Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 03, 2020	2019_808535_0018 (A1)	009928-19, 012955-19, 012963-19, 017197-19, 020290-19	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

Amended by VERON ASH (535) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee requested an extension related to the compliance due date for orders #1, 2 and 4 - extended to April 3, 2020.

Issued on this 3 rd day of February, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by VERON ASH (535) - (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): October 23, 24, 25, 28, 29, 30, 31, November 1, 4, 6, 7, 8, 13, 14, 15, 21, 22, 25, 2019.

The following intakes were completed during this inspection: Log #012963-19 (related to fracture of unknown cause); 017197-19 (related to falls); 020290-19 (related to responsive behavior); 009928-19 (related to fracture of unknown cause); 012955-19 (related to falls); 002076-18 (related to fracture of unknown cause).

PLEASE NOTE: A Written Notification and Compliance Order and a Written Notification and Compliance Order related to LTCHA, 2007, c. 8, s. 6. (7) and s.19 (1), identified in a concurrent complaint inspection #2019_808535_0017, were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant DOCs (ADOCs), Resident Assessment Instrument (RAI) Coordinator, Behavior Support Outreach (BSO) Manager, Resident Program Manager (RPM), Physiotherapist (PT), Recreation Assistant (RA), nursing clerk, receptionist, housekeeping staff, registered staff RN/ RPN; personal support worker (PSW), Substitute Decision Makers (SDMs) and residents.

During the course of the inspection, inspectors made observations related to the home's care processes; staff to resident, and resident to resident interactions; conducted record reviews, interviews, and reviewed relevant 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
Responsive Behaviours

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

7 WN(s)
3 VPC(s)
4 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 residents #002, #007 and #009 were free from neglect by staff in the home.

For the purposes of the Act and this Regulation, ‘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. O. Reg. 79/10, s. 5.

The Ministry of Long-Term Care (MLTC) received a complaint on an identified date, related to verbal abuse and neglect of a resident.

Record review indicated resident #009 was admitted to the home on an identified date, and was assessed using the home’s quarterly Resident Assessment Instrument-Minimum Data Set (RAI-MDS). The resident has multiple medical diagnosis.

Record review of the complaint and an interview with the complainant indicated that on an identified date, resident #008 visited the unit were resident #009 resided and they observed that resident #009 was having a responsive behavior in an open area on the unit.

During an interview, Recreational Assistant (RA) #107 was able to recall and describe the incident which occurred on that date. The RA stated that they immediately went into the nurses’ office, which was near the location of the incident, and informed registered staff RN #129. The RA also stated that resident #008 was very reactive to the situation and therefore, took the resident back to their room. PSW #101 arrived for their shift and helped resident #009.

During an interview, PSW #101 recalled the incident and verified the above information. The PSW also stated that resident #009 displayed the identified responsive behavior at least once daily during their shift. The PSW also stated that the intervention listed in the resident's care plan was not effective. The PSW stated that they had never seen the resident harmed or injured themselves during the behavior with small exception.

PSW #101 verified that the situation was considered verbal abuse, and that it was

reported to registered staff #129, who was in the office during the altercation. The PSW stated that all the staff, residents and sometimes visitors were aware of the resident's behavior, and that the behavior was attention-seeking.

During an interview, registered staff RPN #129 stated that they 'heard an argument out there.' The RPN stated that they did not see what happened; however, they heard resident #008 outside and they left the nursing station to see what was happening. RPN #129 stated that resident #008 was aware of resident #009's responsive behavior.

According to the registered staff, resident #008 informed them that this behavior was a form of 'temper tantrum' shown by resident #009. The RPN stated that during the incident on the identified date, they also witnessed resident #009's responsive behavior. The staff stated that they would usually implement the listed intervention, however, the intervention was not effective. The RPN stated that during the incident, resident #010 was 'around' however they did not hear what the resident had said. The RPN stated that resident #010 also had identified responsive behaviors and that they had witnessed resident #010 being verbally abusive to others in the past. The RPN stated that they did not report the above-mentioned incident which occurred since it was the week-end; that they documented the incident; and that they might have reported the incident to the evening shift. The RPN stated that if resident #009 was their family member, they would not want them to display that responsive behavior, and that they would feel badly about that.

RPN #129 stated that the home was informed of the behavior prior to the resident's admission, however, they were not aware of the degree of the behavior 'the extent was a surprise'. The staff verified that the resident was referred for support and was waiting for the appointment.

During an interview, ADOC #118 stated that they were not aware of the incident which occurred on the identified date, until the initiation of this inspection. The ADOC stated that they did not receive a message from the RN working the shift that weekend but acknowledged that they should have been notified of the incident for reporting purposes. The ADOC verified that they were aware of the resident's responsive behavior, and that the resident had the behavior since admission to the home; however, they did not expect the magnitude of the behavior. The ADOC acknowledged that there was a definite impact on the other resident and visitors to the home; and stated that the staff have 'normalized the

resident’s behavior’.

Regarding the incident, the ADOC stated they would not be surprised if resident #010 engaged in an abusive interaction. The expectation was that staff take the resident aside and speak with them to instruct them that verbally abusing another resident would not be tolerated; the registered staff should inform the ADOC when such incidents occur on the unit; and staff should also document the incident in Point Click Care (PCC). The ADOC verified that verbal abuse should be reported to the Director, and this was a missed opportunity since they were not aware of the incident.

During an interview, DOC #100 verified that they were not aware of the incident which occurred, and stated that they recently witnessed resident #009's responsive behavior. The DOC stated that the staff seemed to have normalized the resident’s behavior and that external resources were consulted and involved with the resident's care. The DOC stated that they informed the staff working on the unit that it was unacceptable for them to walk by when the resident was displaying that behavior.

The DOC stated that other residents also complained that they do not like to see resident #009 displaying the behavior, and acknowledged that it was those residents' home as well. [s. 19.] (535)

2. Review of home’s policy #RC-15-01-01: Falls Prevention and Management Program, indicated that “Intercepted falls which do not prevent the resident from ending up on the floor, ground or other lower level are considered falls and should be coded as a fall.” Regarding post-fall management, the staff are required to complete an initial physical and neurological assessment to determine if the resident can be safely monitored and treated within the home or if transfer to acute care is required. For 72 hours post-fall,
the staff are required to: 1) assess the following at each shift: pain, bruising, change in functional status, change in cognitive status, and change in range of motion; 2) communicate resident status at end of each shift, 3) notify the physician/nurse practitioner if there is a sudden change in vital signs and/or neurological assessment, 4) document the fall and results of all assessments and actions taken during the 72-hour post-fall follow-up.

A CIS report was submitted to the MLTC on an identified date, related to an incident that occurred to resident #002, on a previous identified date.

Record review of the CIS report, indicated that a PSW reported to the nurse that resident #002 was experiencing pain in an identified body part. Physician and family were notified. Resident #002 was transferred to the hospital for assessment. The amended CIS report was submitted to the MLTC on a later identified date. Review of the report indicated that resident #002 had a diagnosed injury and a scheduled procedure. Further review of the report indicated the cause of the injury was a fall.

Review of resident #002's clinical records, indicated the resident was admitted to the home on an identified date, and was assessed using the Resident Assessment Protocols (RAP) on an identified date. Resident #002 often forgot to use their mobility device, and was identified at risk for injury from fall. Fall prevention was put in place and staff provided supervision. Care plan goal was to minimize the risk and maintain the resident's safety.

During the inspection, Inspector #726 reviewed the copy of surveillance video footage provided by the Director of Care #100 and confirmed the sequence of events leading to resident #002's incident as described in the amended CIS report. However, the inspector noticed that the actual date of the fall incident shown on the video was one day earlier then the identified date indicated in the CIS report.

In an interview, the DOC #100 confirmed that the incident occurred on the date as shown in the surveillance video. The DOC also identified PSW #117 as the staff shown in the video who assisted resident #002 and witnessed the incident. The DOC stated that during the investigation, they reviewed the surveillance video footage and discovered that resident #002 had an incident on that identified date, which was the day before the resident was transferred to the hospital. The DOC said that they found the nurse did not treat the identified incident as required because the PSW told the nurse that they had guarded the resident.

Record review indicated that the RPN documented one day later regarding the incident; and indicated in their documentation that the PSW informed them that the identified incident was a near miss. The review of the PCC documentation also indicated that the RPN had a second late entry which documented the sequence of events which led to the resident's identified incident.

Review of resident #002's clinical records during the period of the actual identified

incident indicated no documentation in the progress notes, no post assessment and no post-clinical monitoring records were found related to resident #002's incident.

Review of progress note written by RPN #119 on an identified date, they received report from a PSW that the resident was having pain. The RPN assessed the resident, did vital signs and notified the physician, a diagnostic test was ordered and family notified.

In an interview, PSW #117 stated that on the identified date, during the incident they supported the resident to a safe position, and after the incident occurred, PSW #111 came to help, and RPN #102 came to check the resident. PSW #117 said they told RPN #102 that they supported the resident. PSW #117 stated that they did not inform the staff on the following shift regarding the incident as they thought the nurse would convey the information to the next shift and document the incident.

In an interview, RPN #102 confirmed that they did not complete the full post-fall assessment including range of motion (ROM) assessment, head injury routine and vital signs for resident #002 before assisting the resident and leaving them seated in the chair after the incident occurred. RPN #102 stated that they were not aware of the definition of “intercepted falls” written in the home’s fall prevention policy despite the fact that they had attended training on fall prevention and management. At the end of the interview, RPN #102 acknowledged that the way they managed resident #002's fall incident was neglectful.

In an interview, ADOC #118 stated that the home offered training on fall prevention and management policy to all staff during orientation, and the staff could have forgotten the information learned. ADOC #118 indicated that the RPN was informed about resident #002's incident by the PSW and did not complete a thorough post fall assessment. ADOC #118 also stated that the PSW displayed a lack of judgement and knowledge related to the importance of the resident's mobility device.

In summary, the following items were not completed related to the fall incident: 1) post-fall assessments including ROM assessment were not done and the staff allowed the resident to be moved to sit on the chair. 2) no monitoring was done for resident #002 post-fall, 3) the RPN did not document the fall incident in PCC before the end of their shift and did not report the fall incident to the next shift

during shift report, and 4) resident #002's family was not informed regarding the fall incident. ADOC #118 acknowledged that this incident involving resident #002 would meet the definition of neglect. [s. 19. (1)]

3. The MLTC received a CIS report on an identified date, related to an incident for which the resident was transferred to hospital with an unknown injury.

Resident #007 was assessed using the home's full admission RAI-MDS on an identified date.

Record review of the critical incident report and the home's investigation notes indicated that on an identified date, resident #007 was transferred by PSW #138. When the PSW attempted to transfer the resident, the one person transfer resulted in an injury to the resident. Afterwards, the PSW requested the support of RPN #140 to transfer the resident. At that time, the resident was upset and complaining in their native language, however the resident was brought to the dining room for the meal. During the meal, resident #007 communicated in their native language to a co-resident's family member #139, who also spoke the same language. The resident told family member #139 that their identified body part was hurting, and that someone caused an incident which resulted in the pain. During an interview, family member #139 verified the content of their conversation with the resident; that they spoke with the resident just before the meal was served; and that they informed RPN #140 what the resident had told them in their native language, immediately after the resident communicated the information.

During an interview, PSW #138 denied that the resident fell, however they verified that the resident had 'swayed' while they were transferring them. The PSW verified that they had not arranged to have another PSW present to assist with the resident's transfers; and that they transferred the resident without the support of another staff. The PSW also stated that the resident could have hurt themselves when they 'swayed' during the initial transfer.

During an interview, RPN #140 verified that they helped PSW #138 transfer resident #007 on the identified date, and that the resident was saying something in their native language which they did not understand. RPN #140 verified that during the meal, family member #139 had informed them that resident #007 was complaining in their native language that they had pain in an identified body part. The RPN stated they did not follow up with family member #139 regarding details of the incident or when it occurred. RPN #140 verified that they did not notify the

resident's family and the primary care physician who was onsite to assess resident #007 for an unrelated issue, because they were not sure that a fall incident had occurred. The registered staff also stated that they were busy during the shift and that their mind was focused on the forty residents they had to provide care for on the unit, therefore, they administered pain medication, helped to transfer the resident back to bed, and informed ADOC #132 of the incident.

During the interview, RPN #140 informed the inspector that they did not complete the home's falls, skin and pain assessment tools at the time, since they were unsure that the resident had a fall. However, they documented the information related to the incident in the progress notes. The RPN stated that on a later identified date when they returned to work on the same unit, staff informed them that the resident was assessed and transferred to hospital for further assessment for a possible injury. On the later identified date, RPN #140 completed the required assessments related to the incident.

During an interview, ADOC #132 verified that on the identified date, RPN #140 informed them about the resident's complaint about the incident. The ADOC stated that they advised RPN #140 to complete the required assessments and documentation related to the incident. The ADOC verified that they did not speak with family member #139 during the shift, nor advise RPN #140 to contact another staff member or the resident's family to assist with language translation, assessment and follow up treatment related to the resident's complaint. ADOC #132 acknowledged that if the resident had the identified incident, RPN #140 should have completed the applicable assessments including skin assessment, pain assessment and risk management documentation.

Furthermore, the ADOC verified that following the investigation, both staff members were disciplined related to the incident. A review of the first disciplinary letter indicated that PSW #138 was disciplined related to failure to review the resident's care plan prior to starting their duties; failure to adhere to resident's care plan regarding lift and transferring; and failure to report a critical incident. A review of the second disciplinary letter indicated that RPN #140 was disciplined related to failure to act in the best interest of the resident and acknowledge a resident's complaint when it was brought to their attention; failure to do a comprehensive assessment based on the resident's needs, which would not result in any delay of a resident receiving effective and proper care; failure to document pertinent information regarding resident's care; and failed to communicate a full recount of the details of the related incident to the primary

care physician, family and staff during shift report.

Therefore, the home failed to ensure that resident #002, #007 and #009 were not neglected by the licensee or staff. [s. 19. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: 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 staff used safe transferring techniques when assisting resident #007.

The MLTC received a CIS report on an identified date, related to resident #007's transfer to hospital with an unknown injury.

Record review indicated that on an identified date, resident #007 received a full admission assessment using the home’s RAI-MDS assessment tool.

Record review indicated that on another identified date, PSW #138 admitted to transferring the resident without support from another staff. During an interview, PSW #138 stated that during the transfer, the resident ‘swayed', and that after the resident 'swayed' they managed to support the resident around their waist. At that time, the resident started complaining of pain in an identified body part. The PSW verified that they did not request the support of another PSW to provide the care as was indicated in the resident's care plan.

During an interview, PSW #138 verified that they did not inform RPN #140 that the resident had an incident while they were providing their care; therefore, resident #007 was not properly assessed and transferred to the hospital until the following identified date when they received the diagnosis and had a procedure completed on the same day.

During separate interviews, PSW #138 and RPN #140 verified that the PSW used unsafe transferring techniques while working with resident #007; and the PSW further stated that they did not review the resident’s written care plan prior to providing care to the resident.

A review of the home’s investigation notes indicated that PSW #138 was disciplined related to failure to review the resident's care plan prior to starting duties, and failed to adhere to resident’s care plan regarding lift and transferring. This information was verified by ADOC #132. Therefore, the home failed to ensure PSW #138 used safe transferring techniques when assisting resident #007. [s. 36.]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques were used to assist resident #001, #011 and #014, including safe positioning.

The MLTC received a CIS report regarding resident #001 related to a fall incident.

On an identified date and time, Inspector #726 observed PSW #123 assisting resident #001 during snack time while resident #001 remained in a tilted wheelchair position. The inspector observed resident #001 bending their head forward while they were being fed by PSW #123. Review of resident #001's care plan indicated that the resident required extensive assistance.

In an interview, PSW #123 stated that resident #001 was in a slanted position and acknowledged that they did not check resident #001's position before assisting the resident with the snack. PSW #123 indicated that before assisting the

resident, they should put the resident in an upright position.

In an interview, RPN #102 acknowledged that PSW #123 should have placed resident #001 to an upright position. In an interview, DOC #100 confirmed that the resident should be placed in an upright position. [s. 73. (1) 10.]

2. As a result of non-compliance related to resident #001, resident #011 and #014 were selected to increase the sample size. These residents were identified as seated in a tilted position.

Review of resident #011's care plan indicated that resident #011 was assessed with documentation related to meals.

On an identified date and time, Inspector #726 observed resident #011 sitting in a tilted position. PSW #110 was assisting resident #011 with snacks while the resident remained in the tilted position. The inspector observed resident #011 trying to lift their head up and bend forward while assisted by PSW #110.

In separate interviews, PSW #110 acknowledged that they should have placed resident #011 in an upright position before assisting the resident; RPN #112 acknowledged that PSW #110 should have placed resident #011 in an upright position before assisting the resident; and DOC #100 confirmed that the staff were supposed to place resident #011 in an upright position to prevent choking. [s. 73. (1) 10.]

3. Record review of RAI-MDS assessment on an identified date indicated resident #014's assessment was completed.

Review of resident #014's care plan indicated that the resident was assessed and the required information documented in their care plan.

On an identified date and time, Inspector #726 observed resident #014 was in a tilted position, while PSW #142 was assisting the resident during snack time. The inspector observed resident #014 bending their head down and forward when PSW #142 was assisting them.

In separate interviews, PSW #142 acknowledged that they should have placed resident #014 in an upright position; RPN #102 acknowledged that PSW #142 should have placed resident #014 in an upright position; and DOC #100

confirmed that the staff were supposed to place resident #014 in an upright position to prevent choking.

Therefore, the home failed to ensure that proper techniques were used to assist resident #001, #011 and #014. [s. 73. (1) 10.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #001 and that the plan set out clear directions to the direct care staff related to the use of the tilt function of the wheelchair as a personal assistance services device (PASD).

A CIS report was submitted to the MLTC on an identified date, related to an unwitnessed fall incident resulting in resident #001 being sent to the hospital for assessment.

Record review of the progress notes indicated that resident #001 was admitted to the hospital on an identified date with an identified diagnosis, and underwent a procedure on another identified date. Resident #001 was re-admitted to the home on a later identified date.

On another identified date and time, the inspector observed resident #001 was sitting in a tilted position and trying to get up from the wheelchair; however they were unable to get up.

In an interview, PSW #101 stated that resident #001 could get up if the wheelchair was in an upright position. PSW #101 stated that they placed resident #001’s wheelchair in a tilted position for repositioning, and also for preventing resident #001 from getting up from the wheelchair by themselves when nobody was around to watch them.

Review of physiotherapist (PT) #103's assessment of an identified date indicated that the wheelchair was recommended for resident #001 as a personal assistance services device (PASD) to increase seating endurance, ensure comfort, prevent sliding and pressure injuries.

Record review indicated resident #001’s had a risk assessment completed on an identified date. Review of resident #001's current care plan indicated that there was no focus related to the use of the tilt function on the seating device as a PASD.

In separate interviews, RPN #102 and PT #103 both stated that they were not aware that the PSW had been using the tilt function of the wheelchair to prevent resident #001 from getting up by themselves; and they both acknowledged that a

focus should have been included in resident #001's care plan related to the use of the tilt function as a PASD to provide clear directions to direct care staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #006 so that their assessments were integrated, consistent with and complemented each other.

The MLTC received a CIS report on an identified date, related to an incident for which a resident was transferred to hospital.

Record review indicated that resident #006 was assessed using the home's Resident Assessment Instrument – Minimum Data Set (RAI-MDS) tool on an identified date.

Record review of the critical incident report and the home's investigation notes indicated that on an identified date and time, a PSW student notified PSW #105 that the resident had an identified object and was knocking on the door outside a co-resident's room, and saying unpleasant words. Record review indicated that RN #104 tried unsuccessfully to de-escalate the resident's responsive behavior, then called hospital security, followed by calling 911 to prevent further altercation.

During an interview, co-resident #005 stated that they were not afraid or intimidated by resident #006. The incident was resolved with no harm or injury to residents, staff or visitors. Resident #006 agreed to be transferred to hospital for assessment and returned to the home within 24 hours with no new recommendations or change in treatment.

Record review indicated that resident #006 had experienced recent bouts of responsive behaviors and a referral was sent to the internal and external responsive behavior teams, and they were monitored closely by the staff.

During separate interviews, PSWs #105 and #106 verified that the incident occurred as described above. Both PSWs also indicated that the resident tends to display additional responsive behaviors, and both stated that they recently observed new responsive behaviors exhibited by resident #006.

During an interview, registered nurse (RN) #104 verified that the incident occurred as described above. RN #104 stated they were not aware of resident #006's new responsive behaviors.

During an interview, BSO Manager #131, verified that the resident was transferred for an assessment after the incident; and they were referred to the external behavior team for further assessment and treatment after the incident. The BSO Manager also verified that they were not aware that the resident had displayed new responsive behaviors on the unit. The BSO manager acknowledged that there was a breakdown in collaboration amongst the team.

During an interview, ADOC #118, stated that they were called and attended the home during the incident. The ADOC also stated that they were not aware of the resident's new displayed responsive behaviors; and stated that the expectation was that PSWs should report all new or escalating behaviors displayed by residents. The ADOC acknowledged that the team did not collaborate related to the assessment of the resident’s displayed responsive behaviors since only PSWs were aware of those behaviors.

Therefore, the home failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003, #004 and #007 as specified in the plan.

A CIS report was submitted to the MLTC on an identified date, related to an unwitnessed incident involving resident #003 on another identified date and time. The resident was assessed, physician and family were notified. The resident was transferred to the hospital and the home staff were informed that the resident had an injury as a result of the incident. An amended CIS report was submitted to the MLTC on a later identified date. Review of the report indicated that the home’s surveillance video footage showed that resident #003 had an unwitnessed injury on an earlier identified date than was reported in the critical incident report.

Record review of the RAI-MDS Assessment indicated that the resident received an assessment on an identified date.

During the inspection, the DOC #100 provided the inspector with a copy of the surveillance video footage related to resident #003's incident on the identified date. Review of the video footage confirmed the sequence of events leading to the incident, as described in the amended CIS report.

In an interview, PSW #127 stated that in the past they had worked the “3-9 pm PSW” shift and one of their duties was to monitor the residents for falls and behaviors in the open areas after meals.

In an interview, PSW #120 stated that resident #003 was at risk for falls, and that they were assigned to work as the “3-9 pm PSW” in the unit on the identified date of the incident. The PSW verified that one of their main duty was to provide entertainment for the residents to occupy them after the meal, and to monitor residents for behaviors and falls. PSW #120 stated that on the date of the incident, before the incident occurred, they were feeding resident #018 when the incident occurred. The PSW acknowledged that they could have asked the other PSWs to help with feeding the resident, so that they could focus on only monitoring all residents during their shift.

In an interview, RPN #121 stated that all PSWs had been informed that the two "3 -9pm PSWs" duties were to monitor residents only. RPN #121 stated that on the date of the incident, there were approximately eight to nine residents in the dining room after the meal. RPN #121 acknowledged that PSW #120 was not supposed to feed any resident, and that another PSW should have fed resident #018.

In an interview, the DOC #100 acknowledged that it would be hard for PSW #120 to focus on feeding resident #018 and monitor the other residents in the dining room at the same time.

In summary, PSW #120 was assigned on the '3-9pm' shift to provide support and monitor all residents, including resident #003. During the interview, PSW #120 verified that they did not monitor resident #003 prior to the incident, but instead was feeding resident #018. [s. 6. (7)]

4. Record review of the resident's care plan indicated that resident #007 spoke their native language. The written care plan included a focus related to language barrier since the resident's communication in English was poor. The goal of this focus indicated the resident will be able to understand daily messages and the intervention indicated their native language spoken, little English and may need

someone who speaks their native language or interpret.

Record review of the critical incident indicated that on an identified date, resident #007 experienced an incident while being transferred by PSW #138. After the incident occurred, the resident tried to communicate with the staff in their native language, but was taken to the dining room for the meal. The resident was agitated and saying something in their native language and non-verbally indicated pain in an identified body part. The resident spoke in their native language to another resident's family member #139 who understood their language.

During an interview, family member #139 verified that the resident was upset and told them detailed information about the incident which occurred and caused their pain. Family member #139 stated that they approached RPN #140 and immediately informed them of what the resident had told them. The family member also verified that the RPN and PSW did not ask them to communicate/translate further with the resident during or after the incident occurred.

During an interview, RPN #140 verified that they had heard the resident saying something in their language, but acknowledged that there was a language barrier. The RPN stated that they did not follow up with what the resident was trying to say with a translator, nor did they ask family member #139 to translate what the resident was trying to communicate related to the incident. The RPN stated that they were not able to verify that an incident occurred because a language barrier existed between themselves and the resident. However, they understood the resident's non-verbal language. RPN #140 stated that they administered medication to the resident; however, they did not call the resident's family related to the incident, because they were not sure that an incident had occurred.

In summary, the resident's care plan clearly indicated that the resident may need someone who speak the resident's native language for translation. The resident was in obvious distress and required a translator in order to communicate with staff and to support staff assessment. However RPN #140 and PSW #138 did not follow the plan of care, and provide someone to translate the resident's native language to English so that staff would be aware of what the resident was trying to communicate. [s. 6. (7)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan.

The Ministry of Long-term Care (MLTC) received a complaint related to the provision of recreational activities for the residents in the home during an identified period. Resident #004 was one of the three residents who were selected for review.

In an interview, resident #004's SDM stated that the resident was not assisted out of their room for activities of their interest, although they have made a specific request to the home.

Record review indicated the resident was assessed using the home's RAI-MDS assessment on an identified date.

Review of resident #004's care plan indicated under the focus of psychosocial/activities, specific interventions were listed to be completed every other week. However, a review of resident #004's Multi-day Participation Reports between an identified period of months, indicated that the resident did not receive that intervention.

In an interview, the Resident Programs Manager #116 confirmed that all activities provided to resident #004 in each month were documented on the Multi-day Participation Reports. RPM #116 acknowledged that the recreation staff could have gone back to provide the specific intervention another day if the resident refused or was not available at the time of the staff visit.

Therefore, the home failed to ensure that the care set out in the plan of care was provided to residents #003, #004 and #007 as specified in the plan. [s. 6. (7)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

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

In accordance with O. Reg. 79/10, s. 230 (4) (1) (iii) the licensee was required to have an emergency plan in place to support violent outbursts. Confirmation was made that the home had a policy and procedures related to violent situations in place; however they were not complied with.

A review of the home's Code White - Violent Situation policy #EP-07-01-01, updated in January 2019, revealed the following steps to be taken during a violent or potentially uncontrollable situation: 1. If you identify a crisis situation, feel threatened or there is a possibility of an escalation of violence, remove yourself from the confrontation and immediately call 9-1-1. Provide as much information as possible about the situation to the police. 2. Advise other staff of a Code White identifying the location of the incident and if a weapon is involved. 3. Delegate a staff member to declare a Code White and announce "CODE WHITE (location), 3

times.

Record review of the critical incident and investigation notes indicated that on an identified date and time, a PSW student notified PSW #105 that resident #006 was displaying responsive behaviors outside a co-resident's room. Record review indicated that registered staff RN #104 tried unsuccessfully to de-escalate the situation, therefore, the RN contacted the security team for support in dealing with the incident; then eventually called 911.

During an interview, RN #104 verified that the incident occurred on the identified date, and that they called the hospital security to help with the situation. The staff stated they had not thought about activating the home's Code White procedure at the time of the incident.

During an interview, ADOC #118 expressed gratitude that nobody was hurt or injured during the incident; however, they verified that the home had a Code White – Violent Situation policy and procedure which should have been used during this incident. ADOC #118 stated that RN #104 should have activated the home's Code White protocol which would have summoned the police and staff support to the area immediately. The ADOC stated that the Code White procedure was to be used if/when there was an unmanageable resident with responsive behaviors, and/or if the staff felt threatened. Therefore, the home failed to ensure that the Code White policy was complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home instituted the Emergency Services plan, policy, procedure, and ensure that the policy, procedure is complied with., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that restraining of the resident was included in resident #001's plan of care.

Review of home's policy: Least Restraints was last updated in February 2017, indicated the definition for Physical Restraint - Any manual method, or any physical or mechanical device, material, or equipment, that is attached or adjacent to the person's body, that the person cannot remove easily, and that does, or has the potential to restrict the resident's freedom of movement or normal access to his/her body. It is the effect the device has on the resident that defines it as a restraint, not the name or label given to the device, nor the purpose or intent of the device.

A CIS report was submitted to the Ministry of Long-Term Care (MLTC) on an identified date, related to an unwitnessed fall incident resulting in resident #001 being sent to hospital for assessment.

Record review of progress notes indicated that resident #001 was admitted to the hospital on an identified date, with an injury and underwent a procedure on another identified date. Resident #001 was re-admitted to the home on a later identified day.

On anther identified date and time, the inspector observed resident #001 was in a wheelchair, which was placed in a tilted position. Resident #001 was bending their head and upper body forward repeatedly, and trying to get up from their position; but they were unable to get up.

In an interview, PSW #101 said that resident #001 could get up if the wheelchair was placed in an upright position. PSW #101 stated that they placed resident

#001 in a tilted position to prevent the resident from getting up when they were by themselves. PSW #101 further indicated that the angle that they tilted resident #001's wheelchair was just good enough to prevent resident #001 from getting up by themselves when nobody was around to watch them.

Record review indicated resident #001 was assessed using the home's RAI-MDS assessment on an identified date.

Review of physiotherapist (PT) #103's assessment on an identified date indicated that the tilted wheelchair was recommended for resident #001 as a personal assistance services device (PASD).

Review of resident #001's current care plan on another identified date indicated restraining of resident #001 was not included in their plan of care. Further review of the resident's care plan indicated that there was no focus related to the use of the tilt function on the resident's wheelchair as a PASD.

In an interview, RPN #102 said that the tilt function of resident #001's wheelchair was used for other care support; and that when the wheelchair was tilted, it might prevent resident #001 from getting up by themselves. They were not aware that the PSW had been using the tilt function of the wheelchair to prevent resident #001 from getting up when they were not around to monitor the resident.

In an interview, the PT #103 stated that they had recommended to use the tilt function of the wheelchair as a PASD for supporting the resident and for comfort. After PT #103 became aware that the PSW had been using the tilt function to prevent them from getting up by themselves, they acknowledged that it was being used as a restraint for resident #001.

Therefore, the home failed to ensure that restraining of resident #001 was included in their plan of care. [s. 31. (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 restraining of the resident is included in the resident plan of care, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

The MLTC received a CIS report on an identified date, related to an incident for which the resident was transferred to hospital with an unknown injury.

Record review of the critical incident system report and the home's investigation notes indicated that on an identified date, resident #007 was transferred by PSW #138, which resulted in an incident and an injury to the resident. The resident was complaining in their native language to family member #139, about an incident which occurred that caused them discomfort to an identified body part. During an interview, family member #139 verified the content of their conversation with the resident; that they informed RPN #140 what the resident had told them in their native language.

During an interview, RPN #140 verified that they helped PSW #138 transfer resident #007 on the identified date, and that the resident was saying something in their native language which they did not understand. RPN #140 verified that during the supper meal, family member #139 had informed them that resident #007 was upset and complained to them in their native language that they were experiencing pain in a specific body part and about the incident which had occurred. RPN #140 verified that they did not notify the resident's family because they were not sure that an incident had occurred since the PSW denied that the resident experienced an injury during the transfer. On the next identified date, resident #007 was reassessed, transferred to hospital and was diagnosed with an identified injury.

Therefore, the home failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of a suspected incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being. [s. 97. (1) (a)]

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 resident's SDM and any other person specified by the resident are immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that result in a physical injury or pain to the resident, or cause distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.

Issued on this 3 rd day of February, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by VERON ASH (535) - (A1)
Inspection No. / No de l'inspection :	2019_808535_0018 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	009928-19, 012955-19, 012963-19, 017197-19, 020290-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 03, 2020(A1)
Licensee / Titulaire de permis :	West Park Healthcare Centre 82 Buttonwood Avenue, TORONTO, ON, M6M-2J5
LTC Home / Foyer de SLD :	West Park Long Term Care Centre 82 Buttonwood Avenue, TORONTO, ON, M6M-2J5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Matt Lamb

Ontario

Ministry of Long-Term Care

Ministère 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 West Park Healthcare Centre, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre: 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. 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).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s. 19. (1).

Specifically, the licensee shall ensure that all residents are protected from abuse by anyone and are not neglected by the licensee or staff by completing the following:

1. Ensure additional training is provided to all registered nursing staff and personal support workers related to neglect and the prevention and management of fall incidents including:
- completing a full post-fall assessment to ensure proper post-fall management and timely access to medical assessment and treatment if required
- post-fall monitoring
- documenting fall incidents before the end of the shift
- communicating with the staff in the following shift regarding fall incidents to ensure continuity of care and post-fall monitoring
- communicate fall incidents to primary care physician and substitute decision-maker as required.

2. Ensure additional training is provided to all staff on the home's fall prevention and management policy including the definition of falls and post-fall management for "Intercepted Fall" which do not prevent residents from falling to the floor.

3. Maintain the related training records for items #1 and #2 including names

of staff who attended, dates, who provided the education and training materials.

4. For items #1 and #2, conduct post-training testing or evaluation to ensure knowledge comprehension of the training material and maintain evaluation records.

5. Ensure that resident #009 has appropriate support to promote privacy and dignity.

6. Implement strategies to minimize the length of time resident #009 displays identified responsive behavior.

7. Implement hand hygiene and other infection prevention and control measures as applicable.

8. Provide additional training for registered staff (RN/RPN) related to the importance of their role and responsibilities: supervision of staff and residents, documentation and reporting of incidents to management and at shift change. Maintain a copy of the training material, name of the person most responsible for the training and an attendance record.

Grounds / Motifs :

1. The licensee has failed to ensure residents #002, #007 and #009 were free from neglect by staff in the home.

For the purposes of the Act and this Regulation, "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. O. Reg. 79/10, s. 5.

Review of home's policy #RC-15-01-01: Falls Prevention and Management Program, indicated that "Intercepted falls which do not prevent the resident from ending up on the floor, ground or other lower level are considered falls and should be coded as a fall." Regarding post-fall management, the staff are required to complete an initial physical and neurological assessment to determine if the resident can be safely

monitored and treated within the home or if transfer to acute care is required. For 72 hours post-fall, the staff are required to: 1) assess the following at each shift: pain, bruising, change in functional status, change in cognitive status, and change in range of motion; 2) communicate resident status at end of each shift, 3) notify the physician/nurse practitioner if there is a sudden change in vital signs and/or neurological assessment, 4) document the fall and results of all assessments and actions taken during the 72-hour post-fall follow-up.

A CIS report was submitted to the MLTC on an identified date, related to an incident that occurred to resident #002, on a previous identified date.

Record review of the CIS report, indicated that a PSW reported to the nurse that resident #002 was experiencing pain in an identified body part. Physician and family were notified. Resident #002 was transferred to the hospital for assessment. The amended CIS report was submitted to the MLTC on a later identified date. Review of the report indicated that resident #002 had a diagnosed injury and a scheduled procedure. Further review of the report indicated the cause of the injury was a fall.

Review of resident #002's clinical records, indicated the resident was admitted to the home on an identified date, and was assessed using the Resident Assessment Protocols (RAP) on an identified date. Resident #002 often forgot to use their mobility device, and was identified at risk for injury from fall. Fall prevention was put in place and staff provided supervision. Care plan goal was to minimize the risk and maintain the resident's safety.

During the inspection, Inspector #726 reviewed the copy of surveillance video footage provided by the Director of Care #100 and confirmed the sequence of events leading to resident #002's incident as described in the amended CIS report. However, the inspector noticed that the actual date of the fall incident shown on the video was one day earlier then the identified date indicated in the CIS report.

In an interview, the DOC #100 confirmed that the incident occurred on the date as shown in the surveillance video. The DOC also identified PSW #117 as the staff shown in the video who assisted resident #002 and witnessed the incident. The DOC stated that during the investigation, they reviewed the surveillance video footage and discovered that resident #002 had an incident on that identified date, which was the day before the resident was transferred to the hospital. The DOC said that they found

the nurse did not treat the identified incident as required because the PSW told the nurse that they had guarded the resident.

Record review indicated that the RPN documented one day later regarding the incident; and indicated in their documentation that the PSW informed them that the identified incident was a near miss. The review of the PCC documentation also indicated that the RPN had a second late entry which documented the sequence of events which led to the resident's identified incident.

Review of resident #002's clinical records during the period of the actual identified incident indicated no documentation in the progress notes, no post assessment and no post-clinical monitoring records were found related to resident #002's incident.

Review of progress note written by RPN #119 on an identified date, they received report from a PSW that the resident was having pain. The RPN assessed the resident, did vital signs and notified the physician, a diagnostic test was ordered and family notified.

In an interview, PSW #117 stated that on the identified date, during the incident they supported the resident to a safe position, and after the incident occurred, PSW #111 came to help, and RPN #102 came to check the resident. PSW #117 said they told RPN #102 that they supported the resident. PSW #117 stated that they did not inform the staff on the following shift regarding the incident as they thought the nurse would convey the information to the next shift and document the incident.

In an interview, RPN #102 confirmed that they did not complete the full post-fall assessment including range of motion (ROM) assessment, head injury routine and vital signs for resident #002 before assisting the resident and leaving them seated in the chair after the incident occurred. RPN #102 stated that they were not aware of the definition of "intercepted falls" written in the home's fall prevention policy despite the fact that they had attended training on fall prevention and management. At the end of the interview, RPN #102 acknowledged that the way they managed resident #002's fall incident was neglectful.

In an interview, ADOC #118 stated that the home offered training on fall prevention and management policy to all staff during orientation, and the staff could have forgotten the information learned. ADOC #118 indicated that the RPN was informed

about resident #002's incident by the PSW and did not complete a thorough post fall assessment. ADOC #118 also stated that the PSW displayed a lack of judgement and knowledge related to the importance of the resident's mobility device.

In summary, the following items were not completed related to the fall incident: 1) post-fall assessments including ROM assessment were not done and the staff allowed the resident to be moved to sit on the chair. 2) no monitoring was done for resident #002 post-fall, 3) the RPN did not document the fall incident in PCC before the end of their shift and did not report the fall incident to the next shift during shift report, and 4) resident #002's family was not informed regarding the fall incident. ADOC #118 acknowledged that this incident involving resident #002 would meet the definition of neglect. [s. 19. (1)] (726)

2. b) The MLTC received a CIS report on an identified date, related to an incident for which the resident was transferred to hospital with an unknown injury.

Resident #007 was assessed using the home's full admission RAI-MDS on an identified date.

Record review of the critical incident report and the home's investigation notes indicated that on an identified date, resident #007 was transferred by PSW #138. When the PSW attempted to transfer the resident, the one-person transfer resulted in an injury to the resident. Afterwards, the PSW requested the support of RPN #140 to transfer the resident. At that time, the resident was upset and complaining in their native language, however the resident was brought to the dining room for the meal. During the meal, resident #007 communicated in their native language to a co-resident's family member #139, who also spoke the same language. The resident told family member #139 that their identified body part was hurting, and that someone caused an incident which resulted in the pain. During an interview, family member #139 verified the content of their conversation with the resident; that they spoke with the resident just before the meal was served; and that they informed RPN #140 what the resident had told them in their native language, immediately after the resident communicated the information.

During an interview, PSW #138 denied that the resident fell, however they verified that the resident had 'swayed' while they were transferring them. The PSW verified that they had not arranged to have another PSW present to assist with the resident's transfers; and that they transferred the resident without the support of another staff.

The PSW also stated that the resident could have hurt themselves when they 'swayed' during the initial transfer.

During an interview, RPN #140 verified that they helped PSW #138 transfer resident #007 on the identified date, and that the resident was saying something in their native language which they did not understand. RPN #140 verified that during the meal, family member #139 had informed them that resident #007 was complaining in their native language that they had pain in an identified body part. The RPN stated they did not follow up with family member #139 regarding details of the incident or when it occurred. RPN #140 verified that they did not notify the resident's family and the primary care physician who was onsite to assess resident #007 for an unrelated issue, because they were not sure that a fall incident had occurred. The registered staff also stated that they were busy during the shift and that their mind was focused on the forty residents they had to provide care for on the unit, therefore, they administered pain medication, helped to transfer the resident back to bed, and informed ADOC #132 of the incident.

During the interview, RPN #140 informed the inspector that they did not complete the home's falls, skin and pain assessment tools at the time, since they were unsure that the resident had a fall. However, they documented the information related to the incident in the progress notes. The RPN stated that on a later identified date when they returned to work on the same unit, staff informed them that the resident was assessed and transferred to hospital for further assessment for a possible injury. On the later identified date, RPN #140 completed the required assessments related to the incident.

During an interview, ADOC #132 verified that on the identified date, RPN #140 informed them about the resident's complaint about the incident. The ADOC stated that they advised RPN #140 to complete the required assessments and documentation related to the incident. The ADOC verified that they did not speak with family member #139 during the shift, nor advise RPN #140 to contact another staff member or the resident's family to assist with language translation, assessment and follow up treatment related to the resident's complaint. ADOC #132 acknowledged that if the resident had the identified incident, RPN #140 should have completed the applicable assessments including skin assessment, pain assessment and risk management documentation.

Furthermore, the ADOC verified that following the investigation, both staff members were disciplined related to the incident. A review of the first disciplinary letter indicated that PSW #138 was disciplined related to failure to review the resident's care plan prior to starting their duties; failure to adhere to resident's care plan regarding lift and transferring; and failure to report a critical incident. A review of the second disciplinary letter indicated that RPN #140 was disciplined related to failure to act in the best interest of the resident and acknowledge a resident's complaint when it was brought to their attention; failure to do a comprehensive assessment based on the resident's needs, which would not result in any delay of a resident receiving effective and proper care; failure to document pertinent information regarding resident's care; and failed to communicate a full recount of the details of the related incident to the primary care physician, family and staff during shift report.

c) The Ministry of Long-Term Care (MLTC) received a complaint on an identified date, related to verbal abuse and neglect of a resident.

Record review indicated resident #009 was admitted to the home on an identified date, and was assessed using the home's quarterly Resident Assessment Instrument-Minimum Data Set (RAI-MDS). The resident has multiple medical diagnosis.

Record review of the complaint and an interview with the complainant indicated that on an identified date, resident #008 visited the unit were resident #009 resided and they observed that resident #009 was having a responsive behavior in an open area on the unit.

During an interview, Recreational Assistant (RA) #107 was able to recall and describe the incident which occurred on that date. The RA stated that they immediately went into the nurses' office, which was near the location of the incident, and informed registered staff RN #129. The RA also stated that resident #008 was very reactive to the situation and therefore, took the resident back to their room. PSW #101 arrived for their shift and helped resident #009.

During an interview, PSW #101 recalled the incident and verified the above information. The PSW also stated that resident #009 displayed the identified responsive behavior at least once daily during their shift. The PSW also stated that

the intervention listed in the resident's care plan was not effective. The PSW stated that they had never seen the resident harmed or injured themselves during the behavior with small exception.

PSW #101 verified that the situation was considered verbal abuse, and that it was reported to registered staff #129, who was in the office during the altercation. The PSW stated that all the staff, residents and sometimes visitors were aware of the resident's behavior, and that the behavior was attention-seeking.

During an interview, registered staff RPN #129 stated that they 'heard an argument out there.' The RPN stated that they did not see what happened; however, they heard resident #008 outside and they left the nursing station to see what was happening. RPN #129 stated that resident #008 was aware of resident #009's responsive behavior.

According to the registered staff, resident #008 informed them that this behavior was a form of 'temper tantrum' shown by resident #009. The RPN stated that during the incident on the identified date, they also witnessed resident #009's responsive behavior. The staff stated that they would usually implement the listed intervention, however, the intervention was not effective. The RPN stated that during the incident, resident #010 was 'around' however they did not hear what the resident had said. The RPN stated that resident #010 also had identified responsive behaviors and that they had witnessed resident #010 being verbally abusive to others in the past. The RPN stated that they did not report the above-mentioned incident which occurred since it was the week-end; that they documented the incident; and that they might have reported the incident to the evening shift. The RPN stated that if resident #009 was their family member, they would not want them to display that responsive behavior, and that they would feel badly about that.

RPN #129 stated that the home was informed of the behavior prior to the resident's admission, however, they were not aware of the degree of the behavior 'the extent was a surprise'. The staff verified that the resident was referred for support and was waiting for the appointment.

During an interview, ADOC #118 stated that they were not aware of the incident which occurred on the identified date, until the initiation of this inspection. The ADOC stated that they did not receive a message from the RN working the shift that

weekend but acknowledged that they should have been notified of the incident for reporting purposes. The ADOC verified that they were aware of the resident's responsive behavior, and that the resident had the behavior since admission to the home; however, they did not expect the magnitude of the behavior. The ADOC acknowledged that there was a definite impact on the other resident and visitors to the home; and stated that the staff have 'normalized the resident's behavior'.

Regarding the incident, the ADOC stated they would not be surprised if resident #010 engaged in an abusive interaction. The expectation was that staff take the resident aside and speak with them to instruct them that verbally abusing another resident would not be tolerated; the registered staff should inform the ADOC when such incidents occur on the unit; and staff should also document the incident in Point Click Care (PCC). The ADOC verified that verbal abuse should be reported to the Director, and this was a missed opportunity since they were not aware of the incident.

During an interview, DOC #100 verified that they were not aware of the incident which occurred, and stated that they recently witnessed resident #009's responsive behavior. The DOC stated that the staff seemed to have normalized the resident's behavior and that external resources were consulted and involved with the resident's care. The DOC stated that they informed the staff working on the unit that it was unacceptable for them to walk by when the resident was displaying that behavior.

The DOC stated that other residents also complained that they do not like to see resident #009 displaying the behavior, and acknowledged that it was those residents' home as well.

Therefore, the home failed to ensure that resident #002, #007 and #009 were not neglected by the licensee or staff. [s. 19.]

The severity of this issue was determined as actual harm or actual risk to residents. The scope of the issue was widespread as it relates to three out of three residents. The home had ongoing history of non-compliance in this same subsection including:
- a Voluntary Plan of Correction, inspection #2017_654605_0011 issued on September 26, 2017,
- a Voluntary Plan of Correction, inspection #2019_526645_0005 issued on June 24,

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

2019.
As such, a compliance order (CO) is warranted. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 03, 2020(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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 36.

Specifically, the licensee shall ensure that staff use safe transferring and positioning devices or techniques when assisting all residents in the home, as applicable, by completing the following:

1. Develop and conduct random quality improvement audits on all resident care units and shifts to ensure staff are using safe transferring and positioning devices and techniques when assisting residents. Audits should include but not limited to the date, unit, person conducting the audit, concerns identified, and actions taken to address identified concerns. Records should be maintained for review as required.

2. Promote a culture of transparency and openness to encourage staff to report incidents so that residents receive timely and applicable assessments and treatments when incidents occurs. Document actions taken to promote the change in culture.

3. Identify and promote the use of multilingual communication aids and tools to ensure residents' concerns are addressed in a timely manner, and decrease language barriers between staff and residents in the home.

Grounds / Motifs :

1. The licensee has failed to ensure staff used safe transferring techniques when assisting resident #007.

The MLTC received a CIS report on an identified date, related to resident #007's transfer to hospital with an unknown injury.

Record review indicated that on an identified date, resident #007 received a full admission assessment using the home's RAI-MDS assessment tool.

Record review indicated that on another identified date, PSW #138 admitted to transferring the resident without support from another staff. During an interview, PSW #138 stated that during the transfer, the resident 'swayed', and that after the resident 'swayed' they managed to support the resident around their waist. At that time, the resident started complaining of pain in an identified body part. The PSW verified that they did not request the support of another PSW to provide the care as was indicated in the resident's care plan.

During an interview, PSW #138 verified that they did not inform RPN #140 that the resident had an incident while they were providing their care; therefore, resident #007 was not properly assessed and transferred to the hospital until the following identified date when they received the diagnosis and had a procedure completed on the same day.

During separate interviews, PSW #138 and RPN #140 verified that the PSW used unsafe transferring techniques while working with resident #007; and the PSW further stated that they did not review the resident's written care plan prior to providing care to the resident.

A review of the home's investigation notes indicated that PSW #138 was disciplined related to failure to review the resident's care plan prior to starting duties, and failed to adhere to resident's care plan regarding lift and transferring. This information was verified by ADOC #132. Therefore, the home failed to ensure PSW #138 used safe transferring techniques when assisting resident #007. [s. 36.]

The severity of this issue was determined as actual harm or actual risk to the resident. The scope of the issue was isolated as it relates to one resident. The home had ongoing history of non-compliance in this same subsection including:
- a Voluntary Plan of Correction, inspection #2017_654605_0011 issued on

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

September 26, 2017,
- a Voluntary Plan of Correction, inspection #2018_759502_0018 issued on November 19, 2018,
- a Voluntary Plan of Correction, inspection #2019_526645_0005 issued on June 24, 2019.

As such, a compliance order (CO) is warranted. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 03, 2020(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

Order # / No d'ordre: 003

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 :

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

The licensee must be compliant with O. Reg 79/10, s. 73. (1) 10.

Specifically, the licensee shall ensure that the home has a dining and snack service that includes the proper techniques to assist residents with eating and/or drinking, specifically during snack time, including safe positioning of residents #001, #011, #014 and all other residents who use tilt wheelchairs and require assistance from staff by completing the following:

1a. Ensure additional training is provided to the staff who provide direct care to residents on proper techniques to assist residents with eating and/or drinking specifically during snack time, including safe positioning of residents who use tilt wheelchairs and require assistance from staff.

1b. Maintain the related training records including names of those attended, dates, who provided the education and training materials.

1c. Conduct post-training testing or evaluation to ensure knowledge comprehension of the training material and maintain the evaluation records.

2a. Develop and implement an on-going quality improvement auditing process to ensure direct care staff demonstrate proper techniques when assisting residents with eating and/or drinking specifically, during snack time. The audit tool should include monitoring safe positioning of residents while eating when seated in a tilted wheelchair.

2b. Maintain a written record of the auditing process including the frequency of the audits, who will be responsible for doing the audits and evaluating the results. Documentation should include, but not limited to, the date and location of the audit, the resident's name, staff members audited, the name of the person completing the audit, the outcome and follow-up of the audit results.

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 proper techniques were used to assist resident #001, #011 and #014, including safe positioning.

The MLTC received a CIS report regarding resident #001 related to a fall incident.

On an identified date and time, Inspector #726 observed PSW #123 assisting resident #001 during snack time while resident #001 remained in a tilted wheelchair position. The inspector observed resident #001 bending their head forward while they were being fed by PSW #123. Review of resident #001’s care plan indicated that the resident required extensive assistance.

In an interview, PSW #123 stated that resident #001 was in a slanted position and acknowledged that they did not check resident #001’s position before assisting the resident with the snack. PSW #123 indicated that before assisting the resident, they should put the resident in an upright position.

In an interview, RPN #102 acknowledged that PSW #123 should have placed resident #001 to an upright position. In an interview, DOC #100 confirmed that the resident should be placed in an upright position. [s. 73. (1) 10.] (726)

2. As a result of non-compliance related to resident #001, resident #011 and #014 were selected to increase the sample size. These residents were identified as seated in a tilted position.

Review of resident #011's care plan indicated that resident #011 was assessed with documentation related to meals.

On an identified date and time, Inspector #726 observed resident #011 sitting in a tilted position. PSW #110 was assisting resident #011 with snacks while the resident remained in the tilted position. The inspector observed resident #011 trying to lift their head up and bend forward while assisted by PSW #110.

In separate interviews, PSW #110 acknowledged that they should have placed resident #011 in an upright position before assisting the resident; RPN #112 acknowledged that PSW #110 should have placed resident #011 in an upright position before assisting the resident; and DOC #100 confirmed that the staff were supposed to place resident #011 in an upright position to prevent choking. [s. 73. (1) 10.]
(726)

3. Record review of RAI-MDS assessment on an identified date indicated resident #014's assessment was completed.

Review of resident #014's care plan indicated that the resident was assessed and the required information documented in their care plan.

On an identified date and time, Inspector #726 observed resident #014 was in a tilted position, while PSW #142 was assisting the resident during snack time. The inspector observed resident #014 bending their head down and forward when PSW #142 was assisting them.

In separate interviews, PSW #142 acknowledged that they should have placed resident #014 in an upright position; RPN #102 acknowledged that PSW #142 should have placed resident #014 in an upright position; and DOC #100 confirmed that the staff were supposed to place resident #014 in an upright position to prevent choking.

Therefore, the home failed to ensure that proper techniques were used to assist resident #001, #011 and #014. [s. 73. (1) 10.]

The severity of this issue was determined as minimum harm or risk to residents. The scope of the issue was widespread as it relates to three out of three residents. The licensee had a history of non-compliance to a different subsection of the O. Reg. 79/10. As such, a compliance order (CO) is warranted. (726)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 27, 2020

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 # / No d'ordre: 004

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 LTCHA, 2007, s. 6 (7).

Specifically, the licensee shall ensure that care is provided to residents #003, #004, #007 and all other residents, as specified in the plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003, #004 and #007 as specified in the plan.

A CIS report was submitted to the MLTC on an identified date, related to an unwitnessed incident involving resident #003 on another identified date and time.

The resident was assessed, physician and family were notified. The resident was transferred to the hospital and the home staff were informed that the resident had an injury as a result of the incident. An amended CIS report was submitted to the MLTC on a later identified date. Review of the report indicated that the home's surveillance video footage showed that resident #003 had an unwitnessed injury on an earlier identified date than was reported in the critical incident report.

Record review of the RAI-MDS Assessment indicated that the resident received an assessment on an identified date.

During the inspection, the DOC #100 provided the inspector with a copy of the surveillance video footage related to resident #003's incident on the identified date. Review of the video footage confirmed the sequence of events leading to the

incident, as described in the amended CIS report.

In an interview, PSW #127 stated that in the past they had worked the "3-9 pm PSW" shift and one of their duties was to monitor the residents for falls and behaviors in the open areas after meals.

In an interview, PSW #120 stated that resident #003 was at risk for falls, and that they were assigned to work as the "3-9 pm PSW" in the unit on the identified date of the incident. The PSW verified that one of their main duty was to provide entertainment for the residents to occupy them after the meal, and to monitor residents for behaviors and falls. PSW #120 stated that on the date of the incident, before the incident occurred, they were feeding resident #018 when the incident occurred. The PSW acknowledged that they could have asked the other PSWs to help with feeding the resident, so that they could focus on only monitoring all residents during their shift.

In an interview, RPN #121 stated that all PSWs had been informed that the two "3-9pm PSWs" duties were to monitor residents only. RPN #121 stated that on the date of the incident, there were approximately eight to nine residents in the dining room after the meal. RPN #121 acknowledged that PSW #120 was not supposed to feed any resident, and that another PSW should have fed resident #018.

In an interview, the DOC #100 acknowledged that it would be hard for PSW #120 to focus on feeding resident #018 and monitor the other residents in the dining room at the same time.

In summary, PSW #120 was assigned on the '3-9pm' shift to provide support and monitor all residents, including resident #003. During the interview, PSW #120 verified that they did not monitor resident #003 prior to the incident, but instead was feeding resident #018. [s. 6. (7)] (726)

2. Record review of the resident's care plan indicated that resident #007 spoke their native language. The written care plan included a focus related to language barrier since the resident's communication in English was poor. The goal of this focus indicated the resident will be able to understand daily messages and the intervention indicated their native language spoken, little English and may need someone who speaks their native language or interpret.

Record review of the critical incident indicated that on an identified date, resident #007 experienced an incident while being transferred by PSW #138. After the incident occurred, the resident tried to communicate with the staff in their native language, but was taken to the dining room for the meal. The resident was agitated and saying something in their native language and non-verbally indicated pain in an identified body part. The resident spoke in their native language to another resident’s family member #139 who understood their language.

During an interview, family member #139 verified that the resident was upset and told them detailed information about the incident which occurred and caused their pain. Family member #139 stated that they approached RPN #140 and immediately informed them of what the resident had told them. The family member also verified that the RPN and PSW did not ask them to communicate/translate further with the resident during or after the incident occurred.

During an interview, RPN #140 verified that they had heard the resident saying something in their language, but acknowledged that there was a language barrier. The RPN stated that they did not follow up with what the resident was trying to say with a translator, nor did they ask family member #139 to translate what the resident was trying to communicate related to the incident. The RPN stated that they were not able to verify that an incident occurred because a language barrier existed between themselves and the resident. However, they understood the resident’s non-verbal language. RPN #140 stated that they administered medication to the resident; however, they did not call the resident’s family related to the incident, because they were not sure that an incident had occurred.

In summary, the resident's care plan clearly indicated that the resident may need someone who speak the resident's native language for translation. The resident was in obvious distress and required a translator in order to communicate with staff and to support staff assessment. However RPN #140 and PSW #138 did not follow the plan of care, and provide someone to translate the resident's native language to English so that staff would be aware of what the resident was trying to communicate. [s. 6. (7)]
(535)

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan.

The Ministry of Long-term Care (MLTC) received a complaint related to the provision of recreational activities for the residents in the home during an identified period. Resident #004 was one of the three residents who were selected for review.

In an interview, resident #004's SDM stated that the resident was not assisted out of their room for activities of their interest, although they have made a specific request to the home.

Record review indicated the resident was assessed using the home's RAI-MDS assessment on an identified date.

Review of resident #004's care plan indicated under the focus of psychosocial/activities, specific interventions were listed to be completed every other week. However, a review of resident #004's Multi-day Participation Reports between an identified period of months, indicated that the resident did not receive that intervention.

In an interview, the Resident Programs Manager #116 confirmed that all activities provided to resident #004 in each month were documented on the Multi-day Participation Reports. RPM #116 acknowledged that the recreation staff could have gone back to provide the specific intervention another day if the resident refused or was not available at the time of the staff visit.

Therefore, the home failed to ensure that the care set out in the plan of care was provided to residents #003, #004 and #007 as specified in the plan. [s. 6. (7)]

The severity of this issue was determined as actual harm or actual risk to residents. The scope of the issue was widespread as it relates to three out of three residents. The home had ongoing history of non-compliance in this same subsection including:
- a Compliance Order, inspection #2017_654605_0011 issued on September 26, 2017,
- a Voluntary Plan of Correction, inspection #2017_681654_0009 issued on April 21, 2017.
As such, a compliance order (CO) is warranted. (535)

Ontario

Ministry of Long-Term Care

Ministère 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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Apr 03, 2020(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 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:

Ontario

Ministry of Long-Term Care

Ministère 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

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 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.

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

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

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

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 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 3 rd day of February, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by VERON ASH (535) - (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

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