Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 29, 2014	2014_205129_0004	H-000445-13,H-000056-14	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

BAYWOODS PLACE
330 MAIN STREET EAST, HAMILTON, ON, L8N-3T9

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

PHYLLIS HILTZ-BONTJE (129)

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): April 2, 3 and 4, 2014

During the course of the inspection, the inspector(s) spoke with residents, registered and unregulated nursing staff, the staff person responsible for education and training, the Assistant Director of Care, the Director of Care and the Executive Director in relation to Log #H-000445-13, H-000056-14 and H-000039-14.

During the course of the inspection, the inspector(s) observed residents, reviewed clinical documentation, reviewed training documents provided by the home, reviewed documents provided by the home identifying annual evaluations of the Resident Non-Abuse Program and the Falls Management Program and reviewed the home's Resident Non-Abuse policy and Falls Management Program document.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 did not ensure that the written plan of care for each resident set out clear directions to staff and others who prove direct care to the resident, in relation to the following: [6(1)(c)]
a) Resident #001 was identified at risk for falling on admission to the home and began to demonstrate signs of hypotension in May 2013. The physician ordered the resident's blood pressure to be monitored; however there were no indication or directions in the document used by staff to direct care related to hypotension and falling. The resident was admitted to the home on an identified date in 2013 and experienced a unwitnessed fall eight days later, resulting in bruising to the right elbow and knee as well as a possible head injury. The resident experienced a second unwitnessed fall twelve days later, resulting in left shoulder, arm and left sided head pain. Clinical notes written thirteen days after the last fall indicated that on measurement, there was a greater than 20% drop in systolic blood pressure and

concluded this was a sign that the resident was experiencing postural hypotension. The resident experienced a third unwitnessed fall thirty days after the previous fall which resulted in the resident being transferred to hospital where the resident died.
b)Resident #003 complained to the home on an identified date in 2013 about the care being provided by staff with respect to bowel and bladder elimination. Staff confirmed that at the time of this inspection there were no directions in the document use by the home to direct the care for this resident related to bladder and bowel care. [s. 6. (1) (c)]

2. The licensee did not ensure that the staff and others involved in different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other, in relation to the following: [6(4)(a)]
Nursing staff and Physiotherapy staff did not collaborate with each other in the assessment of resident #001 in relation to falls. The resident was admitted to the home on an identified date in 2013 and at that time documentation indicated the resident had a history of falling.
-The day following admission the Physiotherapist assessed the resident in relation to falls and identified the resident at high risk of falling. A day nursing staff completed an assessment of the resident and identified the resident at medium risk for falling. The physiotherapist confirmed that there were no discussions with nursing staff in relation to these assessments, factors leading to the different risk levels identified or possible care to mitigate those risks. The physiotherapist also confirmed that it is the practice in the home that each discipline do separate assessments and place them in the clinical record.
-The resident experienced an unwitnessed fall eight days following admission, resulting in bruising to the right elbow and knee as well as a possible head injury. Staff and clinical documentation confirmed that nursing staff completed a post fall assessment; however, did not collaborate with physiotherapy in relation to this assessment and physiotherapy staff did not complete an assessment of the resident after this fall.
-The resident experienced an unwitnessed fall twelve days after the first fall, resulting in complaints of left shoulder and arm pain as well as left sided head pain. As a result of this fall the resident was transferred to hospital for further assessment of possible injuries. Staff and clinical documentation confirmed that nursing staff completed a post fall assessment but did not discuss this assessment with physiotherapy. The physiotherapist completed an assessment the following day and indicated that the resident was no longer safe to walk with a walker as a result required the use of a

wheelchair for mobility, a bed alarm and a crash mat should be placed on the floor beside the resident's bed and the resident's transfer status should be changed to one person assist. Staff and the clinical record confirmed that this assessment was not discussed with nursing staff and the changes recommended in this assessment were not implemented.
-The resident experienced an unwitnessed fall thirty days after the previous fall which resulted in the resident being transferred to hospital where the resident died. [s. 6. (4) (a)]

3. The licensee did not ensure that the staff and others involved in different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, in relation to the following: [6(4) (b)]

Nursing and physiotherapy staff did not collaborate with each other in the development and implementation of the plan of care related to the risk of falling for resident #001.
-Staff and clinical record documentation confirmed that the physiotherapist assessed the resident a day after the resident had experienced a second fall. As a result of the assessment the physiotherapist indicated the care for the resident was to change in order to prevent further falls and the risk of injury from falling. The changes to the plan of care that were identified by the Physiotherapist included; the resident was no longer safe to use a walker for ambulation and was to use a wheelchair, a bed alarm and fall mats were to be in place for this resident and that the resident's transfer status was now changed to a one person assist to transfer. The physiotherapist confirmed that these changes to the plan of care were not discussed with nursing staff; the changes were not included in the document that provided care directions to staff and these changes were not implemented. The resident experienced an unwitnessed fall thirty days later, was transferred to hospital and died the following day. [s. 6. (4) (b)]

4. The licensee did not ensure that resident #001's plan of care reviewed and revised when the plan was not effective in relation to the following: [6(10)(c)]
Resident #001 was identified at risk for falling and care directions developed four days after admission identified that the goal of care was to promote the resident's safety and the risk factors for falling would be identified and removed and/or managed. The resident fell four days later resulting in bruising to the right elbow and shoulder as well as a possible head injury. Staff and clinical records confirmed that the plan of care

was not reviewed or revised as a result of this fall. The resident experienced a second fall twelve days later, resulting in complaints of left shoulder and arm pain as well as head pain. The resident was transferred to hospital for assessment; however, staff and the clinical record confirmed that the plan of care was not reviewed or revised as a result of this fall. The resident experienced a third unwitnessed fall 30 days later and was transferred to hospital and died the following day. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001, 002, 003 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 did not ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy or program that the policy or program is complied with, in relation to the following: [8(1)b]
a) Staff in the home did not comply with the home's Falls Interventions Risk Management Program [LTC-E-60 (revised April 2013)]. This policy directed that after a resident falls the nurse will review and update the resident's care plan as appropriate.
-This program was not complied with when resident #001 fell eight days after admission and again twelve days after the first fall; however, there were no updates were made to the resident's plan of care since initial falls care plan was developed four days after admission.

b) Staff in the home did not comply with the home's Resident Non-Abuse [LP-C-20-ON (revised date October 2012) policy. This policy directs that all staff members and volunteers will receive annual training in the areas of the Resident Non-Abuse Policy (LP-C-20) and the duty to make mandatory reports.
-This policy was not complied with when documents provided by the home confirmed that 136 out of 157 staff working in the home did not receive annual retraining in 2013 [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy or program, that the policy or program is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the 24 hour admission care plan for resident #001 included any risk of falling and interventions to mitigate those risks in relation to the following: [24(2)1]
Resident #001 was admitted to the home on an identified date in 2013. At the time of admission clinical records included a medical assessment completed three months prior to admission that indicated falls were a current medical condition of the resident and Community Care Access Centre (CCAC) documents identified that the resident had a history of falls prior to admission. Staff and clinical documents confirmed that the 24-hour admission care plan did not include risks for falling or interventions to mitigate those risks. Care directions for staff related to falling were initiated four days post admission. [s. 24. (2) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. A person who had reasonable grounds to suspect that neglect of resident's care needs had occurred did not immediately reported the suspicion and the information upon which it is based to the Director, in relation to the following: [24(1)2]
The Executive Director and the Director of Care had reasonable grounds to suspect that resident #002's care needs had been neglected by staff when on an identified date in 2014 the roommate of resident #002 reported that this resident's care needs were neglected and staff left the resident who required personal care related to bowel elimination uncared for over an extended period of time. The resident making the allegations was interviewed by leadership staff in the home and interview notes confirmed that the roommate rang the call bell to alert staff that resident #002 required care as the resident had been incontinent of stool and containment measures had not been successful. The roommate also reported that staff responded to the call bell; however the bell was turned off and care was not provided to resident #002. The roommate then rang the call bell a second time because the staff person had not returned to provide care and the same staff person entered the room, sprayed air freshener, but did not provide care to resident #002. After a time the roommate left the room looking for staff to assist the resident and located another Personal Support Worker(PSW) who then came to the room and provided care to the resident. Resident #002 had a cognitive impairment and would not have been able to communicate the need for care to staff. Resident #002 was left uncared for after it was brought to the staff's attention that the resident required continence care for approximately one hour. In accordance with the homes policy the staff person involved in this incident received disciplinary action. The Director was not notified for two days after the incident was reported to management when a critical incident report identified as abuse/neglect was submitted to the Hamilton Service Area Office on January 9, 2014 [s. 24. (1) 2.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee did not ensure that all staff received retraining in accordance with LTCHA 2007, S.O. c.8, s 76(4) and O. Reg. 79/10 s. 219(1) in the area of the home's policy to promote zero tolerance of abuse and neglect of residents, in relation to the following: [76(2)3]
Documents provided by the home confirmed that 136 out of 157 staff in the home did not receive training in the area of the home's policy to promote zero tolerance of abuse and neglect of residents in 2013. [s. 76. (2) 3.]

2. The licensee did not ensure that all staff received retraining in accordance with LTCHA 2007, S.O. c.8, s 76(4) and O. Reg. 79/10 s. 219(1) in the area of the duty under section 24 to make mandatory reports, in relation to the following: [76(2)4]
Documents provided by the home confirmed that 136 out of 157 staff in the home did not receive training in the area of the duty under section 24 to make mandatory reports in 2013. [s. 76. (2) 4.]

3. The licensee did not ensure that all staff received retraining in accordance with LTCHA 2007, S.O. c.8, s 76(4) and O. Reg. 79/10 s. 219(1) in the area of falls prevention and management, in accordance with O.Reg. 79/10 s. 221(1)1, in relation to the following: [76(2)11]
Documents provided by the home confirmed that 91 out of 112 staff who were identified as providing direct care to residents, did not receive training in the area of falls prevention and management in 2013. [s. 76. (2) 11.]

Issued on this 5th day of May, 2014

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

Phyllis Hiltz-Bontje

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2014_205129_0004
Log No. / Registre no:	H-000445-13,H-000056-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 29, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BAYWOODS PLACE 330 MAIN STREET EAST, HAMILTON, ON, L8N-3T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 001

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

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 shall prepare, submit and implement a plan to ensure that the plan of care for all residents who are at risk for falling or who have fallen, provides clear direction to staff and others who provide direct care to resident.
The plan shall include, but is not limited to:
1. The development and implementation of a process and schedule for reviewing the plans of care for all current residents at risk of falling or who have fallen.
2. The development and implementation of a mechanism to ensure that all staff who provide direct care to residents, including personal support staff, review the plans of care once developed to ensure that the directions identified in the plan of care provide clear and specific resident focused interventions for care.
The plan is to be submitted on or before May 16, 2014, to Phyllis Hiltz-Bontje by mail at: 119 King Street West, 11th Floor, Hamilton, Ontario L8P 4Y7 or by e-mail at Phyllis.Hiltzbontje@Ontario.ca.

Grounds / Motifs :

1. Previously identified non-compliant on June 22, 2011 as a WN and on March 11, 2014 as a VPV.
2. Two of three plans of care reviewed during this inspection did not provide clear directions to staff and others who provide direct care to residents.
3. Resident #001 was identified at risk for falling on admission to the home and began to demonstrate signs of hypotension, an additional risk for falling, in May 2013. The physician ordered the resident's blood pressure to be monitored; however there were no indications or directions in the document used by staff to direct care related to hypotension and falling. The resident was admitted to the home on an identified date in 2013 and experienced a unwitnessed fall eight days after admission, resulting in bruising to the right elbow and knee as well as a possible head injury. The resident experienced a second unwitnessed fall twelve days later, resulting in left shoulder, arm and left sided head pain. Clinical notes written thirteen days after the last fall indicated that on measurement, there was a greater than 20% change in systolic blood pressure and this note concluded that this was a sign that the resident was experiencing postural hypotension. The resident experienced a third unwitnessed fall thirty days after the previous fall, which resulted in the resident being transferred to hospital where the resident died.
4. Resident #003 complained to the home on an identified date in 2013 about the care being provided by staff with respect to bowel and bladder elimination. Staff confirmed that at the time of this inspection there were no directions in the document use by the home to direct the care for this resident related to bladder and bowel care.
(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 02, 2014

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all staff involved in different aspects of the care for residents who are at risk for falling or who have fallen, collaborate with each other in the assessment of the resident.
The plan shall include, but is not limited to:
1. The identification of individual staff as well as staff groups who are involved in different aspects of care for residents who are at risk for falling or who have fallen.
2. The development and implementation of a process that clearly describes how and when the identified staff will collaborate in the assessment of residents as well as identifying individual staff's responsibility related to the documentation of the outcome of the collaboration related to falls risks and falls.
3. The development and implementation of a training schedule related to the process identified for collaboration in the assessment of falls risk and falls.
4. The development and implementation of a schedule for assessing all current residents who are at risk of falling or who have fallen based on the process identified.
5. The development and implementation of a system of ongoing monitoring to ensure staff comply with the process identified.
The plan is to be submitted on or before May 16, 2014, to Phyllis Hiltz-Bontje by mail at: 119 King Street West, 11th Floor, Hamilton, Ontario L8P 4Y7 or by e-mail at Phyllis.Hiltzbontje@Ontario.ca.

Grounds / Motifs :

1. Previously identified as non-complaint on October 25, 2012 as a VPC
2. Staff and others involved in different aspects of the care for resident #001 did not collaborate in the assessment of the risk for falling or the assessment of this resident after falling. The resident fell three times over a 44 day period and the third fall resulted in the resident being transferred to hospital were the resident died.
3. Nursing staff and Physiotherapy staff did not collaborate with each other in the assessment of resident #001 in relation to falls. The resident was admitted to the home on an identified date in 2013 and at that time documentation indicated the resident had a history of falling.

-The day following admission the Physiotherapist assessed the resident in relation to falls and identified the resident at high risk of falling. A day after the Physiotherapist assessed the resident nursing staff assessed the resident as being a medium risk for falling. The physiotherapist confirmed that there were no discussions with nursing staff in relation to these assessments, factors leading to the different risk levels identified or possible care to mitigate those risks. The physiotherapist also confirmed that it is the practice in the home that each discipline do separate assessments and place them in the clinical record.

-The resident experienced an unwitnessed fall eight days after admission,which resulted in bruising to the right elbow and knee as well as a possible head injury. Staff and clinical documentation confirmed that nursing staff completed a post fall assessment; however, did not collaborate with physiotherapy in relation to this assessment and physiotherapy did not complete an assessment of the resident after this fall.

-The resident experienced an unwitnessed fall twelve days after the first fall, which resulted in complaints of left shoulder and arm pain as well as left sided head pain. As a result the these injuries the resident was transferred to hospital for further assessment. Staff and clinical documentation confirmed that nursing staff completed a post fall assessment but did not discuss this assessment with physiotherapy staff. The physiotherapist completed an assessment the day after this fall and indicated that the resident was no longer safe to walk with a walker as a result required the use of a wheelchair for mobility, a bed alarm and a crash mat should be placed on the floor beside the resident's bed and the resident's transfer status should be changed to one person assist. Staff and the clinical record confirmed that this assessment was not discussed with nursing staff and the changes recommended in this assessment were not implemented.

-The resident experienced an unwitnessed fall thirty days after the previous fall,

which resulted in the resident being transferred to hospital where the resident died. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 02, 2014

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee shall ensure that all staff involved in different aspects of care for residents who are at risk of falling or who have fallen, collaborate with each other in the development of the plan of care related to falls management.

Grounds / Motifs :

1. Previously identified as non-compliant on September 28, 2011 as a VPC and on March 11, 2014 as a VPC.
2. Staff and others involved in different aspects of the care for resident #001 did not collaborate in the development of the plan of care related to risk for falling and falls.. The resident fell three times over a 44 day period and the third fall resulted in the resident being transferred to hospital were the resident died
3. Nursing and physiotherapy staff did not collaborate with each other in the development and implementation of the plan of care related to the risk of falling for resident #001.
-Staff and clinical record documentation confirmed that the physiotherapist assessed the resident a day after the resident experienced a second fall. As a result of the assessment the physiotherapist indicated the care for the resident was to change in order to prevent further falls and the risk of injury from falling. The changes to the plan of care that were identified by the Physiotherapist included; the resident was no longer safe to use a walker for ambulation and was to use a wheelchair, a bed alarm and fall mats were to be in place for this resident and that the resident's transfer status was now changed to a one person assist to transfer. The physiotherapist confirmed that these changes to the plan of care were not discussed with nursing staff; the changes were not included in the document that provided care directions to staff and these changes were not implemented. The resident experienced an unwitnessed fall thirty days later, was transferred to hospital and died the following day. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 02, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 29th day of April, 2014

Signature of Inspector / Signature de l'inspecteur : Phyllis Hiltz-Bontje

Name of Inspector / Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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