would say resident #001 was at a specified falls risk but it depended on the day. In a separate interview, PSW #103 stated, upon review of the Kardex, that resident #001 was a different specified falls risk. PSW #103 stated that it was not clear direction for staff.

Upon review of PCC, RPN #108 stated to Inspector #765 that resident #001 was a specified falls risk in one area of their plan of care but in their care plan it indicated a different specified falls risk. RPN #108 acknowledge that their falls risk was not clear for staff.

RCC #111 stated to Inspector #765 that two areas of their plan of care denoted a specified falls risk while two other areas indicated a different specified falls risk.

d) During the inspection, Inspector #765 observed that resident #001 had a specified

device. The Inspector reviewed the care plan and the device was not present in the care plan. Inspector #765 reviewed the care plan on PCC and noticed that the interventions for specified device in the care plan had been removed for three days. Upon review of the paper charts it was noticed by Inspector #765 that there were no forms to discontinue and no physician's orders to remove the specified device.

During an interview with Inspector #765, RN #109 indicated that resident #001 did not have the specified device in their care plan. RN #109 stated that the intervention had been resolved from the care plan. RN #109 explained that in order to resolve the interventions there would have to be a form to discontinue as well as a physician's order before the intervention could be removed from the care plan.

During a review of the care plan RCC #111 indicated to Inspector #765 that they did not see any specified device in their care plan. RCC #111 stated they did not see anything in terms of the specified device being discontinued within any assessments, referrals, or progress notes. RN #109 and RCC #111 had no idea that the specified device had been resolved. They both indicated that the resident still needed the specified device for their safety and the interventions were put back into place as a result of the Inspector's discoveries. [s. 6. (1) (c)]

2. 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 CIS report was submitted to the Director regarding resident #001's fall, which caused significant change to the resident's health status.

Resident #001's care plan in place at the time of the inspection, advised staff to ensure that a specified item was used at all times. When Inspector #765 observed resident #001 throughout the week, staff indicated that resident #001 was not using the specified item.

Upon review of progress notes, PT completed an assessment which further indicated that resident #001 was recommended to use the specified item. A different progress note indicated that staff were unable to find the specified item on a specified date and resident #001 was not using the the specified item.

PSW #107 mentioned to Inspector #765 that resident #001 was not using the specified item. PSW #107 also stated that sometimes resident #001 did not always have the specified item available. RPN #108 and RN #109 stated to Inspector #765 that resident

#001 was to use the specified item.

RCC #111 stated that the care plan instructed staff to use the specified item and staff should have followed it. [s. 6. (7)]

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

A CIS report was submitted to the Director regarding resident #002's fall which caused a significant change to the resident's health status. According to the CIS report, resident #002 had sustained previous falls.

Inspector #765 reviewed resident #002's care plan specific to falls interventions. Although resident #002 had 10 falls the past quarter, no new or altered interventions had been trialed or implemented according to the care plan.

Inspector #765 reviewed resident #002's progress notes in PCC which included a PT assessment from a month prior to their fall that indicated resident #002 required a specified item.

PSW #117 stated to Inspector #765 that resident #002 would normally fall at a specified time of day. After resident #002's many falls in the specified month, PSW #117 indicated that there were no new interventions added. PSW #117 stated that a specified device would have been beneficial.

During an interview with Inspector #765, RPN #116 stated they were surprised resident #002 didn't have a specified device as it might have been appropriate for them.

RCC #111 stated to Inspector #765 that there were no interventions implemented after resident #002's increased number of falls. RCC #111 stated that there should have been an increased awareness with resident #002's falls.

Inspector #765 interviewed Manager of Therapeutic Services (MTS) #115 who stated that resident #002's care plan included standard interventions. However, when it was noted that resident #002 had sustained multiple falls, MTS #115 stated that interventions should have been implemented. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the residents; ensuring that the care set out in the plan of care is provided to the resident as specified in the plan; and ensuring that residents are reassessed and the plan of care is reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirement was met where a resident was being restrained by a physical device under section 31 of the Act: that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

Upon the first observation of resident #001, it was noticed by Inspector #765 that they had a specified device being used. They were noticed to have the specified device on three of the four days observed.

Inspector #765 reviewed the home’s policy that described devices and indicated there needed to be an order for the specified device.

PSW #107 mentioned to Inspector #765 that they applied the specified device because that is what they believed was required for the resident. In a separate interview, PSW #110 stated to Inspector #765 that they were "pretty sure" resident #001 required a the specified device.

Upon review of the care plan RN #109 stated to Inspector #765 that they were not able to find any interventions regarding the specified device. RN #109 stated that they could not find an assessment on PCC regarding the specified device.

While reviewing resident #001's care plan, RCC #111 stated there was no permission provided, no physician's order, and the use of the specified device was not assessed and should have been, if resident #001 required the specified device. [s. 110. (2) 1.]

Issued on this 24th day of February, 2020

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

Original report signed by the inspector.

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HILARY ROCK (765), SYLVIE BYRNES (627)
Inspection No. / No de l'inspection :	2020_824765_0002
Log No. / No de registre :	023379-19, 023637-19, 000211-20, 000343-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 14, 2020
Licensee / Titulaire de permis :	City of Greater Sudbury 200 Brady Street, 4th Floor, SUDBURY, ON, P3E-3L9
LTC Home / Foyer de SLD :	Pioneer Manor 960 Notre Dame Avenue, SUDBURY, ON, P3A-2T4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Aaron Archibald

To City of Greater Sudbury, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s.8 (1).

Specifically, the licensee shall ensure that:
1. They develop a process to ensure that staff adhere to the licensee's policy titled "Falls and Fall related injuries: Assessment, Reduction and Management;" and,
2. PSW #107 and #110 are retrained on the home's fall policy.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that where the Long-Term Care Homes Act (LTCHA) required the licensee of a long-term care home to have, institute or otherwise put in place any policy and that the policy was complied with.

In accordance with Ontario Regulations (O.Reg.) section (s) 49(1), the licensee was required to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the licensee's policy titled "Falls and Fall related injuries: Assessment, Reduction and Management", last revised March 5, 2019.

a) A Critical Incident System (CIS) report was submitted to the Director related

to resident #006 who had a fall which caused a significant change to the resident 's health status.

Inspector #627 reviewed the home's policy titled "Falls and Fall related injuries: Assessment, Reduction and Management", last revised March 5, 2019, which indicated that when a resident fell, the responsible registered staff member was to complete the electronic incident report in Point Click Care (PCC) which included any predisposing factors that may have led to the fall. The policy also indicated that a post fall follow-up note was to be completed two days after the fall.

Inspector #627 interviewed Registered Practical Nurse (RPN) #104 who stated that once a resident had been assessed after falling, a "Fall Incident Report" would be completed. As well, a "fall follow up" was to be scheduled two days after the fall and would be added to the Treatment Administration Record (TAR). Upon review of the documentation for resident #006's fall, RPN #104 stated that there had been no scheduled fall follow up events and a 48 hour fall risk assessment had not been documented in the "Fall Incident Report".

Upon review of the documentation regarding resident #006, Registered Nurse (RN) #109 acknowledged to Inspector #627 that the post fall assessment had not been completed in it's entirety as the injuries and contributing factors were not documented, the scheduled event had not been entered, and a post falls follow up had not been completed.

The Resident Care Coordinator (RCC) acknowledged to Inspector #627 that the fall assessment had not been completed entirely as the causative factors and the two-day post follow up had not been completed; as well, a scheduled event had not been created.

b) A CIS report was submitted to the Director regarding a fall of resident #002, which caused a significant change to the resident's health status.

Inspector #765 reviewed resident #002's "Fall Incident Report" and noted that it had not been completed in it's entirety as it had not been updated with a post fall assessment. The "Fall Incident Report" was not updated to include that resident #002 was sent to the hospital, what injury they sustained, and the care plan

review was not indicated as completed. There were also no post fall events created for this fall and the post fall follow up assessment had not been completed.

Upon review of the documentation for resident #002's fall, RPN #116 and RN #109 stated to inspector #765 in separate interviews that the post fall assessment was not done, the injuries were not documented, the scheduled event had not been entered, and a post falls follow up had not been completed.

Inspector #765 interviewed RCC #111 who acknowledged that the "Fall Incident Report" and post fall assessments were not completed as per policy for resident #002's fall.

c) A CIS report was submitted to the Director regarding resident #001's fall, which caused significant change to the resident's health status.

Inspector #765 reviewed resident #001 "Fall Incident Report" and noticed that the injuries, contributing factors, and the resident being sent to the hospital had not been documented. Inspector #765 could not identify a scheduled event for follow up of this fall.

Inspector #765 reviewed resident #001's progress notes which indicated a previous fall on a different specified date, which was not indicated in the CIS report where the resident's history of falls had been documented. Inspector #765 failed to locate a "Fall Incident Report" for this fall. Inspector #765 reviewed resident #001's oneMAR from the month of the fall, and could not identify a scheduled post fall event for follow up of this fall.

Upon review of the documentation for resident #001's fall, RPN #108 stated to Inspector #765 that there had been no scheduled post fall follow up events added to TAR and the "Falls Incident Report" was not updated and should have been. RPN #108 stated that there were no contributing factors indicated and the injuries post incident were not filled out. RPN #108 also confirmed that there was no "Falls Incident Report" or post fall events for their fall on the specified date, and there should have been.

Upon review of the documentation regarding the "Fall Incident Report" for resident #001, RN #109 acknowledged to Inspector #765 that the post fall assessment for the fall indicated in the CIS had nothing in it; it was not completed and should have been. RN #109 stated that the injuries were not documented, the contributing factors were not filled out, the scheduled post fall event had not been entered, and a post falls follow up had not been completed. RN #109 also stated that there was no post fall completed and the "Risk Assessment" was not completed at time of fall. RN #109 said that the "Risk Assessment" was to be completed at the time of incident.

Inspector #765 interviewed RCC #111 who stated that the "Fall Incident Report" from the fall indicated in the CIS was not filled out accurately and it was not updated. RCC #111 acknowledged that the "Fall Incident Report" and post fall assessments were not completed as per policy for resident #001's falls. RCC #111 also stated they were now aware that the "Fall Incident Report" and post fall assessments were not completed for resident #001's fall on the different specified date.

2. In accordance with Ontario Regulations (O.Reg.) section (s) 49(1), the licensee was required to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the licensee's policy titled "Falls and Fall related injuries: Assessment, Reduction and Management", last revised March 5, 2019.

Inspector #765 interviewed Personal Support Worker (PSW) #107 who stated on a specified date, resident #001 had fallen while they were being assisted. PSW #107 described how the resident had fallen and that PSW #110 had assisted them to get resident #001 up off the floor and transferred back to bed as they had been unable to locate a nurse.

Inspector #765 interviewed PSW #110 who indicated the same as PSW #107 regarding the events of resident #001's fall. PSW #110 mentioned that resident #001 was trying to get up from the floor and they had assisted resident #001. PSW #110 stated that PSW #107 had notified the RPN of resident #001's fall

once the resident was in bed. PSW #110 confirmed that a registered staff member had not assessed resident #001 prior to them being transferred to bed after their fall.

Inspector #765 reviewed the home's policy titled "Falls and Fall related injuries: Assessment, Reduction and Management," last revised March 5, 2019, which indicated that if a resident experiences a fall, post fall procedures are to be followed. The processes for assessment included for the resident to be assessed by a registered nursing staff or the RN supervisor if deemed necessary. The resident was to remain where the fall occurred until assessed and once assessed, the resident was to be assisted off the floor using a mechanical device unless the resident was capable of getting up independently.

RPN #108 and RN #109 stated to Inspector #765 in separate interviews that PSWs were not to get residents up after a fall until a registered staff member had completed an assessment.

Inspector #765 interviewed RCC #111 who stated that when a resident fell, the PSW was to call registered staff to assess the resident and that after an assessment was complete an off the floor sling was to be utilized to transfer the resident. RCC #111 acknowledged that the resident should not have been transferred prior to being assessed by registered staff and they should not have been transferred by the PSW without registered staff assisting with the transfer off the floor with the off the floor sling.

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3 as it related to four out of the four falls reviewed. The home had a level 3 compliance history as they had previous non-compliance to the same subsection that included:
- Written Notification (WN) issued April 5, 2019 (2019_752627_0005) (765)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 06, 2020

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:

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

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 14th day of February, 2020

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Hilary Rock

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