Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 24, 2019	2019_526645_0005	004247-18, 005310-18, 006127-18, 007224-18, 007683-18, 008180-18, 008611-18, 022221-18	Critical Incident System

Licensee/Titulaire de permis

West Park Healthcare Centre
82 Buttonwood Avenue TORONTO ON M6M 2J5

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

West Park Long Term Care Centre
82 Buttonwood Avenue TORONTO ON M6M 2J5

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

DEREGE GEDA (645), CHAD CAMPS (609), JULIE KUORIKOSKI (621), LAUREN TENHUNEN (196), STEVEN NACCARATO (744)

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): May 27, 28, 29, 30, and 31, 2019.

During the course of the inspection the following Critical Incidents were inspected:
-Intakes #008611-18 (CIS #2848-000026-18), #006127-18 (CIS #2848-000017-18), #004247-18 (CIS #2848-000011-18), #022221-18 (CIS #2848-000039-18), and #007224-18 (CIS #19278/2848-000023-18) related to prevention of abuse and neglect.
-Intakes #005310-18 (CIS #18988/2848-000015-18), and #007683-18 (CIS #2848-000021-18) related to fall prevention and management and
-Intake #008180-18 (CIS #19472/2848-000025-18) related to improper transfer causing injury.

A Voluntary Plan of Action related to LTCHA,2007, c.8, s. 24(1), identified in a concurrent complaint inspection #2019_526645_0004, (Log #032764-18), was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSW) and Physiotherapist (PT), Housekeeping staff, Behavioural Support Ontario (BSO) Lead, Resident Assessment Instrument (RAI) Coordinator, Clinical Program Lead (CPL), Physiotherapy Assistant (PTA) and residents.

The inspectors performed observations of staff and resident interactions, provision of care, reviewed residents' clinical records, staff training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

9 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #009.

A Critical Incident System (CIS) report was submitted by the home to the Director in August 2018, which outlined how on the same day, resident #009 had a exhibited responsive behaviour that resulted in harm to resident #008.

a) Inspector #609 reviewed resident #009's health care records which indicated that after the incident, the resident continued to exhibit responsive behaviour and that the resident was being "closely" monitored.

A review of resident #009's plan of care at the time of the incident outlined that when the resident was experiencing behaviours on the unit, staff were to monitor and redirect them.

A further review of resident #009's medical records indicated that few hours after the incident, resident #014 exited their room and informed staff that they were hit by resident

#009 while they slept. Staff found resident #009 in resident #014's room.

During an interview with PSW #100, they were asked what close monitoring of resident #009 meant. The PSW stated that they would check hourly to make sure the resident did not go into other residents' rooms.

During an interview with RPN #118, they outlined how resident #009 should be monitored by all staff hourly.

During an interview with RN #113, they indicated that it was the responsibility of the float PSW to monitor resident #009 by keeping an eye on the resident.

A review of the home's policy titled "Care Planning" stated that the plan of care provided information/instructions to the care team regarding the assessed needs, delivered care and outcomes of care. The Inspector found no indication within the policy that the plan of care was required to give clear direction to staff who provided care to the residents.

b) Inspector #609 reviewed resident #009's health care records and found that they continued to have responsive interactions. On an identified date, resident #009 had refused to leave the window in the lounge area. Staff heard a scream and found resident #013 being hit by resident #009 while they sat in the identified home area.

A review of the CIS report submitted by the home to the Director, outlined how minutes after hitting resident #013, resident #009 entered into another resident's room and hit resident #011.

A review of resident #011's progress notes found that resident #009 had hit the resident in the identified part of their body, causing skin alteration.

Inspector #609 observed resident #009 in the halls of the unit unmonitored by staff. The resident was observed sitting unmonitored by staff on the couch at the front of the unit with resident #012 sitting beside them.

During an interview with PSW #100 and #102, both indicated that the resident could be responsive towards other residents. PSW #100 further indicated that they monitored the resident to make sure other residents did not get into their space.

During an interview with RPN #118, they were asked what monitoring of resident #009

meant. They indicated that if the resident was exhibiting responsive behavious the float PSW was to keep track of the resident.

During an interview with RN #113, they were asked what monitoring of resident #009 meant. The RN indicated that the float PSW was to keep other residents away from them.

A review of the resident #009's current plan of care found no mention that the resident was to be monitored to ensure they were not responsive towards other residents, or to monitor to ensure that other residents did not get into resident #009's space.

During an interview with the Behavioural Supports Ontario (BSO), a review of resident #009's plan of care was conducted. They indicated that all PSWs should be monitoring the resident and failed to describe what the resident should be monitored for. The BSO indicated that close monitoring would mean a staff member was providing one to one supervision.

During an interview with the Director of Care (DOC), a review of resident #009's plan of care was conducted as well as RN #113's response that the float PSW was to monitor resident #009. They acknowledged:

That the plan of care did not indicate that staff were to monitor the resident to keep other residents at safe distance away them;
That they were unable to provide the Inspector with clear direction of what the resident's monitoring entailed, the frequency of monitoring or who was to perform the monitoring; and that the plan of care did not provide clear direction to the staff when the resident was found to be exhibiting responsive behaviours. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs changed or care set out in the plan was no longer necessary.

A Critical Incident System (CIS) report was submitted to the Director regarding a resident fall with injury.

The investigation file for this CIS report was reviewed by Inspector #196.

The licensee's, "Falls Prevention and Management Program – RC-15-01-01 – February

2017", identified, "Create an individualized plan addressing identified fall causes and risk factors…" and "Update care plan as necessary."

The residents' health care record, hard copy and electronic, were reviewed. The care plan that was in place at the time of the falls remained unchanged since the date of admission to the home.

During an interview, the DOC reported to the Inspector, upon review of the care plan, that the care plan had not been updated since the resident had been admitted to the home. In addition, the DOC confirmed that the care plan had not been updated to reflect the resident's risk for falls, as the resident had a number of falls within a three week time period prior to the identified date. [s. 6. (10) (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 to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 resident #001 was protected from abuse by anyone.

Physical abuse as outlined in section 2. (1) of the Regulation (O. Reg. 79/10) means the use of physical force by anyone other than the resident which causes physical injury to another resident.

A Critical Incident Systems (CIS) report was submitted to the Director which outlined physical abuse by PSW#114 to resident #001.

Video surveillance of the incident, revealed resident #001 had approached PSW #114. Resident #001 was then seen to be pushed by PSW #114 which resulted in resident #001 falling.

The licensee's policy titled "Zero Tolerance of Resident Abuse and Neglect program last revised April 2017, stated that "physical abuse is the use of physical force by anyone other than a resident that causes physical injury or pain". The policy also stated that "Extendicare has zero tolerance for abuse and neglect. Any form of abuse or neglect by any person, whether through deliberate acts or negligence, will not be tolerated".

The home was not able to provide the video surveillance of the incident for Inspector #744 to view.

Investigation notes of the incident identified that the home's management viewed the video surveillance together with PSW #114 in an interview. Management identified from the video, resident #001 and PSW #114's hands being raised, followed by resident #001 falling. The former DOC identified that after the fall of resident #001, there was no concern or compassion from PSW #114 towards the resident #001.

Inspector #744 interviewed PSW #117 who had witnessed the incident. They verified that in March 2018, PSW #114 had pushed resident #001 on the floor after they had approached PSW #114 aggressively for an item.

Inspector #744 reviewed a letter from the former Executive Director (ED) given to the PSW #114, which identified that they had pushed the resident and showed no concern or compassion to resident #001 who had fallen. Following the home's investigation, PSW #114 received disciplinary action due to direct violation of the Residents' Bill of Rights, Extendicare's Standards of Conduct and Extendicare's Abuse Policy. [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 resident #001 is protected from abuse by anyone, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and position devices or techniques when assisting resident #004.

A Critical Incident System (CIS) report was received by the Director which identified that resident #004 had two falls with injury, on an identified date.

On review of the home's CIS investigation notes, Inspector #621 identified three letters of discipline from the home's former Director of Care #120 to PSW #115 and #116 and RPN #117, which identified that after investigation into resident #004's fall, the PSWs and RPN were found to have attempted to place resident #004 back in the identified assistive mobility device using manual lifting techniques.

On review of resident #004's healthcare record, including their most current care plan, it identified under "Transfer", that the resident required total assistance, using a mechanical Hoyer lift with two person assistance.

During an interview with PSW #119 and RPN #118, they reported to Inspector #621 that under no circumstances should staff transfer a resident without the use of a mechanical lift, if it has been assessed and cared planned that a mechanical lift is required for transfers.

During the interview, the DOC reported to the Inspector that PSW #115 and #116 and RPN #117 did not use safe transferring techniques with resident #004.

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 staff use safe transferring and position devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the falls prevention and management program to reduce incidence of falls and risk of injury were developed and implemented in the home.

A Critical Incident System (CIS) report was submitted to the Director for a resident fall with injury that had occurred and resulted in transfer to hospital. In addition, the report identified a falls history which included falls that had occurred on an identified date.

The licensee's, "Falls Prevention and Management Program – RC-15-01-01 – February 2017", was reviewed and identified the following was to be implemented:
- "ensure a comprehensive assessment is undertaken; an in-depth review is completed post-fall, and the care plan updated as needed";
- "Screen all residents on admission, annually, with a change in condition that could potentially increase the resident's risk of falls/fall injury, or after a serious fall injury or multiple falls (if not already at high risk). See Scott Fall Risk Screen for Residential Long-Term Care, Appendix 4";
- "Create an individualized plan addressing identified fall causes and risk factors such as, but not limited to...";
- "Update care plan as necessary";
- "Hold a post fall huddle, ideally within the hour and complete a post-fall assessment as soon as possible"; and
- "initiate incident report".

The investigation file for this CIS report was reviewed by Inspector #196. The file included a hand written note recorded by RPN #124, which identified resident #006 had a second fall and provided the detail of that fall. There were no internal incident reports for either fall within the file.

The health care record for resident #006, hard copy and electronic, was reviewed. The care plan with a focus of falls was unchanged from the date of admission to the home. The post fall assessments for the two falls were not located. The Scott Falls Risk Screen Tool was incomplete. The progress notes did not identify the two falls and there was no subsequent assessments of the resident documented.

During an interview with RPN #125, they reported that when a resident had a fall the following was to be completed:
- physical assessment of the resident;
- post fall huddle;
- post fall assessment was to be completed online in PCC;
- complete an internal incident report; and
- notifications of the physician and substitute decision maker as required.

During an interview with RN #126, they added that a Scott Fall Risk Screen would need to be completed on admission, and if the resident had frequent falls.

During an interview with the DOC, they reported that the licensee's “Falls Prevention and Management Program" had not been implemented for resident #006. Specifically, the DOC confirmed that the assessment of the resident post the two falls had not been documented; the Scott Fall Risk Screen was incomplete; the post fall assessments had not been completed; the residents care plan was not updated and there were no internal incident reports completed. [s. 48. (1) 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 a fall prevention and management program to reduce the incidence of falls and the risk of injury is developed and implemented in the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

On an identified date, while conducting a daily tour of the home, Inspector #609 observed the door to the lift room #1216A unlocked, open and unsupervised. Inside a Hoyer lift was noted.

During an interview with housekeeper #103, they verified that the door to room #1216A was supposed to be kept closed and locked. They then proceeded to close and lock the door.

The following day, the door to lift room #1216A was unlocked, open and unsupervised. During an interview with RPN#118, they verified that the door to lift room #1216A was supposed to be kept closed and locked. They then proceeded to close and lock the door.

A review of the home's policy titled "Door Surveillance and Secure Outdoor Areas" last updated December 2018 indicated that non-residential areas (utility rooms, storage rooms, loading dock area, etc) must be kept locked to restrict unsupervised access to those areas by non-staff.

During an interview with the DOC, they verified that lift room doors were to be kept locked. [s. 9. (1) 2.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is in place a written policy to promote zero

tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

A Critical Incident Systems (CIS) report was submitted to the Director which outlined physical abuse by PSW #114 to resident #001 witnessed by PSW #107.

Video surveillance of the incident revealed resident #001 had approached PSW #114 was then seen to be pushed by PSW #114 which resulted in resident #001 falling. PSW #107 was seen to witness the event, but did not report the abuse to the nurse on call.

The home was not able to provide the video surveillance of the incident for Inspector #744 to view.

The licensee's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" last revised April 2017, stated that "any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time."

In an interview with Inspector #744, PSW #107 stated that they had witnessed PSW #114 push resident #001, but did not follow the home's policy of reporting the physical abuse to the nurse on call immediately following the incident. PSW# 107 had only reported the fall to the nurse on call.

Inspector #744 reviewed a letter from the former Executive Director given to the PSW #117, which identified that they did not accurately report the cause of the fall to the nurse on call. Disciplinary actions related to inaccurate reporting were given to PSW #117 following the home's investigation. [s. 20. (1)]

2. The licensee has failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

A Critical Incident Systems (CIS) report was submitted to the Director which outlined physical abuse by PSW #114 to resident #001 witnessed by PSW #107.

The licensee's policy titled "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences (RC-02-01-03)" which contained the "Workplace Investigation and

Disciple Toolkit" last revised April 2017, stated that the home is to "Collect all documents from the investigation and organize it for filing in an appropriate, secure and confidential location. It is also stated that the home "may be required to produce these records in an Arbitration so it is important that it remain ready and organized".

The home was not able to provide the video surveillance of the incident for Inspector #744 to view upon request.

In an interview with Inspector #744, the Executive Director (ED) stated that the video surveillance of the incident was not available at the home. The video file was kept in the hard drive of a former employee of the home but was since erased. The ED stated that the previous employee should have secured the investigation files in a secondary location before the files of that computer were wiped out. [s. 20. (1)]

WN #7: 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. The licensee has failed to ensure that a person who had reasonable grounds to suspect that neglect of a resident by the licensee or staff, which resulted in harm or risk of harm to residents, was immediately reported to the Director.

1.A Critical Incident System (CIS) report was received by the Director which identified that resident #004 had two falls with injury.

During a review of the home's CIS investigation notes, Inspector #621 identified three letters of discipline from the home's former Director of Care #120 to PSW #115 and #116 and RPN #117, which identified that after investigation into resident #004's fall, the PSWs and RPN were found to have neglected the resident.

The Inspector reviewed the Long-Term Care Homes.net reporting website and was unable to locate a mandatory critical incident report submitted by the home, regarding the identified neglect of resident #004 by the three staff members as determined from the home's internal investigation.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, RC-02-01-02", last updated April 2017, identified under Appendix 2 that any person who has reasonable grounds to suspect neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, immediately reports the suspicion and information upon which it is based to the Director of the Ministry of Health and Long-Term Care (MOHLTC).

During an interview with the DOC, they reviewed the home's investigation notes and confirmed that PSW #115, #116, and RPN #117 received letters of discipline for neglect of resident #004 and confirmed that there was no immediate report made to the Director concerning the findings of staff neglect of the resident; and it was their expectation that an immediate report was made to the Director, when the former DOC first became aware.

2.A complaint was received via the MOHLTC INFO-Line, regarding alleged staff to resident abuse, indicating resident #050 was verbally abused by the Director of Care (DOC).

Record review of the incident indicated that the home reported the allegation to the MOHLTC, completed an investigation and indicated that the allegation was unfounded.

Interview with resident #050 indicated that they don't recall the incident clearly and agreed that it was not verbal abuse. During the interview, the resident stated to Inspector #645, that it was the Assistant Director of Care (ADOC) that verbally abused and

threaten them on an identified date. Resident #050 stated that the ADOC threatened them by saying "stop complaining to the MOHLTC otherwise there will be consequences". The home was aware of the allegation and did not notify of the MOHLTC.

Review of the email conversation between the Administrator and the resident indicated that the Administrator was aware of the alleged incident on the same day. A review of the home's complaints binder did not indicate if the home notified the Ministry.

An interview with the Administrator confirmed that they received email regarding the alleged abuse but did not report it to the Ministry. [s. 24. (1) 2.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident System (CIS) report was submitted to the Director for a resident fall with injury.

The licensee's, "Falls Prevention and Management Program – RC-15-01-01 – February 2017", indicated that a post-fall assessment was to be completed as soon as possible after a fall.

The residents' health care record, hard copy and electronic, was reviewed and post fall assessments were not located for either of resident #006's falls.

During an interview with RPN #125, they reported to the Inspector that a post fall assessment was to be completed online after a resident had a fall.

During an interview with RN # 126, they reported to the Inspector that a post fall assessment is to be completed in Point Click Care (PCC) online, after a resident had a fall.

During an interview with the DOC, they confirmed that a post fall assessment had not been completed after the fall. They further reported that a post fall assessment had not been completed for the second resident fall that had occurred at the time that the paramedics had come to transfer the resident to the hospital later that same evening. [s. 49. (2)]

WN #9: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day of an incident that caused injury to a resident, for which the resident was taken to hospital and which resulted in a significant change in the resident's health condition.

A Critical Incident System (CIS) report was received by the Director which identified that resident #004 had a fall with injury. Additionally, the CIS report identified that resident #004 sustained a second fall with injury which the home included as an addendum to the same CIS report.

During a review of resident #004's healthcare record, Inspector #621 identified an entry made by RPN #121, which documented that resident #004 fell in their room, and on assessment by Physician #122, the resident was sent to hospital. Documentation by RPN #118 identified that they had contacted the hospital and received confirmation that resident #002 sustained an injury which required treatment. Then Inspector #621 identified entry made by RPN #117, which indicated that resident #004 was found by staff, sitting beside their mobility device. The entry indicated that substitute decision maker (SDM) requested the resident be sent to hospital. Subsequently, RPN #118 documented that they contacted the hospital and confirmed the resident had sustained an injury in a different part of the body location than from the one sustained previously.

During a review of the home's policy entitled "Mandatory and Critical Incident Reporting, RC-09-01-06", last updated April 2017, it was identified that under the "Procedures" section of the policy, that the home was to inform the Ministry of Health (MOH) Director no later than one business day after an incident that causes injury to a resident, that results in a significant change in the resident's health condition and for which the resident was taken to hospital.

During an interview with RPN #118, they confirmed that they had documented confirmed injuries on an identified date but were unable to recall if they reported the incident to anyone at that time. The RPN identified that if a resident sustains a fall with severe injury, that they would be required to report the incident to the Charge RN, who would then report the incident to the home's management. RPN #118 identified that such an incident was required to be reported to the Ministry of Health and Long-Term Care (MOHLTC) within one business day.

During an interview with the Director of Care (DOC), they reported that it was their expectation that when a resident falls and sustains an injury that results in a significant change in health status, and if the home is aware of the significant change, that they report the incident to the Director within one business day. On review of the CIS report for the two falls with injury of resident #004, the DOC reported that the home was aware within one business day of the significant change in status for both falls and did not report within the required timelines. [s. 107. (3) 4.]

Issued on this 26th day of June, 2019

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

Original report signed by the inspector.