Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 2, 2019	2019_782736_0023	016650-19, 017368-19	Critical Incident System

Licensee/Titulaire de permis

Victoria Village Inc.
76 Ross Street BARRIE ON L4N 1G3

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

Victoria Village Manor
78 Ross Street BARRIE ON L4N 1G3

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

AMANDA BELANGER (736)

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): September 5- 6, and September 9-10, 2019.

During the course of this Critical Incident Inspection, the following logs were inspected:
-one log related to a report of an unexpected death, and,
-one log related to a report of a fall with injury and significant change in health status.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Nursing Services (DONS), Associate Director of Nursing Services (ADONS), Registered Nurse(s) (RNs), Registered Practical Nurse(s) (RPNs), Personal Support Worker(s) (PSWs), and, Dietary Aide(s).

During the course of the inspection, the Inspector(s) observed the provision of care, completed observations of the resident home area(s), reviewed resident health records, relevant staff records, as well as internal investigation notes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (1) Every licensee of a long-term care home shall ensure that there is at least one nutrition manager for the home, one of whom shall lead the nutrition care and dietary services program for the home. O. Reg. 79/10, s. 75 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one nutrition manager in the home, one whom was to lead the nutrition care and dietary services program for the home.

A Critical Incident (CI) report was submitted to the Director related to an unexpected death of a resident.

Inspector #736 was informed by the Chief Executive Officer (CEO) that the position of Nutrition Manager (NM) was vacant at the time of the inspection, however, there was a successful candidate whom had accepted the role as of mid-September 2019.

The Inspector requested and reviewed the file of the previous NM #113 and noted that they had not been in the position effective a specified date early in the summer of 2019.

In an interview with the Director of Nursing Services (DONS), they indicated that since the date when NM #113 was no longer in the position at the home, themselves and the Associate Director of Nursing Services (ADONS) #102 had been covering the position. The DONS indicated that neither themselves or the ADONS held the qualifications required to be in the nutrition manager position.

In an interview with the CEO, they indicated to the Inspector that the NM position had been vacant since a specified date in the spring of 2019, and that the DONS and ADONS had been covering the position, with the ADONS being the lead of the dietary program up until that point. The CEO indicated that neither the DONS or the ADONS had the qualifications to be the NM, and that the home had hired a NM that was set to start in the home as of mid-September 2019. The CEO indicated that the home had not met the required hours of a NM from the time the position came vacant in early summer 2019 until the time of inspection. [s. 75. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining service provided for personal assistance for residents to eat as safety and independently as possible.

A CI report was submitted to the Director, related to resident #001, who had a medical emergency and subsequently had a significant change in health status. The CI report was amended to indicate that the resident was to have a specified diet with a specified intervention, and a specified fluid consistency, however, had been provided with a meal that did not have the specified intervention provided.

A review of the Prescriber's Orders form indicated that on a specified date, resident #001 returned to the home, and had a specialized assessment completed. The direction on the assessment indicated to provide the resident with a specified diet, that dietary was to provide a specified intervention with certain foods to a specified measurement.

A review of the resident's care plan at the time of the incident, as well as the dining selection tool, indicated that the resident was to have the specified diet that dietary was to provide a specified intervention to certain foods to a specified measurement.

In separate interviews with Personal Support Workers (PSWs) #104, #105, #106 and #107, as well as Registered Practical Nurse (RPN) #103, and Dietary Aide (DA) #112, they indicated to the Inspector that they were aware that resident #001 had required a specified diet with a specified intervention. None of the staff interviewed by the Inspector were aware of whose responsibility it was to provide the interventions to the resident prior to being served their meal.

In an interview with DA #112, they indicated to the Inspector that they had served the food for resident #001 during the meal service on the specified date. They further indicated that they were aware the resident required a specified intervention, however,

they did not provide the specified intervention as required, as they thought that the PSW would provide the specified intervention prior to giving it to the resident.

In an interview with PSW #107, they indicated to the Inspector that on the specified date, they had provided resident #001 with their selected meal choice, however, they were unaware that the resident required a specified intervention, and therefore, did not provide the specified intervention to the resident's meal prior to providing the meal to the resident.

In a review of the policy titled "Pleasurable Dining Responsibilities and Dining Room Service Process", XI-10.00, issued November 2013, indicated that the Dietary Staff would refer to the dining selection tool to ensure that residents received the correct diet/texture/fluid consistency.

In a review of the policy titled "Pleasurable Dining", VII-I-20.00, last revised July 2017, indicated that the PSW would check the Dining Selection Tool to verify that the meal being served corresponded to the meal provided.

In an interview with the DONS, they indicated to the Inspector that until resident #001 had a medical emergency, they were unaware that any residents in the home were ordered to have the specified diet with a specified intervention. The DONS further indicated that based on the home's investigation into the incident of resident #001, they were unsure of who was responsible to provide the assistance required for resident #001 to eat as safety and independently as possible. [s. 73. (1) 9.]

Additional Required Actions:

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

WN #3: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for a resident provided clear direction to staff providing care.

A CI report was submitted to the Director related to resident #001 who had a medical emergency, and subsequently had a significant change in health status.

Inspector #736 reviewed the Prescriber's Orders form, which indicated that on a specified date, the dietitian changed the resident's fluid consistency from one consistency to another.

A review of the resident's care plan at the time of the incident indicated that the resident was to have the fluid consistency as per the dietitian.

Inspector #736 reviewed the diet roster sheets for resident #001 and noted that it indicated to staff to provide the fluid consistency as per the dietitian.

Inspector #736 then reviewed the diet selection tool for resident #001 and noted that it indicated to staff to provide the fluid consistency that was not ordered by the dietitian.

In separate interviews with PSW #106 and RPN # 113, as well as DA #112 they indicated that nursing staff used the diet roster sheets to provide fluids to the residents, and used the diet selection tool to track what each resident requested for the meal. The staff members also indicated that both sheets should have provided the same direction for food and fluid consistency for each resident. Together with the Inspector, PSW #106, RPN #113, and DA #112 reviewed the diet selection tool and diet roster. The PSW, RPN and DA all indicated to the Inspector that as the diet roster indicated that resident #001 was to receive the fluids as per the dietitian, and the diet selection tool indicated that the resident was to receive a different consistency of fluids; it did not provide clear direction to staff who were providing care.

In an interview with the DONS, they explained to the Inspector that staff would use the resident's care plan, as well as the diet roster and diet selection tool when providing the resident with meals and snacks. The DONS further explained that the diet roster was used by nursing staff when providing fluids in the dining room, and that the diet selection tool was used to record what each resident wanted for the meal. The DONS also explained that the dietary aide had access to both the diet roster and the diet selection tool, however, used the diet selection tool while plating a resident's meal. Together, the DONS and the Inspector reviewed the diet roster and diet selection tool for resident #001. The DONS indicated that the fluid consistency was not the same on both sheets, however, felt that it still provided clear direction to staff, as the dietary staff did not provide fluids 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 set out in the plan of care.

A CI report was submitted to the Director on a specified date related to resident #001, who has a medical emergency and subsequently had a significant change in health status. The CI report was amended to indicate that the resident was to have a specified diet texture with a specified intervention and a specified fluid consistency, however, had been provided with a meal that did not have the interventions provided.

A review of the progress notes for resident #001 indicated that on the specified date, staff noted the resident to be having a medical emergency and called for RPN #103 to come to assist. The progress notes further indicated that a specified medical intervention B was initiated.

A further review of resident #001's clinical records indicated that the resident was not to

receive medical intervention B.

In an interview with RPN #103, they indicated that when they were called to assist resident #001, they initiated medical intervention B.

In an interview with Registered Nurse (RN) #108, they indicated to the Inspector that they had responded to resident #001 and that staff had initiated specified medical intervention B.

The Inspector reviewed a policy of the licensee related to medical interventions.

In an interview with the DONS, they indicated to the Inspector that they were aware that staff had initiated specified medical intervention B on resident #001. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care was documented.

A CI report was submitted to the Director, related to a fall with injury, that resulted in a transfer to hospital. The CI report further indicated that resident #002 fell, and was transferred to hospital. The CI report was amended to indicate that the resident had a significant change in health status.

A specified document was reviewed by the Inspector which provided instructions to staff on how and when to complete the document.

a) A review of resident #002's post fall notes by Inspector #736 indicated that the resident had sustained an unwitnessed fall with a specific injury on a specified date.

Inspector #736 reviewed the identified document and noted missing documentation.

b) A review of resident #002's post fall notes by Inspector #736 indicated that the resident had sustained an unwitnessed fall and was noted to have a specified injury on a second specified date.

Inspector #736 reviewed the identified document and noted missing documentation.

c) A review of resident #002's post fall notes by Inspector #736 indicated that the resident had sustained an unwitnessed fall with a specified injury on a third specified date.

Inspector #736 reviewed the identified document and noted missing documentation.

d) A review of resident #002's progress notes by Inspector #736 indicated that the resident had sustained a fall on a fourth specified date. RPN #109 documented that they were unable to fully complete the document with a corresponding reason.

In a review of resident #002's clinical records, the Inspector was unable to locate the document from the fall on the fourth specified date.

In an interview with RPN #109, they indicated to the Inspector that they had started the document, however, described why they could not complete it. The RPN was unsure of where the form was located after they had initiated it.

The Inspector requested that the DONS locate the document for resident #002, from their fall on the fourth specified date. The DONS was unable to locate the document.

e) A review of the progress notes for resident #003 by Inspector #736 indicated that the resident had sustained a fall on a specified date.

Inspector #736 reviewed the resident's chart and located the identified document, which indicated that there was missing documentation.

In an interview with RPN #115, they indicated to the Inspector that for any resident who had fallen, staff were to initiate and complete a specific document. Together, the RPN and the Inspector reviewed the identified documents for resident #002 from the three specified dates. The RPN indicated that the documents were not completed in their entirety and that they should have been. The RPN further indicated to the Inspector that the care was not documented as set out in the plan of care related to the specified document for resident #002.

Together, the RPN and the Inspector reviewed the identified document for resident #003 for the specified date. The RPN indicated that the document was not filled out in its entirely, and therefore, the care was not documented as set out in the plan of care.

The Inspector reviewed a licensee policy related to documentation specific to falls.

In an interview with the DONS, they indicated to the Inspector that when a resident had

fallen, the documentation was started as per the directions on the form. Together, the DONS and the Inspector reviewed resident #002's identified document from the three specified dates; as well as the specified document for resident #003 on the specified date. The DONS indicated that the residents should have had their identified documents completed in their entirety. The DONS further indicated that as the identified documents were not completed in their entirety, the care set out in resident #002 and #003's plans of care, were not documented and should have been. The DONS indicated that for resident #002's fall on the fourth specified date, they were unsure of where the document was located. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 the plan of care provides clear direction to staff providing resident care, to be implemented voluntarily.

WN #4: 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. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for specific types of critical incidents, that happened after normal business hours, the Director was notified immediately using the Ministry's method for after hours emergency contact.

A CI report was submitted to the Director. The CI report indicated that resident #001 had a medical emergency and had a significant change in health status one day prior to the report being submitted. The CI report also indicated that the Ministry of Health and Long-Term Care after hours pager was not contacted regarding the incident.

In an interview with Inspector #736, the DONS clarified that the resident had a medical emergency and significant change in health status on the same date the CI report was submitted, during a specified meal service, and that the date, was entered into the CI report in error.

A review of resident #001's progress notes by Inspector #736 indicated that at a specified time on the specified date, staff noted that the resident was having a medical emergency.

A memo posted on the Long Term Care Homes site December 18, 2018, clarified for the sector the mandatory reporting requirements related to the Long Term Care Home's Act and Regulations. This memo included a "Reporting Requirements Tip Sheet", which directed the home for a specific type of critical incident, the home was to report immediately during normal business hours (0830-1630 hours) using the CI system portal, and after hours, to call the Service Ontario After Hours Line, and submit the CI report the next business day.

In an interview with the DONS, they indicated to the Inspector that they were present in the home on the specified date, when resident #001 began to have a medical emergency. The DONS indicated that the resident had the medical emergency after a specified time. The DONS indicated that they were aware of the memo related to mandatory and immediate reporting, however, they submitted the CI report online, and were unaware that they were required to call the after hours pager.

In an interview with the CEO, they indicated that they were aware of the memo from the Director related to mandatory and immediate reporting, however, the DONS was responsible to submit the CI report. The CEO was unsure if the after hours pager was contacted in relation the incident involving resident #001. [s. 107. (2)]

Issued on this 3rd day of October, 2019

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care 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) :	AMANDA BELANGER (736)
Inspection No. / No de l'inspection :	2019_782736_0023
Log No. / No de registre :	016650-19, 017368-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 2, 2019
Licensee / Titulaire de permis :	Victoria Village Inc. 76 Ross Street, BARRIE, ON, L4N-1G3
LTC Home / Foyer de SLD :	Victoria Village Manor 78 Ross Street, BARRIE, ON, L4N-1G3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bill Krever

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 75. (1) Every licensee of a long-term care home shall ensure that there is at least one nutrition manager for the home, one of whom shall lead the nutrition care and dietary services program for the home. O. Reg. 79/10, s. 75 (1).

Order / Ordre :

The licensee must be compliant with O.Reg 75(1).

Specifically, the licensee must ensure that there is a nutrition manager in the home, one whom is to lead the nutrition care and dietary services program for the home.

Grounds / Motifs :

1. The licensee has failed to ensure that there was at least one nutrition manager in the home, one whom was to lead the nutrition care and dietary services program for the home.

A Critical Incident (CI) report was submitted to the Director related to an unexpected death of a resident.

Inspector #736 was informed by the Chief Executive Officer (CEO) that the position of Nutrition Manager (NM) was vacant at the time of the inspection, however, there was a successful candidate whom had accepted the role as of mid-September 2019.

The Inspector requested and reviewed the file of the previous NM #113 and noted that they had not been in the position effective a specified date early in the summer of 2019.

In an interview with the Director of Nursing Services (DONS), they indicated that since the date when NM #113 was no longer in the position at the home, themselves and the Associate Director of Nursing Services (ADONS) #102 had

been covering the position. The DONS indicated that neither themselves or the ADONS held the qualifications required to be in the nutrition manager position.

In an interview with the CEO, they indicated to the Inspector that the NM position had been vacant since a specified date in the spring of 2019, and that the DONS and ADONS had been covering the position, with the ADONS being the lead of the dietary program up until that point. The CEO indicated that neither the DONS or the ADONS had the qualifications to be the NM, and that the home had hired a NM that was set to start in the home as of mid-September 2019. The CEO indicated that the home had not met the required hours of a NM from the time the position came vacant in early summer 2019 until the time of inspection.

The severity of this issue was determined to be a level 3 as there was actual risk to the residents. The scope of the issue was a level 3 as it related to all residents in the home. The home had a level 2 compliance history of one or more non-compliances, none of which were for the same subsection. (736)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 22, 2019

Ontario

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with O. Reg 73(1).

Specifically, the licensee must ensure that residents are provided with the assistance required to eat as safety and independently as possible.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee has failed to ensure that the dining service provided for personal assistance for residents to eat as safety and independently as possible.

A CI report was submitted to the Director, related to resident #001, who had a medical emergency and subsequently had a significant change in health status. The CI report was amended to indicate that the resident was to have a specified diet with a specified intervention, and a specified fluid consistency, however, had been provided with a meal that did not have the specified intervention provided.

A review of the Prescriber's Orders form indicated that on a specified date, resident #001 returned to the home, and had a specialized assessment completed. The direction on the assessment indicated to provide the resident with a specified diet, that dietary was to provide a specified intervention with certain foods to a specified measurement.

A review of the resident's care plan at the time of the incident, as well as the dining selection tool, indicated that the resident was to have the specified diet that dietary was to provide a specified intervention to certain foods to a specified measurement.

In separate interviews with Personal Support Workers (PSWs) #104, #105, #106 and #107, as well as Registered Practical Nurse (RPN) #103, and Dietary Aide (DA) #112, they indicated to the Inspector that they were aware that resident #001 had required a specified diet with a specified intervention. None of the staff interviewed by the Inspector were aware of whose responsibility it was to provide the interventions to the resident prior to being served their meal.

In an interview with DA #112, they indicated to the Inspector that they had served the food for resident #001 during the meal service on the specified date. They further indicated that they were aware the resident required a specified intervention, however, they did not provide the specified intervention as required, as they thought that the PSW would provide the specified intervention prior to giving it to the resident.

In an interview with PSW #107, they indicated to the Inspector that on the specified date, they had provided resident #001 with their selected meal choice,

however, they were unaware that the resident required a specified intervention, and therefore, did not provide the specified intervention to the resident's meal prior to providing the meal to the resident.

In a review of the policy titled "Pleasurable Dining Responsibilities and Dining Room Service Process", XI-10.00, issued November 2013, indicated that the Dietary Staff would refer to the dining selection tool to ensure that residents received the correct diet/texture/fluid consistency.

In a review of the policy titled "Pleasurable Dining", VII-I-20.00, last revised July 2017, indicated that the PSW would check the Dining Selection Tool to verify that the meal being served corresponded to the meal provided.

In an interview with the DONS, they indicated to the Inspector that until resident #001 had a medical emergency, they were unaware that any residents in the home were ordered to have the specified diet with a specified intervention. The DONS further indicated that based on the home's investigation into the incident of resident #001, they were unsure of who was responsible to provide the assistance required for resident #001 to eat as safety and independently as possible.

The severity of this issue was determined to be a level 4 as there was serious harm to the resident. The scope of the issue was a level 1, as it related to one resident. The home had a level 2 compliance history of one or more non-compliances, none of which were for the same subsection. (736)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 22, 2019

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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. (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Order / Ordre :

The licensee must be compliant with s. 6(9) of the LTCHA.

Specifically, the licensee must ensure:

a) that the care set out in the plan of care is documented,

b) develop and implement an audit tool and process to ensure that specified documents are completed in their entirely, including the dates of the audits, the outcomes, and the name of the person completing the audits,

c) keep a record of any deficiencies identified in the audit from part b, and document actions taken.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was documented.

A CI report was submitted to the Director, related to a fall with injury, that resulted in a transfer to hospital. The CI report further indicated that resident #002 fell, and was transferred to hospital. The CI report was amended to indicate that the resident had a significant change in health status.

A specified document was reviewed by the Inspector which provided instructions to staff on how and when to complete the document.

a) A review of resident #002's post fall notes by Inspector #736 indicated that the resident had sustained an unwitnessed fall with a specific injury on a specified date.

Inspector #736 reviewed the identified document and noted missing documentation.

b) A review of resident #002's post fall notes by Inspector #736 indicated that the resident had sustained an unwitnessed fall and was noted to have a specified injury on a second specified date.

Inspector #736 reviewed the identified document and noted missing documentation.

c) A review of resident #002's post fall notes by Inspector #736 indicated that the resident had sustained an unwitnessed fall with a specified injury on a third specified date.

Inspector #736 reviewed the identified document and noted missing documentation.

d) A review of resident #002's progress notes by Inspector #736 indicated that the resident had sustained a fall on a fourth specified date. RPN #109 documented that they were unable to fully complete the document with a corresponding reason.

In a review of resident #002's clinical records, the Inspector was unable to locate the document from the fall on the fourth specified date.

In an interview with RPN #109, they indicated to the Inspector that they had started the document, however, described why they could not complete it. The RPN was unsure of where the form was located after they had initiated it.

The Inspector requested that the DONS locate the document for resident #002, from their fall on the fourth specified date. The DONS was unable to locate the document.

e) A review of the progress notes for resident #003 by Inspector #736 indicated that the resident had sustained a fall on a specified date.

Inspector #736 reviewed the resident's chart and located the identified document, which indicated that there was missing documentation.

In an interview with RPN #115, they indicated to the Inspector that for any resident who had fallen, staff were to initiate and complete a specific document. Together, the RPN and the Inspector reviewed the identified documents for resident #002 from the three specified dates. The RPN indicated that the documents were not completed in their entirety and that they should have been. The RPN further indicated to the Inspector that the care was not documented as set out in the plan of care related to the specified document for resident #002.

Together, the RPN and the Inspector reviewed the identified document for resident #003 for the specified date. The RPN indicated that the document was not filled out in its entirely, and therefore, the care was not documented as set out in the plan of care.

The Inspector reviewed a licensee policy related to documentation specific to falls.

In an interview with the DONS, they indicated to the Inspector that when a resident had fallen, the documentation was started as per the directions on the form. Together, the DONS and the Inspector reviewed resident #002's identified document from the three specified dates; as well as the specified document for resident #003 on the specified date. The DONS indicated that the residents should have had their identified documents completed in their entirety. The DONS further indicated that as the identified documents were not completed in their entirety, the care set out in resident #002 and #003's plans of care, were not documented and should have been. The DONS indicated that for resident #002's fall on the fourth specified date, they were unsure of where the document was located

The severity of this issue was determined to be a level 2 as there was minimal risk of harm to the residents. The scope of the issue was a level 2 as it related to

two of three residents reviewed.
The home had a level 3 history of on-going non-compliance with this subsection of the Act that included:
-a Voluntary Plan of Correction (VPC) issued June 6, 2018 (2018_638609_0009), and,
-a VPC issued June 13, 2019 (2019_772691_0007). (736)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 18, 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

Ontario

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

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 2nd day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amanda Belanger

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