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

Central East Service Area Office
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 16, 2021	2021_595110_0001 (A1)	003511-20, 021608-20, 023702-20, 025823-20	Critical Incident System

Licensee/Titulaire de permis

Shepherd Village Inc.
3758/3760 Sheppard Avenue East Toronto ON M1T 3K9

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

Shepherd Lodge
3760 Sheppard Avenue East Toronto ON M1T 3K9

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

Amended by DIANE BROWN (110) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Licensee requested an extension of the compliance due date, for Orders #001 and #002, by one month.

Issued on this 16th day of March, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Amended by DIANE BROWN (110) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 6, 7, 8am, 12, 13am, 14, 15, 21, 22, 25, 2021.

The following intakes were inspected during this Complaint and Follow up Inspection:

- Log #025823-20 related to a critical incident regarding a fall and a significant change in status.

- Log #023702-20 related to a critical incident regarding a fall resulting in a transfer to hospital and significant change in the resident's health status.

- Log #021608-20 related to a critical incident regarding a fall resulting in a transfer to hospital and significant change in the resident's health status.

- Log # 003511-20 related to Compliance Order (CO) #002 from Inspection #2020_626501_0003, specifically related to care not provided to a resident according to their plan of care.

During the course of the inspection, the inspector(s) spoke with Manager for Quality and Compliance(QCM), Physiotherapist (PT), Registered Nurse, RAI Coordinator, BSO-RPN, Nurse Manager, Registered Practical Nurses (RPN), Activation Aide, Resident Assistant, Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector(s) toured residents home areas, conducted observations, reviewed clinical records and reviewed relevant policies.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Food Quality
Infection Prevention and Control
Responsive Behaviours

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

3 WN(s)
1 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

The Ministry of Long Term Care (LTC) received a critical incident reporting that resident #001 had fallen. The resident was subsequently diagnosed with a significant change in health status related to their fall.

A record review and interview with physiotherapist #107 revealed that they had responded to a staff concern that resident #001's mobility aid, referred to as mobility aid A, was not meeting their safety needs to prevent falls. The PT subsequently assessed the resident and provided another mobility aid, referred to as B, which was provided to the resident.

The morning of the resident's fall, care was provided to resident #001 by PSW #102. An interview with PSW #102 confirmed that they had not transferred the resident to mobility aide B but to mobility aid A.

The licensee failed to ensure that resident #001 was provided with mobility aid B as set out in their plan of care.

Sources: Progress notes, PT quarterly assessment, plan of care, interviews with activity aide #100, PSWs #101, #102, #103, #104, RPN #106, #103 and Manager of Compliance and Quality #018. [s. 6. (7)]

2. The home was issued a compliance order on June 2, 2020 within report #2020_626501_0003, related to LTCH Act s. 6 (7), with a compliance due date of October 30, 2020. A follow-up inspection was conducted and staff continued to be non-compliant with providing care as set out in the plan of care to the same identified resident with responsive behaviors.

Resident #002's plan of care identified their ineffective coping related to cognitive impairment. The care plan included interventions for responsive behaviors.

A progress note, created by RPN #110, revealed that resident #002 had an episode of responsive behaviors and documentation of the approach taken by staff. The approach documented was not in keeping with the resident's plan of care.

Interviews with PSWs #109 and #111 confirmed resident #001's episode of responsive behaviors and described the interventions that were used by staff. An interview with RPN #110 confirmed the approach utilized to manage the resident's behaviors was not in keeping with the resident's plan of care.

During an interview with RPN-BSO #114 and separately with the home's lead of Responsive Behaviors program and Manager of Compliance and Quality #108 they both acknowledged the resident's plan of care had not been followed in the approach taken by staff in response to the resident's responsive behaviors.

Sources: Progress notes, Medication Administration record, resident #002's care plan and staff interviews. [s. 6. (7)]

3. The Ministry of Long Term Care (LTC) received a critical incident reporting that resident #003 fell. A record review identified that the resident sustained a significant change in status related to their fall.

An interview with a Resident Assistant (RA) #117 described the resident's fall and confirmed the resident was not using a mobility aid.

An interview with PSW #118 assigned to the resident that shift shared when they last saw the resident prior to their fall. The staff revealed the resident did not have their mobility aid.

Records of a PT assessed and an interview with the PT #107 revealed the resident was at high risk for falls. The PT stated the resident should have been using their mobility aid at the time.

The licensee failed to ensure that resident #003 was provided with their mobility aid, as set out out in the plan of care.

Sources: Progress notes, PT assessment notes, plan of care, interviews with RPN #115, Nurse Manager #116, Resident Assistant #117 and PSW #118. [s. 6. (7)]

4. 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 change or care set out in the plan is no longer necessary.

The Ministry of Long Term Care (LTC) received a critical incident reporting that resident #001 was found on the floor. The resident was subsequently diagnosed with a significant change in status related to their fall.

A review of the resident's plan of care in place identified the resident required fall prevention intervention A and that identified interventions around the resident's sleep pattern.

Staff interviews with PSWs, registered staff and the physiotherapist confirmed that the resident had not required intervention A, that the correct mobility aid had not been updated and documented and that the resident's condition had declined, months back, leaving the resident's sleep pattern interventions not current. Staff confirmed the plan of care had not been revised and ensure the safety needs of the resident have been communicated to staff.

Sources: Resident #001's written plan of care, Physiotherapy assessment and

staff interviews with PSW #101, 102, 104, RPN #103 and PT #107. [s. 6. (10) (b)]

5. The Ministry of Long Term Care (LTC) received a critical incident reporting that resident #004 was found on the floor in the hallway. The resident experienced a significant change in status related to the fall.

A record review and interview with PT #107 identified that from over a year the resident presented with reduced balance, was at high risk for falls, declined use of a specific mobility aid but continued with PT interventions.

Interviews with RPN #119, RN #120 and PT #107 all described the resident as walking in a manner that placed them at risk for falling.

A review of the resident's fall history included three falls prior to the last fall. After each prior fall when the resident was being reassessed there were no different approaches considered in the revision of the plan of care. The resident was identified in the care plan and through interviews as refusing to use mobility device A.

The licensee failed to consider different approaches in keeping resident #003 safe from falling, after each fall.

Sources: Care plan, PT assessments, post fall assessments and progress notes and staff interviews. [s. 6. (11) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

O.Reg. 70/10, s. 48 (1) 1 required the home to have an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

The homes' 'Falls Prevention and Management' policy directed registered staff to complete a Risk Management Incident report, after a resident has fallen and to include an investigation of contributing factors. The investigation promotes the assessment of the root cause of the resident's fall with the aim of reducing further incidence of falls.

Resident #001 fell on and was subsequently diagnosised with a significant change in status related to their fall. A review of the Risk Management Incident report completed by RPN #106 failed to identify the resident was placed in an improper mobility aid according to the resident's assessed safety needs to prevent falls. An interview with RPN #106 stated they were unaware the resident required the identified mobility aid and had not been placed into this chair the morning of their fall. The RPN stated it wasn't until after the resident's fall they heard the resident had the identified mobility aid.

The lead of the Falls Program in the home was unaware that resident #001 had

been placed in an improper mobility aid and may have contributed to their fall.

The homes' 'Falls Prevention and Management' program failed to identify the provision of an improper the identified mobility aid to resident #001 at the time of their fall as a possible predisposing factor to the cause of the fall.

Sources: Policy No. NURS-13-7 Falls Prevention and Management. Effective Date: October 1, 2019, Risk Management Incident report, Interviews with PSWs, RPN #106, RN #015 and the Manager of Compliance and Quality #108. [s. 8. (1) (a),s. 8. (1) (b)]

2. The Ministry of Long Term Care (LTC) received a critical incident reporting that resident #003 fell. The resident was subsequently diagnosed with a significant change in status related to their fall.

A review of the Risk Management Incident report, completed by RPN #115, after the resident's fall, failed to identify that the resident was not using their mobility aid at the time of their fall.

An interview with RPN # 115 revealed awareness that the resident used a mobility aid and that the resident did not have it at the time of the fall. The RPN stated the resident's cognitive status interfered with their use of the mobility aid. The RPN shared that the resident's cognitive status and not using their mobility aid were not captured in the Risk Management Incident Report to help prevent further falls.

An interview with the Manager of Compliance and Quality #108 shared that staff are required to investigate the fall incident and reassess when completing the Risk Management Reports.

The homes' 'Falls Prevention and Management' program failed to identify resident #003's resident's cognitive status and not using their mobility as the possible predisposing factors to the cause of the fall.

Sources: Policy No. NURS-13-7 Falls Prevention and Management. Effective Date: October 1, 2019, Risk Management Incident report, Interviews with registered staff, PSWs and the Manager of Compliance and Quality #108. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure every resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Resident #002 had a diagnosis of responsive behaviors and dementia. Resident #002 had an episode of responsive behaviors that was managed in a way that did not treat the resident with courtesy and respect and that that fully recognized the resident's individuality and respected the resident's dignity.

An interview with the lead of home's Responsive Behavior program confirmed that the resident was not treated with courtesy and had the right to refuse care.

Sources: progress notes and staff interviews. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure every resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

Issued on this 16th day of March, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DIANE BROWN (110) - (A1)
Inspection No. / No de l'inspection :	2021_595110_0001 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	003511-20, 021608-20, 023702-20, 025823-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 16, 2021(A1)
Licensee / Titulaire de permis :	Shepherd Village Inc. 3758/3760 Sheppard Avenue East, Toronto, ON, M1T-3K9
LTC Home / Foyer de SLD :	Shepherd Lodge 3760 Sheppard Avenue East, Toronto, ON, M1T-3K9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cathy Fiore

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Shepherd Village Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2020_626501_0003, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6(7) of the LTCH Act.

Specifically, the licensee must:
1. Ensure that dedicated BSO staff are available days and evenings according the home's staffing plan and provide a contingency plan in the event of unavailable or the absence of any scheduled BSO staff.
2. Keep a record of how many staff are providing personal care, bathing, dressing to resident #002 on each shift x 1 month and on each Friday provide the record to BSO staff.
3. At each shift report the registered staff shall review the triggers and interventions with oncoming staff related to resident #002 and their responsive behaviors until June 30, 2021.
4. Registered staff shall access BSO assistance according to resident's plan of care and document the outcome, ongoing.
5. The nurse manager shall audit, until compliance is achieved, that each intervention in resident #002's plan of care for responsive behavior are provided on each shift according to the resident's plan of care. If non compliance was identified create an action plan with BSO staff.
6. Ensure resident #002 and any other resident with responsive behaviors are provided interventions according to their plan of care.
7. Ensure staff are kept aware of resident's mobility aids and resident's are provided the aid in keeping with their plan of care.
8. Keep documentation of 1-5 for review by an Inspector.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

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

The Ministry of Long Term Care (LTC) received a critical incident reporting that resident #001 was found on the floor in their room on December 26, 2020, around 1100hrs. The resident was subsequently transferred to hospital and passed away December 27, 2020. The cause of death was traumatic subdural hemorrhage.

Resident #001 was known to staff to self propel around the unit with a tendency to slide out from their chair. The resident's cognitive performance scale identified the resident with moderate cognitive impairment.

A record review and interview with physiotherapist #107 revealed they responded to a staff concern on October 29, 2020 that resident #001 was sliding from their current wheelchair. The PT subsequently assessed the resident for a tilt wheelchair which was provided to the resident on November 5, 2020.

On December 26, 2020, morning care was provided to resident #001 by PSW #102. An interview with PSW #102 confirmed that they had not transferred the resident to a tilt wheelchair but their standard/transport wheelchair.

The licensee failed to ensure that resident #001 was provided a tilt wheelchair set out in the plan of care.

Sources: Progress notes, PT quarterly assessment, plan of care, interviews with activity aide #100, PSWs #101, #102, #103, #104, RPN #106, #103 and Manager of Compliance and Quality #018.

(110)

2. The home was issued a compliance order on June 2, 2020 within report #2020_626501_0003, related to LTCH Act s. 6 (7), with a compliance due date of October 30, 2020. A follow-up inspection was conducted and staff continued to be non-compliant with providing care as set out in the plan of care to the same identified resident with responsive behaviors.

Resident #002's plan of care identified their ineffective coping with verbal/physical aggression related to cognitive impairment. The care plan directed staff to use GPA (gentle persuasive approach) techniques when approaching the resident and if resident #002 was still resistive or agitated to stop and re-approach. The care plan directed the charge nurse to consider pain or other medication for responsive behaviors and call BSO (behavioral support ontario) if needing assistance. The plan also included daily visits by BSO staff and engage in Montessori activities.

A progress note dated January 7, 2021 created by RPN #110, revealed that resident #002 had refused care, was very combative, kicking, spitting, punching out at staff and that four staff re approached the resident to be washed in bed and dressed. The note stated that BSO team had not been notified.

The resident's January 2021 medication administration record included the as needed medication, quetiapine, a psychotropic drug used to calm behaviors. Quetiapine was not administered on January 7, 2021.

Interviews with PSWs #109 and #111 confirmed that four staff were present, one each holding the resident's arm and one holding the resident's feet as one staff washed the resident. The PSWs shared that the resident was resisting care. An interview with RPN #110 confirmed that four staff, including themselves were present, that BSO had been called but was unavailable and that PRN medication had not been considered.

An interview with RPN-BSO #114 stated they did not receive a call or message on January 7, 2021 and that BSO staff had not been providing daily visits since November 17, 2020 as specified in the resident's plan of care. The RPN stated that the use of four staff to provide care is contrary to the resident's planned care for GPA (gentle persuasive approach) techniques; that four staff overpowering and constraining the resident could provoke more aggression and potentially harm the resident. The staff further identified that a gentle touch and words works for resident #002 and in this instance the charge nurse should have utilized the PRN medication.

During an interview with home's lead of Responsive Behaviors program and Manager of Compliance and Quality #108 they acknowledged the resident's plan of care had not been followed and the approach by staff was the exact opposite of a GPA approach.

Sources: Progress notes, Medication Administration record for January, resident #002's care plan and staff interviews.

(110)

3. The Ministry of Long Term Care (LTC) received a critical incident reporting that resident #003 fell on October 25, 2020 around 1830hrs. A record review identified that the resident sustained lacerations to their eye, bruising to their knee and a left shoulder fracture and dislocation.

An interview with a Resident Assistant (RA) #117 revealed they had finished escorting a family to a resident's room when they passed resident #003 walking with a co-resident down the hallway. The RA recalled passing and greeting both residents then turning back to witness both residents falling to the floor. The RA confirmed that resident #003 was not using their rollator walker.

An interview with PSW #118 assigned to the resident that evening shared that the last time they saw resident #003 prior to their fall was when the resident walked into the dining room for dinner. The PSW shared the resident did not have their rollator walker at this time but was "walking just fine, a bit confused and told me they were looking for their children'.

An interview with the PT #107 stated that resident presented with an unsteady gait and reduced balance and was at high risk for falls. The PT stated the resident should have been using their rollator walker that evening shift. The PT assessment of August 19, 2020 revealed the intervention of gait training with rollator walker and the resident's risk of falls.

The licensee failed to ensure that resident #003 was provided with their rollator walker, as set out out in the plan of care, when observed walking independently to the dining room and prior to the resident's fall .

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Sources: Progress notes, PT assessment of August 19, 2020, plan of care, interviews with RPN #115, Nurse Manager #116, Resident Assistant #117 and PSW #118.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to resident #001, when being resistive but provided care and overpowered by four staff and there was actual harm to resident's #001 and #003 when an improper mobility aid or no mobility aid was provided according to their plan of care.

Scope: The scope of this non-compliance was widespread as three out of three resident's did not receive care according to their plan of care.

Compliance History: The licensee continues to be in non-compliance with 6 (7) of the LTCH Act resulting in a compliance order (CO) being re-issued. CO #001 was issued on June 2, 2020 , (Inspection 2021_626501_0003) with a compliance due date of October 30, 2020.
(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2021(A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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, r. 8. (1) (b).

Specifically, the licensee must:

1. Ensure that the home implements their interdisciplinary falls prevention and management program with the aim of reducing the incidence of falls and the risk of injury.
2. In the reporting of fall incidents, through the home's Risk Management Incident Report, the registered staff along with the home's Falls Lead shall investigate and document the suspected cause of the fall and document if the resident's fall interventions were being followed prior to the fall and their effectiveness.
3. The Falls Lead shall ensure that information collected in the Risk Management Incident Report is utilized in the reevaluation of the resident's falls related plan of care, in keeping with the home's Fall Prevention program.

4. Educate registered staff on their role in updating the falls preventions care of plan and maintain a record of staff education.

Grounds / Motifs :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

O.Reg. 70/10, s. 48 (1) 1 required the home to have an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

The homes' 'Falls Prevention and Management' policy directed registered staff to complete a Risk Management Incident report, after a resident has fallen and to include an investigation of contributing factors. The investigation promotes the assessment of the root cause of the resident's fall with the aim of reducing further incidence of falls.

Resident #001 fell on December 26, 2020, was transferred to hospital and passed away on December 27, 2020, from a traumatic subdural hemorrhage. A review of the Risk Management Incident report completed by RPN #106 identified the predisposing factor as impaired memory and confusion but failed to identify the resident was placed in an improper chair according to the resident's assessed safety needs to prevent falls. An interview with RPN #106 stated they were unaware the resident required a tilt chair and had not been placed into this chair the morning of their fall. The RPN stated it wasn't until after the resident's fall they heard the resident had a tilt chair.

The lead of the Falls Program in the home was unaware that resident #001 had been placed in an improper chair and may have contributed to their fall.

The home's 'Falls Prevention and Management' program failed to identify the provision of an improper chair to resident #001 at the time of their fall as a possible predisposing factor to the cause of the fall.

Sources: Policy No. NURS-13-7 Falls Prevention and Management. Effective Date: October 1, 2019, Risk Management Incident report, Interviews with PSWs, RPN #106, RN #015 and the Manager of Compliance and Quality #108.
(110)

2. The Ministry of Long Term Care (LTC) received a critical incident reporting that resident #003 fell on October 25, 2020 around 1830hrs. A record review identified that the resident sustained lacerations to their eye, bruising to their knee and a left

shoulder fracture and dislocation. The events leading up to the fall included the resident walking down the hall holding hands with another resident and losing their balance.

A review of the Risk Management Incident report, completed by RPN #115, after the resident's fall, failed to identify that the resident was not using their a rollator walker at the time of their fall.

An interview with RPN # 115 revealed awareness that the resident used a walker and that the resident did not have it at the time of the fall. The RPN stated the resident would walk away from their walker all the time and forget to use it. The RPN shared that the resident's forgetfulness to use the walker was a risk to them falling and not captured in the Risk Management Report to help prevent further falls.
An interview with the Manager of Compliance and Quality #108 shared that staff are required to investigate the fall incident and reassess when completing the Risk Management Reports.

The home's 'Falls Prevention and Management' program failed to identify the lack of adherence to the resident's fall prevention plan of care, the use of a rollator walker and the resident's forgetfulness, as predisposing factors to prevent further falls.

The homes' 'Falls Prevention and Management' program failed to identify resident #003's memory and unavailable walker as possible predisposing factors to the cause of the fall.

Sources: Policy No. NURS-13-7 Falls Prevention and Management. Effective Date: October 1, 2019, Risk Management Incident report, Interviews with registered staff, PSWs and the Manager of Compliance and Quality #108.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to resident #001 and #003, when an improper mobility aid or no mobility aid was provided as care planned. The Risk Management Incident reports failed to identify the improper care provided, predisposing factors to the falls, with the aim of reducing further incidence of falls.

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Scope: The scope of this non-compliance was patterned as the lack of identifying the predisposing factors and risk to the residents that fell, in the Risk Management Incident Report, pertained to two out of three residents reviewed.

Compliance History: The licensee has a past non-compliance with a CO to O. Reg. 79/10, r. 8. (1) (b) was issued on June 2, 2020 in Inspection 2021_626501_0003. (110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 31, 2021(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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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 16th day of March, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by DIANE BROWN (110) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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Service Area Office / Bureau régional de services : Central East Service Area Office