Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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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
May 13, 2019	2018_578672_0020	003867-17, 005573-17, 005791-17, 008865-17, 010731-17, 027335-17, 008782-18, 015285-18, 025305-18	Critical Incident System

Licensee/Titulaire de permis

Unionville Home Society
4300 Highway #7 MARKHAM ON L3R 1L8

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

Union Villa
4300 Highway #7 Unionville ON L3R 1L8

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

JENNIFER BATTEN (672)

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): December 17-21, 24, 27, 28, 2018; January 2, 3, February 5, 8, 14, 15, 19, 20, 2019

The following logs related to falls were inspected during this inspection:

Logs #010731-17, #015285-18, #005791-17, #008782-18, #008865-17, #027335-17, #003867-17 related to resident falls with significant injury
Log #025305-18 related to improper/incompetent care resulting in harm

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical
Nurses (RPN), Personal Support Workers (PSW), residents, family members and volunteers.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Pain
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **2 VPC(s)**
- **4 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. (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 the plan of care set out clear directions to staff and others who provided direct care to the resident.

Related to Log #010731-17:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #004 on a specified date and time. According to the CIR, on a specified date and time, resident #004 received assistance from PSW #108, and was then left in the bed while the PSW went to locate a specified item. When PSW #108 returned, resident #004 was found on the floor, with an identified injury. PSW #108 informed RPN #106 that the resident was on the floor. RPN #106 assessed the resident and observed the resident had sustained two identified injuries. The resident was transferred to hospital for further assessment and was admitted with an identified diagnosis. Resident #004 received a specified intervention for the identified diagnosis, and returned to the home on a later specified date.

During an interview, PSW #108 indicated they did not routinely work on resident #004's

home area, and was not familiar with resident #004. Prior to providing care, PSW #108 reviewed the resident's plan of care, but indicated they found it confusing and it did not provide clear directions regarding the level of care and assistance resident #004 required, therefore asked a colleague about the resident. The colleague indicated they believed resident #004 required a specified number of staff member(s) to provide assistance, therefore PSW #108 proceeded to provide that specified level of personal care to resident #004.

Inspector #672 reviewed resident #004's progress notes for a specified time period, which indicated that on a specified date, resident #004 had received personal care from PSW #102. When PSW #102 had stepped away to secure an identified item for the resident, resident #004 was found on the floor, with an identified injury. RPN #106 had been notified of the fall, and assessed the resident. Following the assessment, RPN #106 documented that a specified intervention was to be implemented, along with changing the amount of staff required to provide personal care/assistance with Activities of Daily Living (ADLs).

Inspector #672 reviewed resident #004's written plan of care in place during a specified time period. The focus section for toileting indicated that resident #004 required an identified level of assistance from a specified number of staff members, but the interventions section for toileting indicated that resident #004 required a different identified level of assistance from a different specified number of staff members. The focus section for transferring indicated that resident #004 required an identified level of assistance from a specified number of staff members, and the resident required an identified type of transfer, but the personal hygiene focus indicated that the resident required assistance from a different number of staff member for a different type of transfer. The focus section for bed mobility indicated that resident #004 required an identified level of assistance from a specified number of staff members, but the interventions section for bed mobility indicated the resident required a different number of staff members. The focus section for personal hygiene indicated that resident #004 required an identified level of assistance from a specified number of staff members, but the intervention section for personal hygiene indicated on one line that the resident required a specified number of staff members for an identified level of assistance and the intervention listed directly below that indicated the resident required a different number of staff members for an identified level of assistance. The focus section for dressing indicated the resident required an identified level of assistance from a specified number of staff members, but the interventions section for dressing indicated on one line that the resident required a specified number of staff members for physical assistance and the

intervention listed directly below that indicated the resident required a different number of staff members for a different level of assistance.

During an interview, the RAI Coordinator indicated that the expectation in the home was that every resident's plan of care should provide clear and concise directions to the front line staff providing care to the resident. The RAI Coordinator further indicated that if a resident's care needs changed, and the level of care or number of staff members required to perform a task changed from what was currently listed in the written plan of care, the nurse on duty when the change was noted was responsible for making the required changes. The RAI Coordinator reviewed resident #004's written plan of care with Inspector #672, and indicated it did not provide clear or concise directions to the front line staff providing direct care to the resident.

During an interview, the DOC indicated that the expectation in the home was that every resident's plan of care should provide clear and concise directions to the front line staff providing care to the resident. The DOC reviewed resident #004's written plan of care with Inspector #672, and indicated it did not provide clear or concise directions to the front line staff providing direct care to the resident.

The licensee failed to ensure that resident #004's plan of care set out clear directions to staff and others who provided direct care to the resident. [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.

Related to Log #015285-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #003 on a specified date and time. According to the CIR, on a specified date and time, resident #003 was found to be laying on the floor beside the bed by PSW #113, calling out in pain. RPN #106, the night RN and the RN on duty were notified of the fall, and resident #003 was assisted back into the bed, after the resident was assessed. Once the resident was returned to the bed, RPN #106 observed an identified injury, and at a specified time the decision was made to transfer the resident to hospital for further assessment.

Inspector #672 reviewed the incident report and progress notes for the day the fall occurred, which indicated at a specified time RPN #106 went to resident #003's room to

assess the resident and ensure they were still in the bed. Resident #003 was found to be exhibiting identified responsive behaviours. RPN #106 left the room to receive shift report and begin a medication pass. Resident #003 was found on the floor at a later identified time, by PSW #113. Once the resident was returned to the bed, RPN #106 observed an identified injury, and at a specified time the decision was made to transfer the resident to hospital for further assessment. Resident #003 was admitted to hospital, and received an identified intervention and passed away in hospital a specified number of days later.

During an interview, RPN #106 indicated that upon entering the resident home area on the specified date and time, they became aware that resident #003 was exhibiting a responsive behaviour. RPN #106 indicated they went to resident #003's room to assess the resident and ensure they were still in the bed, and found the resident to be exhibiting several identified responsive behaviours. RPN #106 further indicated that they did not approach or speak to the resident, and did not provide any interventions listed in the resident's plan of care, due to being focused on getting to the nursing station to complete the shift report, and begin the medication pass. RPN #106 further indicated that they had only gone to resident #003's bedroom to ensure the resident hadn't fallen from the bed, and did not feel they had time to spend to implement any interventions, but did not request another staff member to go and assist resident #003 in their place. RPN #106 indicated that resident #003 was at an identified risk for falls and often exhibited identified responsive behaviours, which had interventions listed in the resident's written plan of care for staff to implement.

Inspector #672 reviewed the written plan of care in place at the time of the incident. There were identified interventions listed for staff to implement when the resident was exhibiting responsive behaviours.

During an interview, Nurse Manager (NM) #104 indicated that resident #003 was at an identified risk for falls, and exhibited identified responsive behaviours. NM #104 further indicated that if resident #003 was found to be exhibiting identified responsive behaviours, they would either stay with the resident, assign a member of the PSW staff to stay with the resident, or get the resident up out of bed. NM #104 indicated that due to being at an identified risk for falls, it was not safe to leave the resident alone in the bedroom when they were exhibiting responsive behaviours.

During an interview, RPN #106 indicated that during a conversation regarding the fall with resident #003's SDM, the SDM requested the resident receive a specified

medication. RPN #106 further indicated that resident #003 had been assessed by a Geriatrician a specified number of days prior to the fall, who had recommended resident #003 receive the specified medication a specified number of times daily, but this order had not been approved by resident #003's primary care physician, MD #119, as of the date of the fall. RPN #106 indicated MD #119 had sent an email which indicated that they did not agree with the Geriatrician's recommendations, due to specified concerns which could put resident #003 at increased risk for falling, therefore ordered a lower dose of the specified medication a specified number of times daily as a trial. RPN #106 indicated they did not feel that the lower dose of the specified medication was a strong enough dosage, therefore administered a double dose, as per the SDM's request. RPN #106 further indicated they did not request an increase in the dosage from MD #119 prior to the administration of the medication due to a concern that MD #119 would decline the request, but informed the physician afterwards that the double dose had been given.

Inspector #672 reviewed resident #003's Physician's orders, which indicated that resident #003 had been assessed by a Geriatrician a specified number of days prior to the fall, who had made several medication recommendations for resident #003, in an effort to assist with exhibited responsive behaviours. One of the recommendations was for a specified medication a specified number of times daily. Review of the Physician's DigiOrder sheet for resident #003 revealed an order transcribed by RPN #106 dated the date of the fall, which listed a telephone order from MD #119 for half the dose of the specified medication to be administered a specified number of times daily.

During separate interviews, the ADOC and DOC both indicated that the expectation in the home was that if a resident was exhibiting responsive behaviours, the staff attempt to implement the interventions listed within the resident's written plan of care. The DOC indicated that RPN #106 had not met resident #003's needs on the date of the fall by not providing care as specified in resident #003's plan of care.

The licensee failed to ensure that RPN #106 provided care to resident #003 as specified in the resident's plan of care, by not ensuring that interventions related to falls prevention and responsive behaviours were implemented, and not ensuring that medications were administered according to the physician's order. [s. 6. (7)]

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

Related to Log #015285-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #003 on a specified date and time. According to the CIR, on a specified date and time, resident #003 was found to be laying on the floor by PSW #113, calling out in pain. RPN #106, the night RN and the RN on duty were notified of the fall, and resident #003 was assisted back into the bed, after the resident was assessed. Once the resident was returned to the bed, RPN #106 observed an identified injury and at a specified time the decision was made to transfer the resident to hospital for further assessment.

Inspector #672 reviewed resident #003's progress notes during a specified time period, and observed frequent progress notes which indicated that resident #003 exhibited symptoms of uncontrolled pain. There were also progress notes which indicated that resident #003's SDM had brought forward concerns on several occasions regarding the pain management for resident #003, and believed the exhibited responsive behaviours were a result of the uncontrolled pain. There were no progress notes which indicated that resident #003's plan of care was reviewed or revised in an attempt to assist in assessing or relieving resident #003's responsive behaviours or pain.

Inspector #672 reviewed resident #003's entire health care record, and observed a Geriatrician consultation report which had been completed a specified number of days prior to the fall, as a result of a referral sent by the LTCH staff. The report indicated there were concerns regarding pain management for resident #003, and believed the exhibited responsive behaviours may be a result of uncontrolled pain. The Geriatrician recommended resident #003 begin a medication regimen which included an identified analgesic be administered a specified number of times daily, to assist with pain control. When resident #003 sustained the fall on the specified date, the Geriatrician's recommendations had not been processed.

Inspector #672 reviewed the "Assessments" section in Point Click Care (PCC) during a specified time period. Inspector observed that pain assessments were completed on two specified dates. The pain assessment completed on one specified date indicated that resident #003 complained of pain daily, and exhibited identified responsive behaviours. The assessment indicated that based on the evaluation, the behaviours were exhibited due to uncontrolled pain, yet the plan of care section of the assessment indicated that the resident had satisfactory pain management, and to continue with the current plan of care.

Inspector #672 reviewed resident #003's written plans of care for a specified time period. The written plans of care indicated that resident #003 experienced pain related to identified reasons and conditions. In each of the written plans of care, there were interventions listed for staff to implement. The written plan of care revealed that each of the interventions had been in place since an earlier identified time period.

During an interview, RPN #106 indicated that resident #003 had been verbally complaining of pain on a daily basis and exhibiting symptoms of pain through identified responsive behaviours for a specified time period prior to the fall which occurred. RPN #106 further indicated they were not aware of any interventions available to be implemented for resident #003 in an attempt to decrease the resident's pain, other than attempting to distract the resident through attending programs provided by the recreation department. RPN #106 indicated the intervention of attempting to distract resident #003 was only effective for short periods of time, and then resident #003 would be observed to be exhibiting responsive behaviours again.

During an interview, RN #104 indicated that resident #003 had verbal complaints of pain on almost a daily basis, and exhibited non-verbal signs of pain through identified exhibited responsive behaviours. RN #104 further indicated being unaware of any interventions for resident #003 specific to the resident's pain.

During a telephone interview, the Recreation Manager (RM) indicated that resident #003 would verbally complain of pain on a daily basis, and would then exhibit identified responsive behaviours. The RM further indicated that the recreation department would frequently receive phone calls from the nursing staff from resident #003's home area, to request recreation staff come to the unit to interact with resident #003, in an attempt to distract the resident from their pain, which was only effective for short periods of time, or not at all. The RM indicated they were not aware of resident #003 having any specific interventions to assist with pain control, but the recreation staff would attempt to involve resident #003 in activities which may be occurring in the home, for as long as the resident could tolerate. The RM indicated resident #003 could not tolerate activities for more than an identified period of time, due to uncontrolled pain and exhibited identified responsive behaviours.

During a telephone interview, the DOC indicated the only non-pharmacological interventions available for staff in the home to implement in an effort to assist with resident's pain management was distraction through contacting the recreation department and requesting the resident attend a program.

During separate interviews, the DOC and RAI Coordinator both indicated that the expectation in the home was that if there was a resident who was complaining of pain, the nurse was expected to assess the resident by completing a pain assessment. Based on the outcome of the pain assessment, the nurse should then review and revise the resident's plan of care to include interventions which provided clear directions for staff to implement, in an effort to relieve the resident's complaints of pain. Both the DOC and RAI Coordinator reviewed resident #003's plan of care, and indicated it did not provide clear interventions to staff who provided care to resident #003 related to pain management.

The licensee failed to ensure that resident #003 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective, related to interventions specific to pain management. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001, 002 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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with O. Reg. 79/10, r. 48 (1), every licensee of a long term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 1) A falls prevention and management program to reduce the incidence of falls and the risk of injury. In accordance with O. Reg. 79/10, r.49 (1) the licensee was required to ensure that the falls prevention and management program at a minimum provided for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices, and assistive aids.

Inspector #672 reviewed an identified internal policy related to falls management, which provided instructions for when and how a specified intervention was to be implemented.

Related to Log #015285-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #003. According to the CIR, on the specified date and time, resident #003 was found to be laying on the floor by PSW #113, calling out in pain. RPN #106, the night RN and the RN on duty were notified of the fall, and resident #003 was assisted into the bed after the resident was assessed. Once the resident was returned to the bed, RPN #106 observed an identified injury, and at a specified time the decision was made to transfer the resident to hospital for further assessment.

Inspector #672 reviewed the incident report and progress notes for the date of the fall which indicated resident #003 was admitted to hospital and received an identified intervention for the identified injury, and passed away a specified number of days later.

Inspector #672 reviewed resident #003's identified clinical records, along with reviewing the CIR, which revealed that during a specified time period, resident #003 had sustained an identified number of falls. Inspector #672 then reviewed the progress notes for a specified time period, along with identified assessments, which revealed that following the falls sustained on a specified number of days, an identified intervention had been initiated for resident #003.

Inspector #672 reviewed resident #003's physical chart, and observed that following the falls sustained on a specified number of days, an identified intervention had been initiated for resident #003. The guidelines for the identified intervention indicated that specified items were to be monitored following each specified type of fall, as follows: 1)

Immediately following the fall 2) every 30 minutes for one hour 3) every hour for three hours 4) every two hours for four hours, and 5) every four hours for 16 hours. Inspector #672 then reviewed the identified assessments which were completed on specified dates, and noted that resident #003 was not assessed, as per the identified guidelines at the following times:

On a specified date, at two specified times, staff documented that resident #003 was not assessed due to an identified reason.

On a specified date, at six specified times, staff documented that resident #003 was not assessed due to an identified reason.

Related to Log #025305-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #005 on a specified date and time. The CIR indicated that on the date of the fall, PSW #109 reported to the RPN that resident #005 had fallen during an identified activity of daily living while using an identified intervention. Resident #005 was noted to have an identified injury, was transferred to the hospital for further assessment, and transferred back to the home with a specified diagnosis.

Inspector #672 then reviewed resident #005's physical chart, and reviewed the identified intervention which was completed following the fall sustained on the specified date. During review of the assessment, Inspector #672 noted that resident #005 was not assessed, as per the specified intervention guidelines at the following times:

On a specified date, at one specified time, there was no documentation related to several areas of the intervention being assessed or implemented.

On a specified date, at one specified time, staff documented that resident #005 was not assessed due to an identified reason.

During separate interviews, the ADOC and DOC indicated that the expectation in the home was that each resident who sustained a specified type of fall was to receive the identified intervention exactly according to the identified intervention assessment form. They further indicated that it was not an acceptable practice to document an identified reason on the identified intervention form, due to identified reasons, therefore it was imperative for the resident to receive the identified intervention for the specified time

period documented in the identified intervention assessment. The DOC further indicated that the only acceptable reason to not assess the resident and complete the identified intervention would be if the resident refused, but in that circumstance the staff would be expected to clearly document why the resident had refused the intervention. The DOC indicated that staff writing an identified reason on the identified intervention form, and not assessing the resident was not considered an acceptable practice in the home, and would be in non-compliance with the licensee's policy.

The licensee failed to ensure that an internal policy was complied with, by not ensuring that residents #003 and #005 received an identified intervention as per the guidelines following falls sustained on specified dates. [s. 8. (1) (a),s. 8. (1) (b)]

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

In accordance with O. Reg. 79/10, r. 48 (1), every licensee of a long term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 4) A pain management program to identify pain in residents and manage pain.

Related to Log #015285-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #003 on a specified date and time. Once the resident was returned to the bed, RPN #106 observed an identified injury, and at a specified time the decision was made to transfer the resident to hospital for further assessment.

During a second interview, RPN #106 indicated that resident #003 had been complaining of pain verbally at identified intervals and exhibiting symptoms of pain through exhibited identified responsive behaviours for an identified time period prior to the fall that occurred on the specified date and time. RPN #106 further indicated that pain assessments were not completed for resident #003 due to a belief that the resident did not truly have pain, despite the resident verbally stating they had pain. RPN #106 indicated they did not believe the resident's complaints of pain due to the resident's inability to consistently be able to describe the pain, or provide a numerical number to rate the pain, on a scale of one to ten.

During a telephone interview, the Recreation Manager indicated that resident #003

expressed verbal complaints of pain and exhibited associated identified behaviours which they believed were related to uncontrolled pain during a specified time period.

Inspector #672 reviewed an identified internal policy which indicated how and when identified assessments were to be completed for residents with complaints of pain.

Inspector #672 reviewed resident #003's progress notes and assessments during a specified time period, which revealed resident #003 complained of pain a specified number of times during that time period. Of the specified number of times resident #003 complained of pain, there was only one pain assessment which had been completed, which was confirmed by the DOC.

Inspector #672 then reviewed the assessments during a specified time period, and observed on a specified date a pain assessment was completed. The assessment indicated that resident #003 complained of pain, and exhibited identified responsive behaviours. The assessment further indicated that resident #003 exhibited the symptoms due to uncontrolled pain, yet the plan of care section of the assessment indicated that the resident had satisfactory pain management, and to continue with the current pain management plan of care.

Inspector #672 reviewed resident #003's Physician's Orders, along with Physician's referrals, assessments and progress notes during a specified time period, and observed an assessment from a Geriatrician which indicated the responsive behaviours exhibited by resident #003 were related to the resident experiencing pain, and recommended a medication to be implemented routinely a specified number of times daily. Inspector #672 reviewed the Physician's Orders and observed that as of a specified date, the recommendations by the Geriatrician had not been implemented, and there were no Physician's orders processed to assist with managing resident #003's pain.

During separate interviews, the Assistant Director of Care (ADOC) and Director of Care (DOC) indicated the expectation in the home was that a pain assessment should be completed each time a resident complained of pain. The ADOC indicated that it was not an acceptable practice in the home to have a resident verbally complaining of pain and exhibiting nonverbal symptoms of pain, and not complete a pain assessment.

The licensee failed to ensure that an internal policy related to pain management was complied with, by not ensuring that resident #003 received pain assessments when the resident complained of pain, which led to the resident experiencing pain during a

specified time period. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

Related to Log #025305-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #005. The CIR indicated that on a specified date and time, PSW #109 reported to the RPN that resident #005 had fallen while PSW #109 and #110 were assisting with transferring the resident from an identified area to another while using an identified intervention. Resident #005 was noted to have identified injuries as a result of the fall and was transferred to the hospital for further assessment. Resident #005 was transferred back to the home with a specified diagnosis related to the identified injuries. The CIR further indicated that an internal investigation into the fall had been conducted, and findings from the internal investigation revealed that PSWs #109 and #110 had failed to follow an identified internal procedure, which led to resident #005 falling.

Inspector #672 reviewed resident #005's progress notes from a specified date, which indicated that resident #005 had sustained a fall while PSW #109 and #110 were assisting with transferring the resident from an identified area to another while using an identified intervention. PSW #110 had informed RPN #112 of the fall, while PSW #109 remained with the resident, and RPN #112 had informed RN #122 of the incident. Both RPN #112 and RN #122 had attended to the resident to provide an assessment and first aid, when RN #122 decided that resident #005 required further assessment at the hospital. Resident #005 returned to the home on the same day, with a specified

diagnosis related to the identified injuries, along with an identified treatment for the injuries.

Inspector #672 then reviewed identified clinical records for resident #005, and observed that resident #005 had not sustained any falls during a specified time period, and required a specified level of assistance from an identified number of staff members utilizing a specified intervention for all transfers.

Inspector #672 reviewed a specified internal policy which indicated the roles and responsibilities of the front line staff members when utilizing a specified intervention for all transfers.

During an interview, RPN #112 indicated that on the specified date, PSW #110 had reported that resident #005 had sustained a fall while PSW #109 and #110 were assisting with transferring the resident from an identified area to another while using an identified intervention, and had sustained identified injuries. RPN #112 further indicated they had informed RN #122 of the incident, and both RPN #112 and RN #122 immediately went to assess the resident, and provide first aid. RPN #112 indicated they had asked PSWs #109 and #110 what had occurred to cause the resident to fall, but neither PSW could provide an answer. RPN #112 indicated that due to the serious nature of the incident, and neither PSW providing a full account of the cause of the fall, the identified intervention was removed from further service until it could be assessed, and management was immediately informed.

PSWs #109 and #110, along with RN #122 were not available for interview during the inspection.

Inspector #672 reviewed the internal investigation notes into resident #005's fall. The investigation notes included statements from PSWs #109 and #110, RPN #112, and RN #122, along with pictures and diagrams of the room, and the identified intervention used. The internal investigation notes included a final summary by the DOC and Administrator, which indicated that PSWs #109 and #110 had failed to ensure that safe transferring and positioning techniques were used when assisting resident #005 in an identified number of ways.

During an interview, the DOC indicated that an immediate internal investigation was initiated into the fall sustained by resident #005. The outcome of the internal investigation was a finding that PSWs #109 and #110 had not followed the internal policy. The DOC

indicated that both PSWs had received the annual safe lift and transfer education. The DOC indicated that PSWs #109 and #110 failed to ensure that safe transferring and positioning techniques were used when assisting resident #005 on the specified date.

The licensee failed to ensure that PSWs #109 and #110 used safe transferring and positioning techniques when resident #005 sustained a fall while the PSWs were assisting with transferring the resident from an identified area to another while using a specified intervention, which led to the resident sustaining identified injuries. [s. 36.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

Related to Log #015285-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #003 on a specified date and time. According to the CIR, on a specified date and time, resident #003 was found to be laying on the floor beside the bed by PSW #113, calling out in pain. RPN #106, the night RN and the RN on duty were notified of the fall, and resident #003 was assisted back into the bed, after the resident was assessed. Once the resident was returned to the bed, RPN #106 observed an identified injury, and at a specified time the decision was made to transfer the resident to hospital for further

assessment.

Inspector #672 reviewed the incident report and progress notes for the specified date, which indicated that at a specified time the decision was made to transfer the resident to hospital for further assessment, due to RPN #106 observing an identified injury. Resident #003 was admitted to hospital, received a specified intervention to treat the identified injury, and passed away on a specified date.

Review of the progress notes revealed that during RPN #106's assessment of resident #003 post fall, the resident was observed to be in significant pain. The pain was assessed to be at a specified level, and was exhibited by the resident through identified responsive behaviours and verbal complaints of pain. RPN #106 administered a specified medication to the resident, to assist with pain control at a specified time. The progress notes went on to indicate that the administration of the medication had not been effective in relieving resident #003's pain, as the resident continued to exhibit identified responsive behaviours and have verbal complaints of pain.

Inspector #672 reviewed identified clinical records for resident #003, and did not observe a pain assessment following the administration of the medication, to indicate the medication had been ineffective.

During an interview, RPN #106 indicated that resident #003 continued to appear to be in significant pain following the fall until the resident was transferred to hospital, despite the administration of the specified medication. RPN #106 indicated that resident #003 continued to complain of pain following the administration of the medication, which was exhibited by the resident through identified responsive behaviours and verbal complaints of pain. RPN #106 further indicated they had documented a progress note at a specified time which indicated the medication had been deemed to be ineffective in managing resident #003's pain, but did not recall completing a follow up pain assessment. RPN #106 indicated that the expectation in the home was that if a resident had uncontrolled pain and/or a medication which had been administered had been deemed ineffective, the nurse was to complete a pain assessment. RPN #106 further indicated that a pain assessment had not been completed for resident #003 due to being preoccupied by completing the medication pass on the resident home area, which was behind schedule due to resident #003's fall, and having a belief that resident #003 could wait to have their pain assessed and treated once they were transferred to the hospital.

During separate interviews, the Assistant Director of Care (ADOC) and Director of Care

(DOC) indicated the expectation in the home was that the nurse should complete a pain assessment on the resident prior to administering a specified type of medication, and then again within one hour following the administration, to assess the effectiveness. The DOC indicated that resident #003 appeared to be in significant pain prior to being transferred to hospital for further assessment.

The licensee failed to ensure that when resident #003's pain was not relieved by the initial intervention, the resident was not assessed using a clinically appropriate assessment instrument specifically designed for that purpose. [s. 52. (2)]

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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for that purpose, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

Related to Log #015285-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #003 on a specified date and time.

Review of the progress notes revealed that during RPN #106's assessment of resident #003 post fall, the resident was observed to be in significant pain. The pain was assessed to be at a specified level, and was exhibited by the resident through identified responsive behaviours and verbal complaints of pain. RPN #106 administered a specified medication to the resident, to assist with pain control at a specified time.

Review of the Physician's DigiOrder sheet for resident #003 revealed an order transcribed by RPN #106 from a specified date and time which listed a telephone order from MD #119 for a specified medication to be administered an identified number of times daily, which was half of the dose which had been requested by resident #003's SDM, and administered by RPN #106.

During an interview, RPN #106 indicated that during the conversation with resident #003's SDM, the SDM requested the resident receive a specified medication to be administered to assist with pain control. RPN #106 further indicated that resident #003 had been assessed by a Geriatrician on a specified date prior to the fall, who had recommended resident #003 receive a specified medication to be administered an identified number of times daily, but this order had not been approved by resident #003's primary care physician, MD #119, as of the date when resident #003 sustained the fall. RPN #106 indicated MD #119 had sent an email which indicated that they did not agree with the Geriatrician's recommendations, due to identified concerns, therefore ordered the specified medication to be administered an identified number of times daily, which was half of the dose which had been recommended by the Geriatrician. RPN #106 further indicated they had not spoken with MD #119 to verbally confirm the contents of the email, when the order was transcribed as a telephone order between RPN #106 and MD #119; RPN #106 had copied the contents of the email onto the Physician's DigiOrder sheet, and proceeded without confirmation. RPN #106 indicated they did not feel the specified medication was a strong enough dosage, therefore administered a double dose of the specified medication. RPN #106 further indicated they did not request an increase in the dosage from MD #119 prior to the administration of the medication due to a concern that MD #119 would decline the request, as MD #119 had clearly outlined identified concerns around the dosage of the specified medication recommended by the Geriatrician, but informed the physician afterwards that the double dose had been given. RPN #106 indicated that the expectation in the home was that no medications were to be given to a resident without a valid Physician's order, which included the precise dosage of the medication, and if the nurse gave a dosage of a medication different than what was prescribed by the Physician, this would be considered a medication incident. RPN #106 further indicated they included the administration of the double dose of the specified

medication in the progress notes for resident #003, and indicated the DOC was aware.

During separate interviews, the Assistant Director of Care (ADOC) and Director of Care (DOC) indicated the expectation in the home was that all nurses administering medications to residents were expected to have confirmed Physician's orders; and the nurses were to follow the directions for administration of the medications contained within each Physician's order at all times.

The licensee failed to ensure that drugs were administered to resident #003 in accordance with the directions for use specified by the prescriber, when RPN #106 administered a double dose of the specified medication. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to the resident in accordance with the directions for use specified by the prescriber., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the organized pain program required under sections 8 to 16 of the Act and section 48 of the regulation included a written description of the program that included its:
• goals and objectives
• methods to reduce risk
• methods to monitor outcomes, and
• protocols for referral of resident to specialized resources where required.

Inspector #672 reviewed the licensee's pain program as a result of findings of non-compliance related to resident #003 specific to pain management. As a result, Inspector requested the internal policies and procedures related to pain management from the Administrator and DOC, who provided one policy entitled "Pain Management"; policy #15735; Date First Approved: June 7, 2003; Date Last Reviewed: January 2013. Inspector #672 reviewed this policy, and observed that it did not include a written

description of the following:
• goals and objectives
• methods to reduce risk
• methods to monitor outcomes
• protocols for referral of resident to specialized resources where required.

During a telephone interview, the DOC indicated that the licensee did not follow any other policies related to pain management for residents, and did not have any policies which included information or a written description of the items listed above. The DOC further indicated being in the process of setting up a Best Practice Committee related to pain, due to an awareness that pain management and education was an area the licensee needed to focus on, and was unaware of the licensee having any specific goals or objectives, methods to reduce risk or monitor outcomes, or specific protocols for referral of a resident to a specialized resource where required, specific to pain management. During a previous interview, the DOC indicated being aware of situations where resident pain levels were not well controlled; times when a resident's pain was not relieved by initial interventions, the resident was not then assessed using a clinically appropriate assessment instrument specifically designed for that purpose; and interventions were not being implemented in an effort to directly reduce a resident's complaints of pain. The DOC indicated they were working with staff to improve the education and knowledge base on pain management in the home.

The licensee failed to ensure that the organized pain program required under sections 8 to 16 of the Act and section 48 of the regulation, included a written description of the program that included its goals and objectives, methods to reduce risk, methods to monitor outcomes, and protocols for referral of residents to specialized resources where required. [s. 30. (1) 1.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the written report included a description of the individuals involved in the incident, including the names of staff members who responded to the incident.

Related to Log #025305-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #005. The CIR indicated that on a specified date and time, PSW #109 reported

to the RPN that resident #005 had fallen while PSW #109 and #110 were assisting with transferring the resident from an identified area to another while using an identified intervention. Resident #005 was noted to have identified injuries as a result of the fall and was transferred to the hospital for further assessment. Resident #005 was transferred back to the home with a specified diagnosis related to the identified injuries.

IInspector #672 reviewed resident #005's progress notes from a specified date, which indicated that resident #005 had sustained a fall while PSW #109 and #110 were assisting with transferring the resident from an identified area to another while using an identified intervention. PSW #110 had informed RPN #112 of the fall, while PSW #109 remained with the resident, and RPN #112 had informed RN #122 of the incident. Both RPN #112 and RN #122 had attended to the resident to provide an assessment and first aid, when RN #122 decided that resident #005 required further assessment at the hospital.

During an interview, RPN #112 indicated that they had been informed of resident #005's fall from PSW #109, then assessed the resident, provided first aid treatment, notified resident #005's MD and SDM of the fall, and transferred the resident to hospital for further assessment.

RN #122 was not available for interview during the inspection.

Inspector #672 reviewed the CIR submitted to the Director related to the fall sustained by resident #005, and observed that the report did not include the name of the RPN or RN who responded to the incident, provided first aid treatment, notified resident #005's MD and SDM of the fall and transferred resident #005 to the hospital.

During an interview, the DOC indicated that they had forgotten to include the names of RPN #112 and RN #122 who responded to the incident, provided first aid treatment, notified resident #005's MD and SDM of the fall and transferred resident #005 to the hospital in the written report submitted to the Director, or when the report was amended on a later specified date.

The licensee failed to ensure that the written report to the Director included the names of RPN #112 and RN #122 who responded to the incident, provided first aid treatment, notified resident #005's MD and SDM of the fall and transferred resident #005 to the hospital. [s. 107. (4) 2.]

2. The licensee failed to ensure that the written report included the outcome or current status of the individual who was involved in the incident.

Related to Log #015285-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #003 on a specified date and time. According to the CIR, on a specified date and time, resident #003 was found to be laying on the floor beside the bed by PSW #113, calling out in pain. RPN #106, the night RN and the RN on duty were notified of the fall, and resident #003 was assisted back into the bed, after the resident was assessed. Once the resident was returned to the bed, RPN #106 observed an identified injury, and at a specified time the decision was made to transfer the resident to hospital for further assessment.

The CIR did not include what the findings were once the resident arrived at the hospital, whether the resident was admitted to the hospital, or what the resident's outcome was.

Inspector #672 reviewed resident #003's progress notes from a specified time period, which indicated that resident #003 was admitted to hospital on a specified date, and received a specified treatment for the identified injury. The progress notes further indicated that resident #003 passed away on a specified date.

During separate interviews, NM #104 and RPN #106 verified that resident #003 had sustained an identified injury, and passed away on a specified date.

During an interview, the DOC indicated that they had not completed the internal investigation into resident #003's fall until five months after the fall, and had forgotten to update the CIR with resident #003's status and outcome following the fall.

The licensee failed to ensure that the written report to the Director included that resident #003 had sustained an identified injury as a result of the fall, and that the resident passed away on a specified date. [s. 107. (4) 3.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart,
i. that was used exclusively for drugs and drug-related supplies,
ii. that was secure and locked,
iii. that protected the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
iv. that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting)

On a specified date and time, Inspector #672 was conducting interviews and observations on an identified resident home area. While sitting at the nursing station waiting to speak with RPN #106, Inspector #672 observed a specified number of bottles of medicated creams sitting on a specified area of the nursing station desk, which was accessible and visible to residents and visitors. A specified number of the medicated creams were prescribed to resident #013, and a specified number of the medicated creams were prescribed to resident #014. At the time of the observation, there were an identified number of residents sitting across from the nursing station in the lounge area, a specified number of residents sitting immediately at the nursing station, and an identified number of family members standing at the nursing desk for an approximate amount of time. All of the medicated creams were visible and accessible during that time.

During an interview, RPN #106 indicated that the expectation in the home was that medicated creams should not be left at the nursing station, but locked in the medication

storage room, or in the treatment cart, which was also locked and stored in the medication storage room, when not in use.

During an interview, the Administrator indicated that the expectation in the home was that all medications and medicated creams were to be kept locked in either the medication or treatment carts, which were to be kept locked at all times when the nurse was not standing right in front of, and then stored in the locked medication room when not in use. The Administrator further indicated that the PSW staff were educated to apply topical creams to the residents, therefore the medicated creams were supplied by the RPN prior to personal care, when the creams were to be administered. The medicated creams were to be returned to the registered staff immediately after use, and the RPN was to store them in the medication rooms, which only the registered staff had access to.

The licensee failed to ensure that drugs were stored in an area or a medication cart which was used exclusively for drugs and drug-related supplies, and was secured and locked. [s. 129. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; that corrective action was taken as necessary, and a written record was kept.

Related to Log #015285-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #003 on a specified date and time.

Review of the progress notes revealed that during RPN #106's assessment of resident #003 post fall, the resident was observed to be in significant pain. The pain was assessed to be at a specified level, and was exhibited by the resident through identified responsive behaviours and verbal complaints of pain. RPN #106 administered a specified medication to the resident, to assist with pain control at a specified time.

Review of the Physician's DigiOrder sheet for resident #003 revealed an order transcribed by RPN #106 from a specified date and time which listed a telephone order from MD #119 for a specified medication to be administered an identified number of times daily, which was half of the dose which had been requested by resident #003's SDM, and administered by RPN #106.

During an interview, RPN #106 indicated they did not create a medication incident report following the administration of the double dosage of the specified medication, but indicated the DOC was aware of the medication incident.

During separate interviews, the Assistant Director of Care (ADOC) and Director of Care (DOC) indicated the expectation in the home was that all nurses administering medications to residents were expected to have confirmed Physician's orders for all medications being administered; and the nurses were to follow the directions for administration of the medications contained within each Physician's order at all times. They further indicated that any deviation from administering the exact medication order prescribed by the physician would be considered a medication incident, and a medication incident report should be completed. The DOC indicated they were aware that resident #003 had received a dosage of the specified medication prior to the hospital transfer, but did not request a medication incident report be completed. The DOC further indicated that no corrective actions had been taken in regards to the medication incident following the administration of the double dose of the specified medication, therefore there was no written record of the medication incident, outside of RPN #106's documentation in resident #003's progress notes.

The licensee failed to ensure that the medication incident which occurred when RPN #106 purposefully administered a double dose of a specified medication to resident #003 was documented, reviewed and analyzed; that corrective action was taken as

necessary, and a written record was kept. [s. 135. (2)]

Issued on this 17th day of May, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BATTEN (672)
Inspection No. / No de l'inspection :	2018_578672_0020
Log No. / No de registre :	003867-17, 005573-17, 005791-17, 008865-17, 010731-17, 027335-17, 008782-18, 015285-18, 025305-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 13, 2019
Licensee / Titulaire de permis :	Unionville Home Society 4300 Highway #7, MARKHAM, ON, L3R-1L8
LTC Home / Foyer de SLD :	Union Villa 4300 Highway #7, Unionville, ON, L3R-1L8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Roxanne Adams

To Unionville Home Society, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with the LTCHA, 2007, s. 6.(1).

The licensee is ordered to:

1. Ensure that the written plans of care for all residents in the home provide clear directions to staff and others who provide direct care to the residents.

2. The written plans of care shall be reviewed with all direct care staff to ensure the directions are clear and staff are aware of any updates/changes made.

3. The plan shall include an auditing process to ensure the directions in the resident's written plans of care are clear.

4. Maintain documentation to demonstrate steps 1-3 have been completed and are available upon Inspector request.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Related to Log #010731-17:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #004 on a specified date and time. According to the CIR, on a

specified date and time, resident #004 received assistance from PSW #108, and was then left in the bed while the PSW went to locate a specified item. When PSW #108 returned, resident #004 was found on the floor, with an identified injury. PSW #108 informed RPN #106 that the resident was on the floor. RPN #106 assessed the resident and observed the resident had sustained two identified injuries. The resident was transferred to hospital for further assessment and was admitted with an identified diagnosis. Resident #004 received a specified intervention for the identified diagnosis, and returned to the home on a later specified date.

During an interview, PSW #108 indicated they did not routinely work on resident #004's home area, and was not familiar with resident #004. Prior to providing care, PSW #108 reviewed the resident's plan of care, but indicated they found it confusing and it did not provide clear directions regarding the level of care and assistance resident #004 required, therefore asked a colleague about the resident. The colleague indicated they believed resident #004 required a specified number of staff member(s) to provide assistance, therefore PSW #108 proceeded to provide that specified level of personal care to resident #004.

Inspector #672 reviewed resident #004's progress notes for a specified time period, which indicated that on a specified date, resident #004 had received personal care from PSW #102. When PSW #102 had stepped away to secure an identified item for the resident, resident #004 was found on the floor, with an identified injury. RPN #106 had been notified of the fall, and assessed the resident. Following the assessment, RPN #106 documented that a specified intervention was to be implemented, along with changing the amount of staff required to provide personal care/assistance with Activities of Daily Living (ADLs).

Inspector #672 reviewed resident #004's written plan of care in place during a specified time period. The focus section for toileting indicated that resident #004 required an identified level of assistance from a specified number of staff members, but the interventions section for toileting indicated that resident #004 required a different identified level of assistance from a different specified number of staff members. The focus section for transferring indicated that resident #004 required an identified level of assistance from a specified number of staff members, and the resident required an identified type of transfer, but the

personal hygiene focus indicated that the resident required assistance from a different number of staff member for a different type of transfer. The focus section for bed mobility indicated that resident #004 required an identified level of assistance from a specified number of staff members, but the interventions section for bed mobility indicated the resident required a different number of staff members. The focus section for personal hygiene indicated that resident #004 required an identified level of assistance from a specified number of staff members, but the intervention section for personal hygiene indicated on one line that the resident required a specified number of staff members for an identified level of assistance and the intervention listed directly below that indicated the resident required a different number of staff members for an identified level of assistance. The focus section for dressing indicated the resident required an identified level of assistance from a specified number of staff members, but the interventions section for dressing indicated on one line that the resident required a specified number of staff members for physical assistance and the intervention listed directly below that indicated the resident required a different number of staff members for a different level of assistance.

During an interview, the RAI Coordinator indicated that the expectation in the home was that every resident's plan of care should provide clear and concise directions to the front line staff providing care to the resident. The RAI Coordinator further indicated that if a resident's care needs changed, and the level of care or number of staff members required to perform a task changed from what was currently listed in the written plan of care, the nurse on duty when the change was noted was responsible for making the required changes. The RAI Coordinator reviewed resident #004's written plan of care with Inspector #672, and indicated it did not provide clear or concise directions to the front line staff providing direct care to the resident.

During an interview, the DOC indicated that the expectation in the home was that every resident's plan of care should provide clear and concise directions to the front line staff providing care to the resident. The DOC reviewed resident #004's written plan of care with Inspector #672, and indicated it did not provide clear or concise directions to the front line staff providing direct care to the resident.

The licensee failed to ensure that resident #004's plan of care set out clear

directions to staff and others who provided direct care to the resident.

The severity of the issue was determined to be a level 3 as there was actual harm to resident #004, which resulted in an identified injury. The scope of the issue was a level 2. The licensee had a level 4 compliance history related to on-going non-compliance under the LTCHA, 2007, s. 6 (1) (c) as follows:
A Written Notification (WN) was issued during a complaint inspection under LTCHA, 2007, s. 6 (1) (c);
A Voluntary Plan of Compliance (VPC) was issued during a Resident Quality Inspection under LTCHA, 2007, s. 6 (1) (c). (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 13, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # /
Ordre no : 002

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 the LTCHA, 2007, s. 6.(7).

The licensee is ordered to:

1) Develop and implement a monitoring tool to ensure that all residents are provided with assistance and monitoring with falls prevention, exhibited responsive behaviours and pain management according to their assessed needs.

2) Maintain documentation of the monitoring tool, and have it available upon Inspector request.

3) Develop and implement an auditing process to ensure that the written plan of care for all residents who exhibit responsive behaviours, who are at high risk for falls; or are at risk for experiencing pain is provided to the resident as specified in the plan.

4) Maintain documentation of the audits conducted, and have available upon Inspector request.

5) Ensure that supervision from nursing supervisors/managers is heightened, to ensure that all residents are provided with proper care, assistance and supervision with all care needs, according to the planned care.

6) Create an outline of corrective actions to be taken and by whom, if staff fail to implement the interventions as identified.

7) Keep a documented record of the outline, and have it available upon Inspector request.

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.

Related to Log #015285-18:

A Critical Incident Report was submitted to the Director related to a fall sustained

by resident #003 on a specified date and time. According to the CIR, on a specified date and time, resident #003 was found to be laying on the floor beside the bed by PSW #113, calling out in pain. RPN #106, the night RN and the RN on duty were notified of the fall, and resident #003 was assisted back into the bed, after the resident was assessed. Once the resident was returned to the bed, RPN #106 observed an identified injury, and at a specified time the decision was made to transfer the resident to hospital for further assessment.

Inspector #672 reviewed the incident report and progress notes for the day the fall occurred, which indicated at a specified time RPN #106 went to resident #003's room to assess the resident and ensure they were still in the bed. Resident #003 was found to be exhibiting identified responsive behaviours. RPN #106 left the room to receive shift report and begin a medication pass. Resident #003 was found on the floor at a later identified time, by PSW #113. Once the resident was returned to the bed, RPN #106 observed an identified injury, and at a specified time the decision was made to transfer the resident to hospital for further assessment. Resident #003 was admitted to hospital, and received an identified intervention and passed away in hospital a specified number of days later.

During an interview, RPN #106 indicated that upon entering the resident home area on the specified date and time, they became aware that resident #003 was exhibiting a responsive behaviour. RPN #106 indicated they went to resident #003's room to assess the resident and ensure they were still in the bed, and found the resident to be exhibiting several identified responsive behaviours. RPN #106 further indicated that they did not approach or speak to the resident, and did not provide any interventions listed in the resident's plan of care, due to being focused on getting to the nursing station to complete the shift report, and begin the medication pass. RPN #106 further indicated that they had only gone to resident #003's bedroom to ensure the resident hadn't fallen from the bed, and did not feel they had time to spend to implement any interventions, but did not request another staff member to go and assist resident #003 in their place. RPN #106 indicated that resident #003 was at an identified risk for falls and often exhibited identified responsive behaviours, which had interventions listed in the resident's written plan of care for staff to implement.

Inspector #672 reviewed the written plan of care in place at the time of the

incident. There were identified interventions listed for staff to implement when the resident was exhibiting responsive behaviours.

During an interview, Nurse Manager (NM) #104 indicated that resident #003 was at an identified risk for falls, and exhibited identified responsive behaviours. NM #104 further indicated that if resident #003 was found to be exhibiting identified responsive behaviours, they would either stay with the resident, assign a member of the PSW staff to stay with the resident, or get the resident up out of bed. NM #104 indicated that due to being at an identified risk for falls, it was not safe to leave the resident alone in the bedroom when they were exhibiting responsive behaviours.

During an interview, RPN #106 indicated that during a conversation regarding the fall with resident #003's SDM, the SDM requested the resident receive a specified medication. RPN #106 further indicated that resident #003 had been assessed by a Geriatrician a specified number of days prior to the fall, who had recommended resident #003 receive the specified medication a specified number of times daily, but this order had not been approved by resident #003's primary care physician, MD #119, as of the date of the fall. RPN #106 indicated MD #119 had sent an email which indicated that they did not agree with the Geriatrician's recommendations, due to specified concerns which could put resident #003 at increased risk for falling, therefore ordered a lower dose of the specified medication a specified number of times daily as a trial. RPN #106 indicated they did not feel that the lower dose of the specified medication was a strong enough dosage, therefore administered a double dose, as per the SDM's request. RPN #106 further indicated they did not request an increase in the dosage from MD #119 prior to the administration of the medication due to a concern that MD #119 would decline the request, but informed the physician afterwards that the double dose had been given.

Inspector #672 reviewed resident #003's Physician's orders, which indicated that resident #003 had been assessed by a Geriatrician a specified number of days prior to the fall, who had made several medication recommendations for resident #003, in an effort to assist with exhibited responsive behaviours. One of the recommendations was for a specified medication a specified number of times daily. Review of the Physician's DigiOrder sheet for resident #003 revealed an order transcribed by RPN #106 dated the date of the fall, which

listed a telephone order from MD #119 for half the dose of the specified medication to be administered a specified number of times daily.

During separate interviews, the ADOC and DOC both indicated that the expectation in the home was that if a resident was exhibiting responsive behaviours, the staff attempt to implement the interventions listed within the resident's written plan of care. The DOC indicated that RPN #106 had not met resident #003's needs on the date of the fall by not providing care as specified in resident #003's plan of care.

The licensee failed to ensure that RPN #106 provided care to resident #003 as specified in the resident's plan of care, by not ensuring that interventions related to falls prevention and responsive behaviours were implemented, and not ensuring that medications were administered according to the physician's order.

The severity of the issue was determined to be a level 3 as there was actual harm to resident #003, which resulted in an identified injury. The scope of the issue was a level 2. The licensee had a compliance history with non-compliance in similar areas under the LTCHA, 2007, to s. 6 as follows:
A WN was issued during a Complaint Inspection related to s. 6 (1) (c) and s. 6 (10) (b).
A VPC was issued during a Resident Quality Inspection related to s. 6 (1) (c), s. 6 (10) (b), s. 6. (4) (a), s. 6. (4) (b), and s. 6. (5).

(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 13, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

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) (b).

The licensee is ordered to:

1. Ensure that the licensee's policies entitled "Falls Management Policy"; Policy Number: 15500; Date First Approved: November 2008; Date Last Reviewed: April 10, 2014, and "Pain Management"; Policy Number: 15735; Date First Approved: June 7, 2003; Date Last Reviewed: January 2013, are complied with.

2. Re-educate all registered and PSW staff on the identified policies.

3. Test the staff member's knowledge, to ensure understanding of their role regarding falls prevention and pain management - what is required, specifically related to implementing interventions, assessments and documentation.

4. Maintain records of the education and testing provided to staff, and ensure it is available upon Inspector request.

5. Develop and implement an auditing process to ensure the above mentioned policies are complied with.

6. Develop an outline of corrective actions to be taken and by whom, if staff fail to implement the interventions as identified.

Grounds / Motifs :

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

In accordance with O. Reg. 79/10, r. 48 (1), every licensee of a long term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 1) A falls prevention and management program to reduce the incidence of falls and the risk of injury. In accordance with O. Reg. 79/10, r.49 (1) the licensee was required to ensure that the falls prevention and management program at a minimum provided for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices, and assistive aids.

Inspector #672 reviewed an identified internal policy related to falls management, which provided instructions for when and how a specified intervention was to be implemented.

Related to Log #015285-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #003. According to the CIR, on the specified date and time, resident #003 was found to be laying on the floor by PSW #113, calling out in pain. RPN #106, the night RN and the RN on duty were notified of the fall, and resident #003 was assisted into the bed after the resident was assessed. Once the resident was returned to the bed, RPN #106 observed an identified injury, and at a specified time the decision was made to transfer the resident to hospital for further assessment.

Inspector #672 reviewed the incident report and progress notes for the date of the fall which indicated resident #003 was admitted to hospital and received an identified intervention for the identified injury, and passed away a specified number of days later.

Inspector #672 reviewed resident #003's identified clinical records, along with reviewing the CIR, which revealed that during a specified time period, resident #003 had sustained an identified number of falls. Inspector #672 then reviewed

the progress notes for a specified time period, along with identified assessments, which revealed that following the falls sustained on a specified number of days, an identified intervention had been initiated for resident #003.

Inspector #672 reviewed resident #003's physical chart, and observed that following the falls sustained on a specified number of days, an identified intervention had been initiated for resident #003. The guidelines for the identified intervention indicated that specified items were to be monitored following each specified type of fall, as follows: 1) Immediately following the fall 2) every 30 minutes for one hour 3) every hour for three hours 4) every two hours for four hours, and 5) every four hours for 16 hours. Inspector #672 then reviewed the identified assessments which were completed on specified dates, and noted that resident #003 was not assessed, as per the identified guidelines at the following times:

On a specified date, at two specified times, staff documented that resident #003 was not assessed due to an identified reason.

On a specified date, at six specified times, staff documented that resident #003 was not assessed due to an identified reason.

Related to Log #025305-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #005 on a specified date and time. The CIR indicated that on the date of the fall, PSW #109 reported to the RPN that resident #005 had fallen during an identified activity of daily living while using an identified intervention. Resident #005 was noted to have an identified injury, was transferred to the hospital for further assessment, and transferred back to the home with a specified diagnosis.

Inspector #672 then reviewed resident #005's physical chart, and reviewed the identified intervention which was completed following the fall sustained on the specified date. During review of the assessment, Inspector #672 noted that resident #005 was not assessed, as per the specified intervention guidelines at the following times:

On a specified date, at one specified time, there was no documentation related to several areas of the intervention being assessed or implemented.

On a specified date, at one specified time, staff documented that resident #005 was not assessed due to an identified reason.

During separate interviews, the ADOC and DOC indicated that the expectation in the home was that each resident who sustained a specified type of fall was to receive the identified intervention exactly according to the identified intervention assessment form. They further indicated that it was not an acceptable practice to document an identified reason on the identified intervention form, due to identified reasons, therefore it was imperative for the resident to receive the identified intervention for the specified time period documented in the identified intervention assessment. The DOC further indicated that the only acceptable reason to not assess the resident and complete the identified intervention would be if the resident refused, but in that circumstance the staff would be expected to clearly document why the resident had refused the intervention. The DOC indicated that staff writing an identified reason on the identified intervention form, and not assessing the resident was not considered an acceptable practice in the home, and would be in non-compliance with the licensee's policy.

The licensee failed to ensure that an internal policy was complied with, by not ensuring that residents #003 and #005 received an identified intervention as per the guidelines following falls sustained on specified dates. (672)

2. In accordance with O. Reg. 79/10, r. 48 (1), every licensee of a long term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 4) A pain management program to identify pain in residents and manage pain.

Related to Log #015285-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #003 on a specified date and time. Once the resident was returned to the bed, RPN #106 observed an identified injury, and at a specified time the decision was made to transfer the resident to hospital for further assessment.

During a second interview, RPN #106 indicated that resident #003 had been complaining of pain verbally at identified intervals and exhibiting symptoms of pain through exhibited identified responsive behaviours for an identified time period prior to the fall that occurred on the specified date and time. RPN #106 further indicated that pain assessments were not completed for resident #003 due to a belief that the resident did not truly have pain, despite the resident verbally stating they had pain. RPN #106 indicated they did not believe the resident's complaints of pain due to the resident's inability to consistently be able to describe the pain, or provide a numerical number to rate the pain, on a scale of one to ten.

During a telephone interview, the Recreation Manager indicated that resident #003 expressed verbal complaints of pain and exhibited associated identified behaviours which they believed were related to uncontrolled pain during a specified time period.

Inspector #672 reviewed an identified internal policy which indicated how and when identified assessments were to be completed for residents with complaints of pain.

Inspector #672 reviewed resident #003's progress notes and assessments during a specified time period, which revealed resident #003 complained of pain a specified number of times during that time period. Of the specified number of times resident #003 complained of pain, there was only one pain assessment which had been completed, which was confirmed by the DOC.

Inspector #672 then reviewed the assessments during a specified time period, and observed on a specified date a pain assessment was completed. The assessment indicated that resident #003 complained of pain, and exhibited identified responsive behaviours. The assessment further indicated that resident #003 exhibited the symptoms due to uncontrolled pain, yet the plan of care section of the assessment indicated that the resident had satisfactory pain management, and to continue with the current pain management plan of care.

Inspector #672 reviewed resident #003's Physician's Orders, along with Physician's referrals, assessments and progress notes during a specified time period, and observed an assessment from a Geriatrician which indicated the

responsive behaviours exhibited by resident #003 were related to the resident experiencing pain, and recommended a medication to be implemented routinely a specified number of times daily. Inspector #672 reviewed the Physician's Orders and observed that as of a specified date, the recommendations by the Geriatrician had not been implemented, and there were no Physician's orders processed to assist with managing resident #003's pain.

During separate interviews, the Assistant Director of Care (ADOC) and Director of Care (DOC) indicated the expectation in the home was that a pain assessment should be completed each time a resident complained of pain. The ADOC indicated that it was not an acceptable practice in the home to have a resident verbally complaining of pain and exhibiting nonverbal symptoms of pain, and not complete a pain assessment.

The licensee failed to ensure that an internal policy related to pain management was complied with, by not ensuring that resident #003 received pain assessments when the resident complained of pain, which led to the resident experiencing pain during a specified time period.

The severity of the issue was determined to be a level 3 as there was actual harm to resident #003, related to pain management; and actual risk to residents #003 and #005 by not following the Falls Management policy. The scope of the issue was a level 1, as it involved two out of six residents reviewed. The licensee had a level 4 compliance history related to on-going non-compliance under the LTCHA, 2007, r. 8 (1) (b) as follows:
A WN was issued during a Resident Quality Inspection on a specified date.
A VPC was issued during a Resident Quality Inspection on a later specified date.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 13, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with the LTCHA, 2007, r. 36.

The licensee is ordered to:

(1) Ensure that staff are using safe transferring and positioning techniques when assisting residents, especially when utilizing a mechanical lift.

(2) Conduct random monthly supply audits to ensure that each resident home area is supplied with the equipment required to ensure staff use safe transferring and positioning techniques when assisting residents, such as ensuring slings being used are in a good state of repair and are the size/type assigned to the resident through an assessment of the resident's transfer needs.

(3) Keep a documented record of the supply audits conducted and have them available upon Inspector request.

(4) Conduct random transfer and positioning observations twice per month for a six month period, for residents transferred via mechanical lift, to ensure staff are using safe transferring and positioning techniques when assisting residents.

(5) Keep a documented record of the observational audits conducted and have them available upon Inspector request.

(6) Create an outline of corrective actions to be taken and by whom, if staff fail to implement the interventions as identified.

Grounds / Motifs :

1. The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

Related to Log #025305-18:

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #005. The CIR indicated that on a specified date and time, PSW #109 reported to the RPN that resident #005 had fallen while PSW #109 and #110 were assisting with transferring the resident from an identified area to another while using an identified intervention. Resident #005 was noted to have identified injuries as a result of the fall and was transferred to the hospital for further assessment. Resident #005 was transferred back to the home with a specified diagnosis related to the identified injuries. The CIR further indicated that an internal investigation into the fall had been conducted, and findings from the internal investigation revealed that PSWs #109 and #110 had failed to follow an identified internal procedure, which led to resident #005 falling.

Inspector #672 reviewed resident #005's progress notes from a specified date, which indicated that resident #005 had sustained a fall while PSW #109 and #110 were assisting with transferring the resident from an identified area to another while using an identified intervention. PSW #110 had informed RPN #112 of the fall, while PSW #109 remained with the resident, and RPN #112 had informed RN #122 of the incident. Both RPN #112 and RN #122 had attended to the resident to provide an assessment and first aid, when RN #122 decided that resident #005 required further assessment at the hospital. Resident #005 returned to the home on the same day, with a specified diagnosis related to the identified injuries, along with an identified treatment for the injuries.

Inspector #672 then reviewed identified clinical records for resident #005, and observed that resident #005 had not sustained any falls during a specified time period, and required a specified level of assistance from an identified number of staff members utilizing a specified intervention for all transfers.

Inspector #672 reviewed a specified internal policy which indicated the roles and responsibilities of the front line staff members when utilizing a specified intervention for all transfers.

During an interview, RPN #112 indicated that on the specified date, PSW #110 had reported that resident #005 had sustained a fall while PSW #109 and #110 were assisting with transferring the resident from an identified area to another while using an identified intervention, and had sustained identified injuries. RPN #112 further indicated they had informed RN #122 of the incident, and both RPN #112 and RN #122 immediately went to assess the resident, and provide first aid. RPN #112 indicated they had asked PSWs #109 and #110 what had occurred to cause the resident to fall, but neither PSW could provide an answer. RPN #112 indicated that due to the serious nature of the incident, and neither PSW providing a full account of the cause of the fall, the identified intervention was removed from further service until it could be assessed, and management was immediately informed.

PSWs #109 and #110, along with RN #122 were not available for interview during the inspection.

Inspector #672 reviewed the internal investigation notes into resident #005's fall. The investigation notes included statements from PSWs #109 and #110, RPN #112, and RN #122, along with pictures and diagrams of the room, and the identified intervention used. The internal investigation notes included a final summary by the DOC and Administrator, which indicated that PSWs #109 and #110 had failed to ensure that safe transferring and positioning techniques were used when assisting resident #005 in an identified number of ways.

During an interview, the DOC indicated that an immediate internal investigation was initiated into the fall sustained by resident #005. The outcome of the internal investigation was a finding that PSWs #109 and #110 had not followed the internal policy. The DOC indicated that both PSWs had received the annual safe lift and transfer education. The DOC indicated that PSWs #109 and #110 failed to ensure that safe transferring and positioning techniques were used when assisting resident #005 on the specified date.

The licensee failed to ensure that PSWs #109 and #110 used safe transferring and positioning techniques when resident #005 sustained a fall while the PSWs were assisting with transferring the resident from an identified area to another while using a specified intervention, which led to the resident sustaining identified injuries.

A Compliance Order was warranted as the scope and severity was demonstrated by the following:

1) The severity was a level 3, as there was actual harm to resident #005 when the resident sustained identified injuries as a result of the fall.

2) The scope was a level 1, as there was one inspected incident of staff failing to use safe transferring and positioning techniques when assisting residents.

3) The compliance history was a level 2, as the licensee had more than one unrelated area of non-compliance within the last three years.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 13, 2019

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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, 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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 13th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Batten

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