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
Jul 8, 2021	2021_623626_0006	002025-21, 002034-21	Complaint

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South Whitby ON L1N 9W2

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

Glen Hill Strathaven
264 King Street East Bowmanville ON L1C 1P9

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

DENISE BROWN (626)

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): April 13, 14, 15, 16,19, 20, 21, 26, 27, 28, 29 and 30, 2021.

The following intakes were inspected:

A Complaint log related to fall, pain, weight change, physician visit, visitation and SDM notification, and a related Critical Incident System (CIS) log pertaining to a fall incident.

Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 6 (7), identified in a concurrent inspection #2021_623626_0007 (Log #000388-21, CIS 2605_000002_21) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Dietitian, Nurse Practitioner (NP), Nurse Educator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), resident and family member.

The inspector also reviewed applicable policies, resident health records, investigation reports, observed the delivery of resident care and services, including staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Nutrition and Hydration
Pain
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 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 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #008 as specified in the plan.

A complaint was received from resident #008's Substitute Decision Maker (SDM). The complaint involved the resident's fall, pain, weight change and physician visit. After the fall, a diagnostic test performed on the following day, revealed that the resident had sustained an injury. In a follow-up call to CIATT, the complainant indicated that the resident had died. In a conversation with the Inspector, the complainant indicated additional concerns pertaining to visitation and SDM notification.

A CIS report was also received regarding resident #008's fall. The CIS report indicated that the fall occurred when PSW #121 and PSW #139 was providing care to the resident. At the time of the fall one PSW was with the resident. The licensee's investigation found that the care plan was followed.

The care plan current at the time of the fall, directed that two staff were to provide care to the resident. Not following the plan of care could place the resident at risk for fall and injury.

A review of the Fall Prevention and Management Policy, directs that PSWs will utilize the fall prevention interventions, identified on the resident's plan of care and the ACES-Fall Risk Factors related interventions.

In an interview Personal Support Worker (PSW) #120, indicated that two staff were to provide care to the resident. In another interview, PSW #121 indicated being aware that two staff were required to provide care to the resident. The PSW also indicated that one staff was with the resident at the time of the fall. The Administrator indicated that two staff were required to provide care and stay with the resident during the provision of care. Personal Support Worker #139 and Registered Practical Nurse (RPN) #140 were not available for interview.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, as two PSWs were not with the resident at the time of the fall, when care was being provided.

Sources: Complaint log, CIS, resident #008's care plan, progress notes, Incident

Investigation Template, Fall Prevention and Management Policy, interview with PSW#120, PSW #121 and the Administrator. [s. 6. (7)]

2. The licensee has failed to ensure resident #008's meal/food, fluid, snack and nutritional supplement intake were documented according to the plan of care.

A complaint was received from resident #008's SDM, regarding the resident's fall, weight change and physician visit. A CIS report related to the fall was also submitted to the Director. In a conversation with the Inspector, the complainant indicated concerns about visitation and SDM notification.

The Hydration and Nutrition Monitoring Policy indicated that all residents' hydration and nutrition will be accurately monitored and recorded daily.

Resident #008 care plan indicated that meal/food, fluid, snack and nutritional intake amount must be recorded.

A review of resident #008's Daily Food and Fluid Intake Record – Meals for a two-month period, indicated that there were inconsistent or omitted documentation of the resident's meals and snack intake. The resident's Medication Administration Record (MAR) for the same two-month period, indicated that staff did not sign to indicate the administration of the nutritional supplement on a number of occasions. Not accurately documenting the resident's meal/food, fluid and nutritional supplement intake could place the resident at a higher nutritional risk.

In an interview PSW #118 indicated, that the resident's food and fluid intake were to be documented in the snack book. In another interview PSW #120 indicated, that the resident's food and fluid intake were to be documented in the meal and snack book. In an interview, the Director of Care (DOC) indicated that the food, fluid and snack intake records must be completed, and the nutritional supplement intake must be documented.

The licensee failed to ensure that the plan of care was followed. Staff did not consistently initial the MAR to note the nutritional supplement administration, and document on the Daily Food and Fluid Intake Record for meals and snacks, to keep accurate daily account of the resident's meal/food, fluid, snack and nutritional supplement intake.

Sources: Complaint log, CIS, resident #008's care plan and progress notes, MAR; The Hydration and Nutrition Monitoring Policy; Daily Food and Fluid Intake Record – Meals;

The Daily Food and Fluid Intake Record – Snack; Interview with PSW #118 and #120 and the DOC. [s. 6. (7)]

3. The licensee has failed to ensure resident #012's meal/food, fluid, snack and nutritional supplement intake were documented according to the plan of care.

The Hydration and Nutrition Monitoring Policy indicated that all residents' hydration and nutrition will be accurately monitored and recorded daily.

Resident #012 care plan indicated that meal/food, fluid, snack and nutritional supplements intake amount must be recorded.

A review of the resident #012’s MAR for a three-month period, indicated that a nutritional supplement which was to be administered twice daily was noted on the MAR as dietary. Another nutritional supplement was also on the MAR and noted in the care plan to be administered in the morning.

A review of the Daily Food and Fluid Intake Record - Snack, showed that on multiple occasions over the three-month period that meals, snacks and nutritional supplements intake were not consistently documented.

In an interview PSW #126 indicated that the resident’s nutritional supplements are documented by the PSWs, and the meals are documented by the registered staff. Registered Practical Nurse #104 indicated that the nutritional supplement for this resident was provided in the snack service and was given to the resident by the PSWs. In an interview, the DOC indicated that the food, fluid and snack intake records must be completed, and the nutritional supplement intake must be documented.

The licensee failed to ensure that the plan of care was followed. Staff did not consistently document on the Daily Food and Fluid Intake Record for meals and snacks, to keep accurate daily account of the resident’s meal/food, fluid, snack and nutritional supplement intake.

Sources: CIS, resident # 012’s care plan, MAR; The Hydration and Nutrition Monitoring Policy; Daily Food and Fluid Intake Record – Meals; The Daily Food and Fluid Intake Record; Interview with PSW #126, RPN #104 and DOC. [s. 6. (7)]

4. The licensee has failed to ensure resident #003's meal/food, fluid, snack and

nutritional supplement intake were documented according to the plan of care.

The Hydration and Nutrition Monitoring Policy indicated that all residents' hydration and nutrition will be accurately monitored and recorded daily.

Resident #003 care plan indicated that meal/food, fluid, snack and intake amount must be recorded.

A review of resident #003's Daily Food and Fluid Intake Record -Meal forms over a three months period, showed no documented entry for meals on multiple occasions. The Daily Food and Fluid Intake Record -Snack form for a three-month period, had no entry for snacks on multiple occasions. There were also multiple dates when the special snack was not entered. Not accurately documenting the resident's meal/food, fluid and supplement intake could place the resident at a higher nutritional risk.

In an interview with PSW #133 indicated the PSW delivering the snack would record the resident's intake. In another interview PSW #137, indicated the meal, fluid and snack intake record sheets were completed by PSWs after each meal. Registered Practical Nurse #134 indicated that the PSWs were to complete the meal, fluid and snack records. In an interview, the Director of Care (DOC) indicated that the food, fluid and snack intake records must be completed, and the nutritional supplement intake must be documented.

The licensee failed to ensure that staff followed the resident's plan of care. Staff did not consistently document on the Daily Food and Fluid Intake Record for meals and snacks, to keep accurate daily account of the resident's meal/food, fluid, snack and nutritional supplement intake.

Sources: Resident # 003's care plan and progress notes, MAR; The Hydration and Nutrition Monitoring Policy, Daily Food and Fluid Intake Record – Meals; The Daily Food and Fluid Intake Record – Snack; Interview with PSW #133 and #137, RPN #134 and DOC. [s. 6. (7)]

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. 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 the SmartMeds Pharmacy, Pharmacy Policy and Procedure Manual, Section 3: Medication System, Policy 3-7 Medication Administration, and the Medication -Security and Accountability policies were complied with, related to resident #008.

A complaint was received from resident #008's SDM regarding the resident's fall, pain, weight change and physician visit. A CIS report related to the fall was also submitted to the Director. In a conversation with the Inspector, the complainant indicated additional concerns about visitation and SDM notification.

O. Reg. 79/10, s.114 (2), the licensee shall ensure that written policies and protocols are developed as outlined by the medication management system, to ensure the accurate administration of all drugs used in the home.

The Medication -Security and Accountability Policy VI-J-10.24, outline that as part of the nursing role, nurses can assign care to unregulated care providers (UCPs). Administration of a topical medication is not a controlled act; therefore, UCPs may apply topical medication such as treatment creams.

The SmartMeds Pharmacy, Pharmacy Policy and Procedure Manual, Section 3: The Medication System, Policy 3-7 Medication Administration directs, that the Medication Administration Record (MAR) must be initialed to indicate that the medication has been given and to use the appropriate code if the dose is omitted.

Specifically, a review of resident #008's MAR and Treatment Administration Record (TAR) revealed that a medication and treatment cream were not initialed to indicate that the doses were administered. On an identified date a medication was not initialed on the MAR as administered. The medication was signed on the medication count record. A review of the resident #008's TAR for a two-month period indicated that staff did not initial to indicate that the medicated cream was applied, on a number of occasions. Not signing that the medication was administered, and prescribed treatment was applied could place the resident at risk for a medication incident.

In an interview RPN #131 indicated, that the medication was administered to the resident but was not signed on the MAR. During an interview, RPN #119 indicated that the PSWs apply the treatment cream and registered staff would initial the MAR. Personal Support Worker #121 could not recall the application of the medication cream for a number of dates. Registered Practical Nurse #122 indicated working on a specified shift that the medicated cream was not signed. In an interview, RN #124, indicated that medications and treatments must be initialed on the MAR and TAR when administered. The DOC indicated in an interview that registered staff are expected to sign medications they administer.

The licensee failed to ensure that the SmartMeds Pharmacy, Pharmacy Policy and Procedure Manual, Section 3: Medication System, Policy 3-7 Medication Administration, and the Medication -Security and Accountability policies were complied with, when registered staff did not consistently initial the MAR and TAR after the administration of resident #008's prescribed medication and treatment.

Sources: Complaint log, CIS, resident #008's care plan and progress notes, MAR, Medication -Security and Accountability Policy; the SmartMeds Pharmacy, Pharmacy Policy and Procedure Manual, Section 3: The Medication System, Policy 3-7 Medication Administration, interviews with RN #124, RPN #119, #122, #131, PSW #121 and DOC.

2. The licensee failed to ensure the SmartMeds Pharmacy, Pharmacy Policy and Procedure Manual, Section 3: The Medication System, Policy 3-7 Medication Administration was complied with, related to resident #003.

O. Reg. 79/10, s.114 (2), the licensee shall ensure that written policies and protocols are developed as outlined by the medication management system, to ensure the accurate administration of all drugs used in the home.

The SmartMeds Pharmacy, Pharmacy Policy and Procedure Manual, Section 3: The Medication System. Policy 3-7 Medication Administration, directs, that the Medication Administration Record (MAR) must be initialed to indicate that the medication has been given and to use the appropriate code if the dose is omitted.

Specifically, a review of resident #003's MAR for a specified month indicated that identified medications and treatment were not initialed as administered. Not signing that medications were administered, and prescribed treatments were applied could place the resident at risk for a medication incident.

In an interview RPN #129, indicated that the medications were given but were not signed. In another interview RPN #132, indicated that a specified medication was administered but was not signed on the MAR. The DOC indicated that staff are expected to sign for the medication they administer.

The licensee failed to ensure that the SmartMeds Pharmacy, Pharmacy Policy and Procedure Manual, Section 3: Medication System. Policy 3-7 Medication Administration was complied with, when registered staff did not consistently initial the MAR, after the administration of resident #003's prescribed medications.

Sources: Resident #003's care plan, MAR, the SmartMeds Pharmacy, Pharmacy Policy and Procedure Manual, Section 3: The Medication System. Policy 3-7 Medication Administration, interviews with RPN #129, #132 and DOC. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance 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, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #008's pain was not relieved and the pain medication was changed, the resident was assessed using a clinically appropriate assessment instrument, specifically designed for this purpose.

A complaint was received from resident #008's SDM, regarding the resident's fall, pain, weight change and physician visit. A CIS report related to the fall was also submitted to the Director. In a conversation with the Inspector, the complainant indicated concerns about visitation and SDM notification.

The licensee's Pain and Symptom- Assessment and Management Protocol, Policy VII-G-70.00, directs that registered staff will conduct the Point Click Care (PCC) pain assessment. The registered staff will initiate pain and symptom monitoring via PCC documentation, when a schedule pain medication does not relieve the pain, pain remains regardless of the interventions, pain medication is changed, and an empiric trial of analgesics is started; review, evaluate and document pain as needed.

A review of the MAR for a two-month period indicated, multiple changes were made to the resident's pain medication regime. Another review of the resident's health record indicated that the most current Pain Assessment V4 was done after the fall. There were no other pain assessments using a clinically appropriate assessment instrument found after this date. Not using a clinically appropriate assessment instrument to perform a comprehensive pain assessment could place the resident at risk for inadequate pain control.

In an interview RPN #119, indicated that pain assessments are done when residents start a new medication. Registered Practical Nurse #119, indicated that a pain

assessment was done when the resident fell. There were pain assessment notes entered in the progress notes and were done every shift. In an interview, the Administrator indicated that the pain assessment is used for new pain and for a change or increase in medication. The pain management note is a soap note. The DOC indicated that the pain assessment note is the clinical tool and that the home's clinically appropriate pain assessment tool, is under the assessment tab in PCC.

The licensee failed to comply with the Pain and Symptom- Assessment and Management Protocol, Policy, when resident #008's pain medications were changed on a number of occasions, and the resident's pain was not assessed using a clinically appropriate assessment instrument, specifically designed for this purpose.

Sources: Complaint log, CIS, Pain and Symptom- Assessment and Management Protocol, Policy, resident #008's care plan, progress note, MAR, Pain Assessment V4; Interview with RPN #119, DOC and Administrator. [s. 52. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 151. Obstruction, etc.
Every person is guilty of an offence who,
(a) hinders, obstructs or interferes with or attempts to hinder, obstruct or interfere with an inspector conducting an inspection, or otherwise impedes an inspector in carrying out the inspector's duties; 2017, c. 25, Sched. 5, s. 32 (1)
(b) destroys or alters a record or other thing that has been demanded under clause 147 (1) (c); or
(c) fails to do anything required under subsection 147 (3) or (3.1). 2017, c. 25, Sched. 5, s. 32 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Inspector was provided with an unaltered copy of resident #008's MAR and TAR.

The Inspector was provided with resident #008's MAR and the TAR for a two-month period on a specified date. On a later specified date the Inspector requested another copy of the MAR for the same time period, as the previous copies received were faint in color. A closer review indicated that the second copies of the documents were not the same as the first copies provided.

The Administrator was asked to review and compared the original copies of the MAR and TAR, with the first copies and second copies, as differences were observed. When the copies were compared it was observed that there were initials in blank spaces on the second copies, which were not present in the first copies of the MAR and TAR. Not providing accurate documents could impede the inspection.

In an interview RPN #122 indicated that they might have missed signing the medicated cream on a specified date. In another interview RPN #122 indicated not being sure, and only saw the MAR when it was reviewed with the inspector. During an interview RPN #130 indicated, that the initial on the second copy of the MAR did not belong to the RPN. The RPN also confirmed that on the first copy of the MAR the initial area was blank, and they may had left it unsigned. In an interview regarding the medicated cream, RPN #119 indicated that it was applied on a specified date but was not signed and claimed that the initial on the second copy of the MAR was not signed by them. During an interview, the Administrator indicated to the inspector that it was strange, as the original copies of the MAR and TAR were with them all the time.

The licensee has failed to ensure that the Inspector was provided with an unaltered copy of resident #008's MAR and TAR.

Sources: Resident #008's MAR and TAR; interviews with RPN #119, #122, #130 and the Administrator. [s. 151. (b)]

Issued on this 24th day of August, 2021

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DENISE BROWN (626)
Inspection No. / No de l'inspection :	2021_623626_0006
Log No. / No de registre :	002025-21, 002034-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 8, 2021
Licensee / Titulaire de permis :	Glen Hill Terrace Christian Homes Inc. 200 Glen Hill Drive South, Whitby, ON, L1N-9W2
LTC Home / Foyer de SLD :	Glen Hill Strathaven 264 King Street East, Bowmanville, ON, L1C-1P9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michelle Stroud

To Glen Hill Terrace Christian Homes 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

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6 (7) of LTCHA.

The licensee specifically must:

1. Educate all direct care staff (PSW, RPN and RN), to provide care as outlined in the plan, specifically, as it relates to safety interventions during bathing. Keep a documented record of this training.

2. Re-educate all direct care staff (PSW, RPN and RN), to record the nutritional intake of resident #003 and #012, as outlined in the plan of care, and in accordance to the Hydration and Nutrition Monitoring Policy XI-H-70.00, specifically the documentation of the residents' meal/food fluid, snack and nutritional supplements. Keep a documented record of this training.

3. Develop and implement an audit process to ensure that direct care staff are accurately and consistently documenting resident #003, #012 and any other resident's intake of meal/food, fluid, snack and nutritional supplements, on the Daily Food and Fluid Intake Record – Meals, and the Daily Food and Fluid Intake Record – Snack forms. Keep a documented record of the process and audits.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #008 as specified in the plan.

A complaint was received from resident #008's Substitute Decision Maker (SDM). The complaint involved the resident's fall, pain, weight change and

physician visit. After the fall, a diagnostic test performed on the following day, revealed that the resident had sustained an injury. In a follow-up call to CIATT, the complainant indicated that the resident had died. In a conversation with the Inspector, the complainant indicated additional concerns pertaining to visitation and SDM notification.

A CIS report was also received regarding resident #008's fall. The CIS report indicated that the fall occurred when PSW #121 and PSW #139 was providing care to the resident. At the time of the fall one PSW was with the resident. The licensee's investigation found that the care plan was followed.

The care plan current at the time of the fall, directed that two staff were to provide care to the resident. Not following the plan of care could place the resident at risk for fall and injury.

A review of the Fall Prevention and Management Policy, directs that PSWs will utilize the fall prevention interventions, identified on the resident's plan of care and the ACES-Fall Risk Factors related interventions.

In an interview Personal Support Worker (PSW) #120, indicated that two staff were to provide care to the resident. In another interview, PSW #121 indicated being aware that two staff were required to provide care to the resident. The PSW also indicated that one staff was with the resident at the time of the fall. The Administrator indicated that two staff were required to provide care and stay with the resident during the provision of care. Personal Support Worker #139 and Registered Practical Nurse (RPN) #140 were not available for interview.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, as two PSWs were not with the resident at the time of the fall, when care was being provided.

Sources: Complaint log, CIS, resident #008's care plan, progress notes, Incident Investigation Template, Fall Prevention and Management Policy, interview with PSW#120, PSW #121 and the Administrator. [s. 6. (7)] (626)

2. The licensee has failed to ensure resident #008's meal/food, fluid, snack and nutritional supplement intake were documented according to the plan of care.

A complaint was received from resident #008's SDM, regarding the resident's fall, pain, weight change and physician visit. A CIS report related to the fall was also submitted to the Director. In a conversation with the Inspector, the complainant indicated concerns about visitation and SDM notification.

The Hydration and Nutrition Monitoring Policy indicated that all residents' hydration and nutrition will be accurately monitored and recorded daily.

Resident #008 care plan indicated that meal/food, fluid, snack and nutritional intake amount must be recorded.

A review of resident #008's Daily Food and Fluid Intake Record – Meals for a two-month period, indicated that there were inconsistent or omitted documentation of the resident's meals and snack intake. The resident's Medication Administration Record (MAR) for the same two-month period, indicated that staff did not sign to indicate the administration of the nutritional supplement, on a number of occasions. Not accurately documenting the resident's meal/food, fluid and nutritional supplement intake could place the resident at a higher nutritional risk.

In an interview PSW #118 indicated, that the resident's food and fluid intake were to be documented in the snack book. In another interview PSW #120 indicated, that the resident's food and fluid intake were to be documented in the meal and snack book. In an interview, the Director of Care (DOC) indicated that the food, fluid and snack intake records must be completed, and the nutritional supplement intake must be documented.

The licensee failed to ensure that the plan of care was followed. Staff did not consistently initial the MAR to note the nutritional supplement administration, and document on the Daily Food and Fluid Intake Record for meals and snacks, to keep accurate daily account of the resident's meal/food, fluid, snack and nutritional supplement intake.

Sources: Complaint log, CIS, resident #008's care plan and progress notes, MAR; The Hydration and Nutrition Monitoring Policy; Daily Food and Fluid Intake Record – Meals; The Daily Food and Fluid Intake Record – Snack; Interview

with PSW #118 and #120 and the DOC. [s. 6. (7)] (626)

3. The licensee has failed to ensure resident #012's meal/food, fluid, snack and nutritional supplement intake were documented according to the plan of care.

The Hydration and Nutrition Monitoring Policy indicated that all residents' hydration and nutrition will be accurately monitored and recorded daily.

Resident #012 care plan indicated that meal/food, fluid, snack and nutritional supplements intake amount must be recorded.

A review of the resident #012's MAR for a three-month period, indicated that a nutritional supplement which was to be administered twice daily was noted on the MAR as dietary. Another nutritional supplement was also on the MAR and noted in the care plan to be administered in the morning.

A review of the Daily Food and Fluid Intake Record - Snack, showed that on multiple occasions over the three-month period that meals, snacks and nutritional supplements intake were not consistently documented.

In an interview PSW #126 indicated that the resident's nutritional supplements are documented by the PSWs, and the meals are documented by the registered staff. Registered Practical Nurse #104 indicated that the nutritional supplement for this resident was provided in the snack service and was given to the resident by the PSWs. In an interview, the DOC indicated that the food, fluid and snack intake records must be completed, and the nutritional supplement intake must be documented.

The licensee failed to ensure that the plan of care was followed. Staff did not consistently document on the Daily Food and Fluid Intake Record for meals and snacks, to keep accurate daily account of the resident's meal/food, fluid, snack and nutritional supplement intake.

Sources: CIS, resident # 012's care plan, MAR; The Hydration and Nutrition Monitoring Policy; Daily Food and Fluid Intake Record – Meals; The Daily Food and Fluid Intake Record; Interview with PSW #126, RPN #104 and DOC. [s. 6. (7)] (626)

4. The licensee has failed to ensure resident #003's meal/food, fluid, snack and nutritional supplement intake were documented according to the plan of care.

The Hydration and Nutrition Monitoring Policy indicated that all residents' hydration and nutrition will be accurately monitored and recorded daily.

Resident #003 care plan indicated that meal/food, fluid, snack and intake amount must be recorded.

A review of resident #003's Daily Food and Fluid Intake Record -Meal forms over a three months period, showed no documented entry for meals on multiple occasions. The Daily Food and Fluid Intake Record -Snack form for a three-month period, had no entry for snacks on multiple occasions. There were also multiple dates when the special snack was not entered. Not accurately documenting the resident's meal/food, fluid and supplement intake could place the resident at a higher nutritional risk.

In an interview with PSW #133 indicated the PSW delivering the snack would record the resident's intake. In another interview PSW #137, indicated the meal, fluid and snack intake record sheets were completed by PSWs after each meal. Registered Practical Nurse #134 indicated that the PSWs were to complete the meal, fluid and snack records. In an interview, the Director of Care (DOC) indicated that the food, fluid and snack intake records must be completed, and the nutritional supplement intake must be documented.

The licensee failed to ensure that staff followed the resident's plan of care. Staff did not consistently document on the Daily Food and Fluid Intake Record for meals and snacks, to keep accurate daily account of the resident's meal/food, fluid, snack and nutritional supplement intake.

Sources: Resident # 003's care plan and progress notes, MAR; The Hydration and Nutrition Monitoring Policy, Daily Food and Fluid Intake Record – Meals; The Daily Food and Fluid Intake Record – Snack; Interview with PSW #133 and #137, RPN #134 and DOC. [s. 6. (7)]

An order was made by taking factors such as the severity, scope and compliance history into account. The level of severity was determined, as there was actual harm to one out of three residents, who sustained an injury. A total of three residents' meal/food, fluid, snack and supplement intake were not consistently signed as administered. The scope of the non-compliance was a pattern, as three residents were involved. The compliance history was determined based on the two Voluntary Plan of Correction (VPC) that were previously issued under s. 6 (7) in the past 36 months. (626)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 11, 2021

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

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

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 8th day of July, 2021

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Denise Brown

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