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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
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Amended Public Copy/Copie modifiée 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
Jul 17, 2019	2019_766500_0012 (A1)	026471-18, 029784-18, 030181-18, 001168-19, 001191-19, 006302-19, 008090-19	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor
TORONTO ON M4W 3L4

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

Wesburn Manor
400 The West Mall ETOBICOKE ON M9C 5S1

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

Amended by NITAL SHETH (500) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date was extended from August 30, 2019 to September 30, 2019.

Issued on this 17th day of July, 2019 (A1)

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

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*

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

Amended by NITAL SHETH (500) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 11, 16, 17, 18, 23, 24, 25, 26, 29, 30, May 1, 2019.

The following intakes were completed during this inspection:

Logs #008090-19, #029784-18, #001168-19, #001191-19 related to falls prevention, #006302-19 related to duty to protect and falls prevention, #026471-18 related to improper transfer and falls prevention, #030181-18 related to minimizing restraint.

A non-compliance identified for resident #007, under plan of care s. 6. (11) (b), during complaint inspection #2019_766500_0013 for intake logs #: 026830-18, #030012-18, #001438-19, which was completed during the same time period, is issued in this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Managers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

During the course of the inspection, the inspector observed staff to resident interactions, residents' care areas, reviewed residents' health records, and the homes' policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.
3 WN(s)
2 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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

Findings/Faits saillants :

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

A review of a Critical Incident System (CIS) report and progress note, indicated that resident #002 had a fall on an identified day, during care, witnessed by the Personal Support Worker (PSW) #105. The Registered Practical Nurse (RPN) #106 was alerted by the assigned PSW #105 of the resident's fall. The RPN went to the room, and found the resident on the floor, and moderate amount of blood was noted on an identified area of the resident's body due to an injury. As per the staff, while they were providing care, the resident rolled out of the bed, bed rail was noted in downward position.

A review of the care plan indicated that the resident required total assistance from two staff for a specified care. Bed rails on both sides of the bed to be applied.

Interview with PSW #105 indicated that they put the resident's rails down, and was helping the resident from the opposite side. The resident was holding the rail which was down and rolled down onto the floor. The PSW indicated that they leaned over and tried to protect the resident but was not able to and the resident fell on the floor. The PSW indicated that they should have used two staff for care,

and apply the rail and accepted their mistake.

Interview with RPN #106, #110, RN #112, and DOC indicated that PSWs are expected to provide care set out in the resident's care plan.[s. 6. (7)]

2. A review of a CIS report indicated that on an identified day, resident #003 was neglected by staff during care. As a result the resident fell from the bed onto the floor and sustained an injury.

A review of the resident's care plan indicated that the resident required total assistance from two staff for a specified care activity, as the resident was unable to focus on the task.

Interview with PSW #113 indicated that the resident had a fall incident while receiving care from them and sustained an injury. PSW #113 indicated that they are expected to follow the resident's care plan.

Interview with RPN #106, #110, Registered Nurse (RN) #112, and Director of Care (DOC) indicated that PSWs are expected to provide care set out in the resident's care plan.

This non-compliance was issued as the staff members put the residents at risk by not implementing the care outlined in their plans of care. [s. 6. (7)]

3. The licensee has failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care.

A review of a CIS report indicated that on an identified day, resident #003 was neglected by staff during care. As a result the resident fell from the bed onto the floor and sustained an injury.

A review of the resident's care plan indicated that the resident required total assistance from two staff for a specified care activity, as the resident was unable to focus on task.

A review of a progress note indicated that the PSW called the RPN on an identified day. The RPN found the resident lying on the floor. The resident was unable to explain what happened. The PSW stated the resident was sitting on the bed and the PSW was helping the resident with a specified care activity. PSW

went to the resident's closet to grab the required items for care and at the same time the resident fell onto the floor.

Interview with PSW #113, indicated that they were not aware of the resident's care plan, as they do not get enough time to review the resident's care plan upon starting of their shift. They do not work regularly with the resident and they pick up shifts on various floors. PSW #113 confirmed that they are expected to be aware of the residents' care plan and implement it.

Interview with RPN #110, RN #112, and DOC indicated that PSWs are expected to be aware of the content of residents' care plans and able to implement it.

This non-compliance was issued as the staff put the resident at risk by not being aware of the content of the resident's care plan. [s. 6. (8)]

4. The licensee has failed to ensure that when a resident is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective, the licensee ensured that different approaches are considered in the revision of the plan of care.

A review of a CIS report indicated that resident #006 was found on the floor in a common area of the home on an identified day with an injury and bilateral limbs were partially resting on an identified device. The resident passed away in the hospital the following day.

A review of the resident's written care plan indicated that the resident had a responsive behaviour and was at high risk for falls, the goal identified was to keep the resident free from falls and potential injury. There were six falls prevention interventions included the resident's plan of care.

A review of the resident's clinical record indicated that the resident had six falls in a two month time period, three with injury.

Interview with RPNs #110 and #108 indicated that the resident's falls prevention care plan was not effective as the resident continued falling.

Interview with RN #109 indicated that it was difficult to say that the resident's care plan was effective as the resident was continuously falling.

Interview with Nurse Manager #111 indicated that the care plan was not effective and different approaches should have been considered. [s. 6. (11) (b)]

5. A review of a complaint received by the Ministry of Health and Long-term Care (MOHLTC), indicated that resident #007 had a fall on an identified day, which resulted in injury and raised a concern about the resident's safety in the home.

A review of a CIS report indicated that resident #007 had a fall on an identified day and sustained injuries. The resident denied any pain. After a few hours, the RPN reported the resident having severe pain and the resident was assessed by the nurse practitioner, sent to the hospital and diagnosed with an injury.

The care plan indicated that the resident had an identified number of falls in 2017.

A review of the resident's care plan indicated that resident #007 was at high risk for falls, and there were nine falls prevention interventions included in their plan of care.

A review of the resident's clinical record including progress notes, and post fall huddle assessments indicated that the resident had more falls in 2018 than in 2017, two with injury.

Interview with PSW #117 indicated that the resident was at high risk for falls and the staff were trying their best to monitor the resident, however, it was not effective and the resident continued to fall.

Interview with RPN #118 and Nurse Manager #103 indicated that there were falls preventions strategies in place for the resident but the resident would not ask for assistance and continued to fall.

A review of the home's policy #RC-0518-21, entitled, "Falls Prevention and Management", published, January 10, 2016, indicated that all residents who have fallen require an interdisciplinary team assessment to clearly understand the contributing factors and appropriate interventions to prevent further falls. Any risk contributing factors identified shall be followed up by the nurse. Methods to reduce risk of falls including to formulate individualized strategies based on the resident's condition and assessed needs to prevent and manage falls and the injury related to falls including the type of equipment, safety interventions and restorative approaches. Review, conduct care conference and revised care plan

when the evaluation of interventions demonstrates that the interventions are ineffective.

Interview with Nurse Manager #111 indicated that different approaches should have been considered when the resident had frequent falls.

This non-compliance was issued due to:
-a result of the resident's fall with significant change in health status,
-a significant history of multiple falls,
-the home not considering different approaches, being aware about the resident's increased risk for falls while wandering with unsteady gait in the home area. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 001,002

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

A review of a CIS report indicated that resident #006 was found on the floor in a

common area of the home an identified day with an injury and bilateral limbs were partially resting on an identified device. The resident passed away in the hospital the following day.

A review of the resident's written care plan indicated that the resident had a responsive behaviour and was at high risk for falls, the goal identified was to keep the resident free from falls and potential injury. There were six falls prevention interventions included the resident's plan of care.

A review of resident #006's progress notes indicated that on an identified day, the physician assessed the resident and indicated that it appeared that the resident fell over the identified device.

Interview with PSW #107 indicated that on an identified day, they could not locate resident #006, and initiated a search for the resident on the unit. PSW #107 went to an identified common area to look for the resident. They found the resident on the floor with injury and bilateral limbs partially rested on an identified device. PSW #107 indicated that the fall was unwitnessed, but it looked like the resident injured themselves on the identified device. The PSW confirmed that the residents' common areas should be free from any clutter, equipment and safe for residents. The PSW confirmed that if the identified device was not there, the injury or incident could have been prevented.

Interview with RPN #108 indicated that it looked like the resident tripped on the identified device and fell. Due to severity of the injury, the resident was sent to the hospital immediately as directed by the physician. RPN #108 indicated that the resident's environment should be safe at all times, and if the identified device was not here, the injury or incident could have been prevented.

Interview with RN #109 indicated that the resident's environment should be safe all the time.

A review of the home's policy #RC-0518-21, entitled, "Falls Prevention and Management", published, January 10, 2016, indicated that the interdisciplinary team will perform environmental rounds to promote safe environment.

Interview with Nurse Manager #111 indicated that the identified device was removed from the identified common area of the home, after the above mentioned incident involving resident #006, and indicated that nobody identified it as a risk.

This non-compliance was issued as the resident sustained significant injury and as a result of a fall, due to the unsafe environment. [s. 5.]

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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

For the purposes of the Act and Regulation, O. Reg. 79/10, s. 5, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A review of a CIS report indicated that on an identified day, resident #003 was neglected by staff during care activity. As a result the resident fell from the bed

onto the floor and sustained an injury.

A review of the resident's care plan indicated that the resident required total assistance from two staff for a specified care activity, as the resident was unable to focus on the task.

Interview with PSW #113 indicated that the resident had a fall incident while receiving care from them and sustained an injury. PSW #113 indicated that they are expected to follow the resident's care plan.

A review of the home's investigation notes indicated that the identified staff member's actions towards resident #003 were unacceptable and contrary to the home's policy on Zero Tolerance of Abuse and Neglect. [s. 19. (1)]

2. A review of a CIS report and progress note, indicated that resident #002 had a fall on an identified day, during care, witnessed by the Personal Support Worker (PSW) #105. The Registered Practical Nurse (RPN) #106 was alerted by the assigned PSW #105 of the resident's fall. The RPN went to the room, and found the resident on the floor, and moderate amount of blood was noted on an identified area of the resident's body due to an injury. As per the staff, while they were providing care, the resident rolled out of the bed, bed rail was noted in downward position.

A review of the care plan indicated that the resident required total assistance from two staff for a specified care. Bed rails on both sides of the bed to be applied.

Interview with PSW #105 indicated that they put the resident's rails down, and was helping the resident from the opposite side. The resident was holding the rail which was down and rolled down onto the floor. The PSW indicated that they leaned over and tried to protect the resident but was not able to and the resident fell on the floor. The PSW indicated that they should have used two staff for care, and apply the rail and accepted their mistake.

Interview with RPN #106 indicated that the resident had a fall rolling out of the bed and sustained an injury. The PSW said that they were providing a specified care activity to the resident, and the resident rolled out of the bed and fell on the floor. RPN #106 indicated the PSW should have asked for help and followed the care plan.

A review of the home's investigation notes indicated that the identified staff member did not follow the resident's care plan and violated the home's policy on safety and Zero Tolerance of Abuse and Neglect.

A review of the home's policy entitled, "Zero Tolerance of Abuse and Neglect", published, January 8, 2016, indicated that the home will neither tolerate the abuse and neglect of any resident in the home by staff or volunteers, nor condone the abuse and neglect of any resident by any other person at the home.

Interview with the DOC indicated that the identified staff members were disciplined for not following a care plan and neglecting the resident.

This non-compliance was issued as a result of staff neglecting the resident, by not following their care plans during care which resulted in jeopardizing the residents' safety. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 17th day of July, 2019 (A1)

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by NITAL SHETH (500) - (A1)
Inspection No. / No de l'inspection :	2019_766500_0012 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	026471-18, 029784-18, 030181-18, 001168-19, 001191-19, 006302-19, 008090-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 17, 2019(A1)
Licensee / Titulaire de permis :	City of Toronto c/o Seniors Services and Long-Term Care, 365 Bloor Street East, 15th Floor, TORONTO, ON, M4W-3L4
LTC Home / Foyer de SLD :	Wesburn Manor 400 The West Mall, ETOBICOKE, ON, M9C-5S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Schendel

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

To City of Toronto, 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

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

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

Order / Ordre :

The licensee must be compliant with s. 6. (7) of the LTCHA, 2007. Specifically, the licensee must do the following:

1. Develop a system that provides opportunity for all direct care staff including Personal Support Workers (PSWs) and Registered Staff to be aware of the content of residents' plans of care, in order to implement them.
2. Conduct monthly audits by a designate to ensure that residents receive care as indicated in their care plans, and develop and implement action plans based on the outcome of the evaluation of these audits. Keep and maintain record of the audits.

Grounds / Motifs :

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

A review of a Critical Incident System (CIS) report indicated that on an identified day, resident #003 was neglected by staff during care. As a result the resident fell from the bed onto the floor and sustained an injury.

A review of the resident's care plan indicated that the resident required total assistance from two staff for a specified care activity, as the resident was unable to focus on the task.

Interview with Personal Support Worker (PSW) #113 indicated that the resident had a fall incident while receiving care from them and sustained an injury. PSW #113 indicated that they are expected to follow the resident's care plan.

Interview with RPN #106, #110, Registered Nurse (RN) #112, and Director of Care (DOC) indicated that PSWs are expected to provide care set out in the resident’s care plan. (500)

2. A review of a CIS report and progress note, indicated that resident #002 had a fall on an identified day, during care, witnessed by the PSW #105. The Registered Practical Nurse (RPN) #106 was alerted by the assigned PSW #105 of the resident's fall. The RPN went to the room, and found the resident on the floor, and moderate amount of blood was noted on an identified area of the resident's body due to an injury. As per the staff, while they were providing care, the resident rolled out of the bed, bed rail was noted in downward position.

A review of the care plan indicated that the resident required total assistance from two staff for a specified care. Bed rails on both sides of the bed to be applied.

Interview with PSW #105 indicated that they put the resident's rails down, and was helping the resident from the opposite side. The resident was holding the rail which was down and rolled down onto the floor. The PSW indicated that they leaned over and tried to protect the resident but was not able to and the resident fell on the floor. The PSW indicated that they should have used two staff for care, and apply the rail and accepted their mistake.

Interview with RPN #106, #110, RN #112, and DOC indicated that PSWs are expected to provide care set out in the resident's care plan.

This non-compliance was issued as the staff members put the residents at risk by not implementing the care outlined in their plans of care.

The severity of this issue is a level 3 (actual harm), the scope was a level 2 (pattern), as it related to two out of three residents reviewed, and compliance history was a level 4, ongoing non-compliance in this section of the LTCHA that included Voluntary Plan of Action (VPC) and Written Notification (WN) issued during Inspection:
#2017_659189_0009, dated June 23, 2017,
#2017_378116_0008, dated June 21, 2017,
#2017_486653_0009, dated June 2, 2017,
#2017_486653_0010, dated June 20, 2017. (500)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2019(A1)

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

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. (11) When a resident is reassessed and the plan of care reviewed and revised,

(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee must be compliant with s. 6. (11) (b) of the LTCHA, 2007. Specifically, the licensee must do the following:

1. Identify all residents who are at high risk for falls and analyse all falls in order to determine effectiveness of the falls prevention strategies identified in their plan of care.
2. Consider and implement different approaches to prevent falls for these residents by conducting interdisciplinary meetings involving direct care staff as well as substitute decision makers (SDMs). Keep and maintain meeting minutes records.
3. Conduct monthly audits by a designate to ensure that residents receive care as indicated in their care plans, and develop and implement action plans based on the outcome of the evaluation of these audits. Keep and maintain record of the audits.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective, the licensee ensured that different approaches are considered in the revision of the plan of care.

A review of a CIS report indicated that resident #006 was found on the floor in a common area of the home on an identified day with an injury and bilateral limbs were partially resting on an identified device. The resident passed away in the hospital the following day.

A review of the resident's written care plan indicated that the resident had a responsive behaviour and was at high risk for falls, the goal identified was to keep the resident free from falls and potential injury. There were six falls prevention interventions included the resident's plan of care.

A review of the resident's clinical record indicated that the resident had six falls in a two month time period, three with injury.

Interview with RPNs #110 and #108 indicated that the resident's falls prevention care plan was not effective as the resident continued falling.

Interview with RN #109 indicated that it was difficult to say that the resident's care plan was effective as the resident was continuously falling.

Interview with Nurse Manager #111 indicated that the care plan was not effective and different approaches should have been considered.
(500)

2. A review of a complaint received by the Ministry of Health and Long-term Care (MOHLTC), indicated that resident #007 had a fall on an identified day, which resulted in injury and raised a concern about the resident's safety in the home.

A review of a CIS report indicated that resident #007 had a fall on an identified day and sustained injuries. The resident denied any pain. After a few hours, the RPN reported the resident having severe pain and the resident was assessed by the nurse practitioner, sent to the hospital and diagnosed with an injury.

The care plan indicated that the resident had an identified number of falls in 2017.

A review of the resident's care plan indicated that resident #007 was at high risk for falls, and there were nine falls prevention interventions included in their plan of care.

A review of the resident's clinical record including progress notes, and post fall huddle assessments indicated that the resident had more falls in 2018 than in 2017, two with injury.

Interview with PSW #117 indicated that the resident was at high risk for falls and the staff were trying their best to monitor the resident, however, it was not effective and the resident continued to fall.

Interview with RPN #118 and Nurse Manager #103 indicated that there were falls preventions strategies in place for the resident but the resident would not ask for assistance and continued to fall.

A review of the home's policy #RC-0518-21, entitled, "Falls Prevention and Management", published, January 10, 2016, indicated that all residents who have fallen require an interdisciplinary team assessment to clearly understand the contributing factors and appropriate interventions to prevent further falls. Any risk contributing factors identified shall be followed up by the nurse. Methods to reduce risk of falls including to formulate individualized strategies based on the resident's condition and assessed needs to prevent and manage falls and the injury related to falls including the type of equipment, safety interventions and restorative approaches. Review, conduct care conference and revised care plan when the evaluation of interventions demonstrates that the interventions are ineffective.

Interview with Nurse Manager #111 indicated that different approaches should have been considered when the resident had frequent falls.

This non-compliance was issued due to:
-a result of the resident's fall with significant change in health status,
-a significant history of multiple falls,
-the home not considering different approaches, being aware about the resident's increased risk for falls while wandering with unsteady gait in the home area.

The severity of this issue was a level 3 (actual harm), the scope was a level 2

(pattern), as it related to two out of three residents reviewed, and compliance history was a level 3 (previous WN in related areas) during inspection #2017_685648_0018, dated February 14, 2018. (500)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2019(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 17th day of July, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by NITAL SHETH (500) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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Ordre(s) de l'inspecteur

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