Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 22, 2019	2019_543561_0002	034049-16, 008917-17, 008918-17, 009452-17, 009745-17, 017073-17, 021826-17, 023151-17, 027711-17, 003857-18, 005258-18, 006359-18, 018389-18, 028486-18	Critical Incident System

Licensee/Titulaire de permis

Halton Healthcare LTC Inc.
327 Reynolds Street OAKVILLE ON L6J 3L7

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

Wyndham Manor Long Term Care Centre
291 Reynolds Street OAKVILLE ON L6J 3L5

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

DARIA TRZOS (561), DIANNE BARSEVICH (581), YULIYA FEDOTOVA (632)

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): January 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 24, and 25, 2019.

The following intakes were completed during this Critical Incident System (CIS) inspection:
034049-16, CIS #2910-000023-16 - related to an injury of unknown cause,
008917-17, CIS #2910-000009-17 - related to an injury of unknown cause,
008918-17, CIS #2910-000010-17 - related to a fall with injury,
009452-17, CIS #2910-000011-17 - related to a fall with injury,
009745-17, CIS #2910-000012-17 - related to a fall with injury,
017073-17, CIS #2910-000013-17 - related to alleged staff to resident abuse,
021826-17, CIS #2910-000015-17 - related to an injury of unknown cause,
023151-17, CIS #2910-000016-17 - resident to resident alleged abuse,
027711-17, CIS #2910-000018-17 - related to an injury of unknown cause,
003857-18, CIS #2910-000004-18 - related to an injury of unknown cause,
005258-18, CIS #2910-000005-18 - related to a fall with injury,
006359-18, CIS #2910-000008-18 - related to an injury of unknown cause,
018389-18, CIS #2910-000013-18 - related to improper care of resident resulting in injury,
028486-18, CIS #2910-000015-18 - related to a fall with injury.

The following Complaint Inspection intakes were completed concurrently with this CIS Inspection:
025121-17 – related to safety concerns from shortage of staff and responsive behaviours,
027673-17 – related to medication management,
007551-18 – related to management of skin and wound and other issues related to care of resident

PLEASE NOTE: Non-compliance identified in a Complaint Inspection number 2019_560632_0001 related to LTCHA, s. 6(1)(a), has been issued in this report as a VPC.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Associated Director of Care (ADOC), Office Coordinator, Physiotherapist, Physician, Resident Behavioural Support Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers, and residents.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed investigation notes, clinical records, program evaluations, training

materials, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.
- **0 AMP(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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).

(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

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

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out, the planned care for the resident.

A) A review of Critical Incident System (CIS) submitted to the Director on an identified date in 2018, identified that resident #009 sustained an injury and the cause was not determined.

On an identified date in 2019, resident #009 was observed sitting in the wheelchair with a device in place. Review of the current written plan of care identified they required an identified device in place as a falls prevention intervention; however, did not identify the resident required the device that they were observed to have in place.

During an interview with RPN #109, they stated the resident did have the identified device in place in 2018; however, when they received a new wheelchair the device was changed.
RPN #109 confirmed that the device was planned care for the resident and was not documented in the written plan of care.

B) A review of a CIS submitted to the Director on an identified date in 2018, identified that resident #010 sustained an injury and the cause was not determined.

Review of the clinical record identified the resident was diagnosed with a condition related to the injury on an identified date in 2018, and after consultation with the resident's family care decisions were made and the resident returned to the home with an identified device in place.

Review of the written plan of care reviewed and revised by the home on two dates in 2018, did not identify that the device was to be applied as part of the planned care for the resident.
Review of the physician's orders identified that the device was discontinued on an identified date in 2018.

RPN #109 was interviewed and reviewed the clinical record and acknowledged the resident did return from the hospital with a device in place. They stated that the device was not documented in the written plan of care.

RPN #109 confirmed that the application of the device was planned care for resident #010 and was not documented in the written plan of care.

C) A review of a CIS, submitted to the Director on an identified date in 2018, identified

that resident #001 fell, was transferred to hospital and was diagnosed with an injury.

On an identified date in 2019, resident #001's room was observed with an identified intervention in place. Review of the written plan of care did not identify that the resident had the intervention in place.

PSW #122 was interviewed and stated that the resident had a history of falling and had the identified intervention in place.

RN #101, after they reviewed the plan of care, acknowledged that the identified intervention was part of the planned care for the resident as a falls intervention.

RN #101 confirmed that the identified intervention was planned care for the resident and was not documented in the written plan of care.

D) A complaint was received by the Ministry of Health and Long Term Care (MOHLTC) on an identified date in 2018, indicating that resident #031 had altered skin integrity.

Resident #031's clinical records were reviewed and identified that the resident had altered skin integrity on an identified date in 2018. The resident was using a wheelchair for locomotion and had an intervention in place as indicated in progress notes. The clinical records did not indicate when the intervention was implemented. The written plan of care was reviewed from an identified period of time in 2017 to 2018 and did not identify the intervention was in place.

The interview with registered staff #107 confirmed that resident #031 had the identified intervention in place to prevent deterioration.
RN #100 acknowledged that the written plan of care did not identify the identified intervention was in place.

The licensee failed to ensure that the written plan of care set out the planned care for resident #031 related to altered skin integrity. [s. 6. (1) (a)]

2. The licensee 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 complement each other.

A review of a CIS submitted on an identified date in 2018, identified that resident #010

sustained an injury and the cause was not determined.

Review of the plan of care on an identified date in 2018, indicated that resident #010 was sent to the hospital and was diagnosed with a condition and a device was applied. Review of the diagnostic imaging report, identified the resident had an identified injury.

Review of the Minimum Data Set (MDS) significant change in status assessment completed on an identified date in 2018, identified they had not fallen in the past 30 days and did not indicate they had an injury in the last 180 days.

In an interview with RN #100, they stated the resident had sustained an injury on an identified date in 2018, and the cause was unknown and confirmed the MDS assessment and diagnostic imaging report were not integrated and consistent with each other. [s. 6. (4) (a)]

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

Review of the clinical record identified that resident #001 fell on an identified date in 2018. An assessment was done and identified they could not exclude the possibility of an identified condition related to falls and there should be further investigation. On an identified date in 2018, another assessment was completed and identified there was a possible condition and further assessment was required in several days. Several weeks later, another assessment was completed which identified that there was a change in condition.

During an interview with RN #101 and review of the assessments indicated that the last assessment was delayed and should have been done as indicated in the clinical records

RN #101 confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan related to the timing of the assessments. [s. 6. (7)]

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

A review of a CIS report submitted to the Director on an identified date in 2018, identified that resident #001 fell, was transferred to hospital and was diagnosed with an injury. c

A) On an identified date in 2019, resident #001's room was observed and two different logo's related to the level of assistance for transfers were posted on the cupboard door.

Review of the Point of Care (POC) documentation under the transfer task indicated that the PSW staff documented under two questions, one related to how the resident was moved between surfaces and the choices that were available were independent, supervision, limited assistance, extensive assistance and total dependence. The second question documented the type of support provided when the resident was moved between surfaces and the choices that were available were no setup or physical help, set up help only, one person physical assist and two or more person physical assist.

PSW #117 was interviewed and stated that the resident was transferred with an identified level of assistance using a device and was no longer transferred as indicated in one of the logos posted in the room. The POC documentation was reviewed with PSW #117 and they stated that PSW staff were unable to document which specific transfer was completed between an identified level of assistance or if they used a device.

During an interview with RN #101 and review of the POC documentation, they acknowledged that the POC program did not differentiate between the identified level of assistance and the device used. They confirmed that the PSW staff were not able to specifically document which transfer was performed related to the identified transfer types.

B) Review of the current plan of care for resident #018 identified they were transferred with an identified level of assistance and a device was used as needed.

On an identified date in 2019, the resident's room was observed and two different logos were posted on the cupboard door which indicated the resident required an identified level of assistance for transfers or a device was used.

During an interview with PSW #122 they stated the resident was currently transferred with a device.

Review of POC with PSW #122, they acknowledged that when they documented the resident's daily care in POC under the transfer task they were unable to document specifically if they used a device or an identified level of assistance.

RPN #119 was interviewed and reviewed POC documentation and confirmed the

program on POC did not allow the PSW staff to document which specific transfer was performed.

C) Review of the current plan of care for resident #002 identified they were transferred with an identified level of assistance and required a device as needed.

On an identified date in 2019, the resident's room was observed and two different logos were posted on the cupboard door which indicated the resident required an identified level of assistance and a device as needed.

During an interview with PSW #122 they stated the resident was currently transferred using a device.

Review of POC with PSW #122, they acknowledged that when they documented the resident's daily care in POC under the transfer task they were unable to document specifically if they used a device or an identified level of assistance.

RPN #119 was interviewed and reviewed POC documentation and confirmed the program on POC did not allow the PSW staff to document which specific transfer was performed.

The licensee failed to ensure that the provision of care set out in the plan of care was documented for resident #001, #002 and resident #018. [s. 6. (9) 1.]

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

A) A review of a CIS report submitted to the Director on an identified date in 2018, identified that resident #010 sustained an injury and the cause was not determined.

Resident #010's plan of care was reviewed and identified that the written plan of care was not revised when the resident's care needs changed in relation to mobility, their condition and symptoms associated with the condition and sleep and rest patterns when they returned from hospital on an identified date in 2018, with an injury. The clinical records indicated that resident returned from the hospital with a device in place.

In an interview with PSW #108 they stated when the resident returned from hospital with

an injury their mobility and sleep and rest routine had changed.

RPN #109 was interviewed and after they reviewed the plan of care they acknowledged that when the resident returned from hospital their care needs changed related to mobility, change in condition and symptoms related to the identified condition, and sleep patterns and confirmed the written plan of care was not revised until several weeks later.

RPN #109 confirmed that resident #010's plan of care had not been reviewed or revised when the resident's care needs changed. (581)

B) A review of a CIS report submitted to the Director on an identified date in 2018, identified that resident #001 fell, was transferred to hospital and was diagnosed with an identified condition which was treated at the hospital.

i. Review of the clinical record identified that resident #001 fell on an identified date in 2018, and reported identified symptoms. The home completed an assessment which indicated a possibility of an injury and further assessment was required. Another test was performed several days later and identified there was a possible further injury and further assessment was required in several days. Several weeks later an identified test confirmed a change in condition.

PSW #122 was interviewed and stated that after the resident fell they were transferred with a device. PSW documentation was reviewed.

Review of the written plan of care prior to the fall identified the resident was transferred with an identified level of assistance; however, after the fall the plan of care was not reviewed and revised until several weeks post fall, to identify that the resident required a device for transfers.

During an interview with RN #101, they stated the resident's transfer status was changed on an identified date in 2018, and acknowledged that the plan of care was not reviewed and revised until several weeks post fall.

RN #101 confirmed that the plan of care was not reviewed and revised when the resident's care needs changed related to transfers.

ii. Resident #001's plan of care after the injury post fall, included a care focus related to mobility that had an identified goal with interventions.

PSW documentation was reviewed and identified the changes in mobility post fall.

RN #101 was interviewed and after they reviewed the plan of care they acknowledged that after the resident fell and sustained in injury their care needs changed related to mobility and the plan of care was not reviewed and revised.

iii. Resident #001's plan of care after the fall with injury included a care focus related to falls that had an identified goal with an identified intervention.

RN #101 was interviewed and after they reviewed the plan of care they acknowledged that after the resident fell and sustained an injury, their care needs changed and that the PSW staff were no longer applying the identified intervention. They acknowledged the plan of care related to application of the intervention should have been reviewed and revised when there was a change in their condition.

RN #101 confirmed that resident #001's plan of care was not reviewed or revised when the resident's care needs changed related to the application of an identified intervention after they fell and sustained an injury.

iv. Resident #001's plan of care post fall with injury included a care focus related to the resident's identified health condition and symptoms associated with it with an identified goal and interventions related to management of the symptom.
Review of the clinical record, specifically the progress notes, identified on an identified date in 2018, that the resident had increase of the identified symptom.

Review of a progress note completed on an identified date 2018, by registered staff, documented the identified resident's symptom and an increase next day. Review of the electronic medication administration record (EMAR) indicated that a medication was administered for the management of the symptom for several weeks. This medication was later increased to manage the symptom.

During an interview with RN #101, they reviewed the plan of care and stated that the resident had the identified symptom and was receiving medications and the plan of care was not revised to reflect this change in the resident plan of care.

RN #101 confirmed that resident #010's plan of care was not reviewed or revised when the resident's care needs changed related to symptoms associated with the injury.

C) A review of a CIS report submitted to the Director on an identified date in 2018, identified that resident #009 sustained an injury and the cause was not determined.

Review of the clinical record identified the resident had a device in place. On an identified date in 2019, the resident was observed sitting in a wheelchair and did not have the device in place; however, had alternative device in place.

In an interview with PSW #108, they stated that the resident did not have the device but a different device in place. During an interview with RPN #109, and review of the plan of care, they stated that the resident no longer required the device.

RPN #109 confirmed that the plan of care was not reviewed and revised when the resident's care needs changed and the plan was no longer necessary.

D) A CIS report was submitted to the Director on an identified date in 2017, alleging abuse of resident #003 by resident #002.
Review of resident #002's written plan of care indicated resident had identified behaviours and had an intervention in place. Review of the records provided by RN #100 indicated that the intervention was initiated on identified dates in 2017. Interview with RN #100, identified that the identified intervention was temporary and the written plan of care was not updated.

The home failed to ensure that the plan of care for resident #002 was reviewed and revised at the time when the care set out in the plan was no longer necessary.

E) Resident #013 had an identified diagnosis and was admitted to the home on an identified date in 2018. Review of progress notes for the resident identified that the resident had identified behaviours and an identified intervention was to be initiated. Review of an identified document for resident #013 indicated that the intervention was provided to the resident on identified dates in 2018. Review of the written plan of care did not identify that the intervention was in place. Interview with RN #100, identified that the intervention was temporary and the written plan of care was not updated.

The home failed to ensure that the plan of care for resident #013 was reviewed and revised at the time when resident #013's care needs changed.

F) Review of the plan of care for resident #018, identified they were transferred with an

identified level of assistance and also required a device as needed.
During an interview with PSW #122, they stated the resident was transferred using a device and no longer required the identified level of assistance as indicated in the plan of care. Review of the logos posted at the bedside with PSW #122 and they acknowledged the logos were not correct and needed to be changed to indicate that the resident was transferred using a device.

RPN #119 was interviewed and stated that the resident was no longer transferred with the identified level of assistance and confirmed that the plan of care was not reviewed and revised when the resident's care needs changed.

G) Review of the plan of care for resident #002, identified they were transferred with an identified level of assistance and a device was used as needed.
During an interview with PSW #122, they stated the resident was transferred using a device and was no longer transferred with the level of assistance identified in the plan of care. Review of the logos posted at the bedside with PSW #122 and they acknowledged the logos were not correct and needed to be changed to indicate that the resident was transferred using a device.

RPN #119 was interviewed and stated that the resident was no longer transferred with the identified level of assistance and confirmed that the plan of care was not reviewed and revised when the resident's care needs changed related to transfers.

H) A CIS report was submitted to the Director on an identified date in 2017, related to an incident that caused an injury to resident #012 for which the resident was taken to hospital and which resulted in a significant change in their health status.

i. Clinical record review identified that resident #012 had a condition noted on an identified date in 2017. The progress note and the interview with the RPN #116 who made the documentation, indicated that the oncoming shift was to assess the resident's condition. There was no evidence indicating that the resident was assessed. RN #100 was interviewed and stated that the resident was not assessed when the staff noted the identified condition.

ii. Review of the progress note on an identified date in 2017, identified that resident #012 was diagnosed with an injury.
Progress note made by the physician indicated that a medication was increased for an identified condition. Progress noted made by the physiotherapist stated that the resident

required change in transfer related to the condition.
The written plan of care last reviewed and revised by the home, indicated that interventions related to the change in condition were not added to the written plan of care until several weeks later.

RN #100 was interviewed and acknowledged that resident was not reassessed and the written plan of care was not updated with the change in the resident's condition.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed. [s. 6. (10) (b)]

6. The licensee failed to ensure when a resident was reassessed and the plan of care reviewed and revised, if the plan of care was being revised because care set out in the plan had not been effective, the licensee shall ensure that different approaches were considered in the revision of the plan of care.

A review of a CIS report that was submitted to the Director on an identified date in 2018, identified that resident #001 fell was diagnosed with an injury and was transferred to hospital for treatment several days later.

A) Review of the clinical record identified that resident #001 fell on an identified date in 2018, and reported identified symptom and change in condition. The home completed an assessment which indicated a possibility of an injury and further assessment was required. Another test was performed several days later and identified there was a possible further injury and further assessment was required in several days. Several weeks later an identified test confirmed a change in condition.

i. Review of identified assessments and EMARs revealed the resident continued to complain of an identified symptom and was receiving medications as needed. The review of identified assessments indicated that the identified symptom was not relieved with current interventions.

ii. Review of the written plan of care included a care focus related to the resident's chronic condition with a goal to improve the condition and interventions in place. The written plan of care was not reviewed and revised related to the resident's increase in an identified symptom post fall with injury. There were no new goals or interventions documented in the written plan of care to manage the resident's symptom. RPN #101

confirmed that the resident's plan of care had not been reviewed or revised when the resident's care needs changed related to management of the condition post fall.

iii. Review of the plan of care did not include any revisions to the plan of care or that different approaches were considered, related to the identified symptom when the current management of it was not effective.

B) Review of the plan of care identified that the home was notified of the results of the second assessment which confirmed the injury that had deteriorated with significant changes.

i. Review of the PSW flow sheets for an identified period of time in 2018, identified that the resident was transferred daily from the bed to wheelchair with an identified level of assistance and received assistance with activities of daily living several weeks after the fall, at which time, it was documented that the resident's mobility changed and the resident was later transferred to hospital for further interventions.

ii. PSW #122 was interviewed and stated that after the resident fell their mobility changed and resident reported identified symptoms. They acknowledged the resident was transferred with a device after the fall.

iii. Interview with RN #100 confirmed that PSW staff continued to transfer the resident and no interventions were put in place to stabilize the injury.

iv. Interview with Physiotherapist (PT) stated they received a referral post fall but did not assess the resident for transfers as was told by registered staff that the first assessment was not conclusive of an injury and the assessment needed to be repeated. PT stated they assumed that the resident's mobility status was changed after the fall.

C) On an identified date post fall an assessment identified the injury and further deterioration. Resident was sent to hospital for further interventions.

RN #100 confirmed that when the plan of care was being revised because care set out in the plan had not been effective, the licensee did not ensure that different approaches were considered in the revision of the plan of care, related to management of symptoms and mobility status. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out the planned care for the resident, to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary and to ensure that different approaches are considered in the revision of the plan of care, to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The Long Term Care Homes Act (LTCHA), 2007, O. Reg 79/10, defines abuse and different types of abuse.

A CIS report was submitted to the Director on an identified date in 2017, alleging abuse by resident #002 towards resident #003.

Progress notes review indicated that resident #002 had an incident towards co-resident #003. Resident #003's assessment indicated there were no visible injuries or distress noted and the resident did not recall the incident.
RPN #115 indicated that resident #003 was not aware of the incident related to their cognitive status.

ED acknowledged that resident #003 was not protected from abuse by resident #002.

The home did not ensure that resident #003 was protected from abuse by anyone in the home. [s. 19. (1)]

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

The LTCHA, 2007, O. Reg 79/10, defines neglect as the failure to provide resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A CIS report was submitted to the Director on an identified date in 2018, related to a fall of resident #001 with injury and transfer to hospital for further interventions.

Review of the clinical record identified that resident #001 fell on an identified date in 2018, and reported identified symptom and change in condition. The home completed an assessment which indicated a possibility of an injury and further assessment was required. Another test was performed several days later and identified there was a possible further injury and further assessment was required in several days. Several weeks later an identified test confirmed a change in condition.

Review of identified assessments and EMARs revealed the resident continued to complain of an identified symptom and was receiving medications as needed. The review of identified assessments indicated that the identified symptom was not relieved with current interventions.

Review of the plan of care did not include any revisions to the plan of care or that different approaches were considered, related to management of the symptoms of the condition.

Review of an assessment, which identified the resident had constant symptoms of the condition and were not relieved with medication. It was documented that it was effecting all aspects of the resident's activities of daily living (ADLs). Review of physician order included an increase in medications.

The review of progress notes and identified assessments documented that resident #001 continued to have symptoms of the condition.

On an identified date, the home was notified of the results of the second assessment which confirmed the injury with significant deterioration.
The physician was notified and medication orders included a specified intervention.

On an identified date in 2018, the progress note identified that morning care was provided after medications were administered; however, an identified level of assistance was required due to the symptoms. The resident was transferred with a device and refused to eat.

Review of the PSW flow sheets for an identified period of time in 2018, identified that the resident was transferred daily from the bed to wheelchair with an identified level of assistance and received assistance with activities of daily living several weeks after the fall, at which time, it was documented that the resident's mobility changed and the resident was later transferred to hospital for further interventions.

PSW #122 was interviewed and stated that after the resident fell their mobility changed and resident reported identified symptoms. They acknowledged the resident was transferred with a device after the fall.

Interview with RN #100 confirmed that PSW staff continued to transfer the resident and no interventions were put in place to stabilize the injury. During an interview with RN #101, after reviewing the clinical health record they acknowledged the Safe Lift and Transfer Assessment was not completed after the resident fell, sustained an injury and had a change in their condition. RN #101 confirmed that the licensee's policy, Safe Lifting with Care Program was not complied with.

Furthermore, interview with Physiotherapist (PT) stated they received a referral post fall but did not assess the resident for transfers as was told by registered staff that the first assessment was not conclusive of an injury and the assessment needed to be repeated. PT stated they assumed that the resident's mobility status was changed after the fall.

On an identified date in 2018, an assessment indicated that a comparison was made with previous assessments and identified the injury had deteriorated. There was significant change in the injury.

The home's inaction following resident #001's fall, related to transfer assessments, management of symptoms, and other assessments, jeopardized the health and well-being of the resident, resulting in ongoing symptom changes and worsening injury, until they were transferred to the hospital for further intervention.

The licensee failed to ensure that resident #001 was protected from neglected by anyone. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting Policy", policy number RC-02-01-02, last updated in April 2017, indicated that anyone who witnessed or suspected abuse or neglect of a resident by another resident, staff or other person must report the incident. At minimum, any individual who witnessed or suspected abuse or neglect of a resident must notify management immediately.

A) A CIS report was submitted to the Director on an identified date in 2017, alleging abuse and/or neglect of resident #004 by PSW #105 on an identified date in 2017. Resident #004 with an identified diagnosis required assistance with transfer. PSW #105 did not provide assistance to PSW #103 with the transfer of resident #004 and PSW #114 assisted PSW #103.
Review of resident #004's written plan of care indicated that they required an identified level of assistance with transfers.

PSW #103 was interviewed and indicated that they reported this incident to PSW #114 on the same date. RPN #121 indicated that once the registered staff was informed about the incident of alleged abuse or neglect towards a resident, they would document it in progress notes and would report it to the Charge Nurse and the Charge Nurse would inform the Manager-on-Call. ED indicated that staff reported the incident to the DOC late.

B) A CIS report was submitted to the Director on an identified date in 2018, alleging abuse of resident #014 by PSW #124.

Review of the resident's written plan of care indicated that resident #014 required an identified level of assistance with care. RPN # 125, who was present at the time of the incident, reported the incident to RN #101 on an identified date in 2018. ED acknowledged that the incident was not reported immediately to management by staff.

The licensee failed to ensure that the home's Zero Tolerance of Resident Abuse and Neglect: Response and Reporting Policy, RC-02-01-02, was complied with. [s. 20. (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 the policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: 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 failed to ensure that the staff used safe transferring and positioning devices or techniques when assisting residents.

A CIS report was submitted to the Director on an identified date in 2018, related to an improper/incompetent treatment of resident #006 that resulted in harm. The CIS report indicated that PSW #105 was getting resident #006 ready to be transferred, they left the room to call for assistance and returned to the resident. There was an incident and resident sustained an injury.

The home's investigation notes were reviewed and indicated that when PSW #105 was interviewed by the home they stated that they were getting resident #006 ready for transfer, and resident sustained an injury; however, they were not aware of how.
PSW #106 who went to assist PSW #105 with the transfer stated in the interview with the home that when they walked into the resident's room they observed the injury.
RPN #107 was interviewed by the home during the investigation and stated that they went to their room and saw the resident had several injuries.

The plan of care at the time of the incident, stated that resident #006 required a device for transfers. The risk management report was reviewed and description of the injuries were documented.

PSW #106 was interviewed and confirmed the statement provided by the home during the investigation.
PSW #105 could not be interviewed.

The ED was interviewed and stated that the investigation concluded that PSW #105 attempted to transfer the resident by themselves using a device from which the resident sustained the injuries.

The licensee failed to ensure that the staff used safe transferring and positioning devices or techniques when assisting resident #006. [s. 36.]

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

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 failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

The licensee failed to ensure policies included in the required Falls Prevention and Management program were complied with.

In accordance with O. Reg. 79/10, s. 48(1) 1 the licensee is required to have an interdisciplinary Fall Prevention and Management program and in accordance with O. Reg. 79/10, s. 30 (1) 1, the licensee is required to ensure that each of the required programs includes policies, procedures and protocols.

The home's policy titled "Neurological Signs/Head Injury Routine" (HIR), policy number RC-25-01-38, last updated in February 2017, included as part of the licensee's Falls Prevention and Management program, directed that registered staff, “will implement a head injury routine and obtain neurological signs whenever a resident experiences or is

suspected of sustaining a head injury due to a fall or who have been found on the floor (experienced an unwitnessed fall)." The HIR should be completed every hour for the first four hours and then if stable every eight hours for 72 hours.

A review of a CIS report submitted to the Director on an identified date in 2018, identified that resident #001 fell, sustained an injury and was transferred to hospital for further interventions.

A review of the clinical record for resident #001 identified that registered staff initiated a HIR post fall, but did not consistently complete the HIR.

RN #100 was interviewed after reviewing the Clinical Monitoring Record for resident #001 and confirmed the HIR was not completed according to the licensee HIR policy post fall.

The home's HIR policy for resident #001 after the fall was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

The licensee failed to ensure that policies included in the organized program of nursing services were complied with.

In accordance with the Long Term Care Homes Act (LTCHA) 2007, c. 8, s. 8(1)(a) the licensee is required to ensure there is an organized program of Nursing Services for the home to meet the assessed needs of the resident and in accordance with O. Reg. 79/10, s. 30 (1) 1, the licensee is required to ensure that each of the organized programs include policies, procedures and protocols.

The home's policy titled "Safe Lifting with Care Program", policy number LP-01-01-0, last updated in August 2017, provided directions for registered staff to assess residents upon admission, quarterly and with any change in condition. Each assessment included an evaluation of the assistance required to transfer safely from one surface to another.

A) A review of a CIS report submitted to the Director on an identified date in 2018, identified that resident #001 fell, sustained an injury and was transferred to hospital for further interventions.

Review of the Safe Lift and Transfer Quarterly Assessment on an identified date in 2018, identified a level of assistance for transfers and toileting for resident #001.
Review of the plan of care identified that after the fall the resident was treated at the hospital and had a significant change in their condition.

PSW #122 was interviewed and stated after the resident fell their transfer status changed.

Review of the documentation on the PSW flow sheet for an identified period of time, indicated the resident was transferred with an identified level of assistance.

During an interview with RN #101, after reviewing the clinical record they acknowledged the Safe Lift and Transfer Assessment was not completed after the resident fell, sustained an injury and had a change in their condition.

RN #101 confirmed that the home's policy, Safe Lifting with Care Program was not complied with.

B) A review of a CIS report submitted to the Director on an identified date in 2018, identified that resident #009 sustained an injury and the cause was not determined. The resident was transferred to hospital for treatment.

Review of the clinical record for resident #009 identified the resident sustained an injury and the cause was not determined. The resident was transferred to hospital for treatment and had a significant change in their condition.

Review of the Safe Lift and Transfer Assessment identified that a quarterly assessment was completed on an identified date in 2018, which indicated a level of assistance for transfers. The next Safe and Lift Transfer Assessment was not completed several weeks after the fall which identified the change in resident's transfer status.

Review of the written plan of care identified the resident's transfer status changed; however, the safe lift and transfer assessment was not completed when the resident returned from hospital with a significant change in condition.

It was confirmed in an interview with RN#100, that registered staff did not complete the safe lift and transfer assessment when the resident returned from hospital with a change

in their condition.

The home's policy, "Safe Lifting with Care Program" had not been complied with.

C) A CIS report was submitted to the Director on an identified date in 2017, related to an incident that caused an injury to resident #012 for which the resident was taken to hospital and which resulted in a significant change in their health status.

Clinical record review identified that resident #012 was diagnosed with an injury on an identified date in 2017. The clinical record review indicated that the resident was not assessed for safe lift and transfer using the Safe Lift and Transfer assessment under the assessment tab in PCC as indicated in the home's Safe Lifting with Care Program.

RN #100 stated that resident #012 was not assessed using the Safe Lift and Transfer assessment when they had a change in condition, as per the home's Safe Lifting with Care Program.

D) A review of a CIS report submitted to the Director on an identified date in 2018, identified that resident #010 sustained an injury on an identified date in 2018 and the cause was not determined.

Review of the clinical record identified that resident #010 was sent to hospital and was diagnosed with an injury which was treated. They returned to the home with a significant change in their condition.

Review of the quarterly Safe Lift and Transfer Assessment completed on an identified date in 2018, identified the level of assistance for transfers. The next Safe lift and Transfer Assessment was not completed until several months later, which indicated a change in transfer status.

During an interview with RN #100, they stated the resident had a significant change in condition post injury and confirmed the Safe Lift and Transfer Assessment was not completed according to the licensee's policy when the resident was readmitted from hospital.

The home's "Safe Lifting with Care Program" was not complied with. [s. 8. (1) (b)]

3. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or

system was complied with.

The licensee failed to ensure policies included in the required Pain Management program were complied with.

In accordance with O. Reg. 79/10, s. 52 (1), the licensee is required to have an interdisciplinary Pain Management program and in accordance with O. Reg. 79/10, s. 30 (1) 1, the licensee is required to ensure that each of the required programs include policies, procedures and protocols.

The home's policy titled, "Pain Management", last updated in February 2017, indicated that residents would be assessed and systematically monitored for pain. Registered staff would assess residents for pain using the Pain Flow Note in Point Click Care (PCC) to assist in completing the note. A pain flow note would be completed on all residents who meet any of the following criteria, including but not limited to; admission, readmission, resident stated they have pain and any change in condition that had the potential to impact the residents' pain level.

A) A CIS report was submitted to the Director on an identified date in 2017, related to an incident that caused an injury to resident #012 for which the resident was taken to hospital and which resulted in a significant change in their health status.

Clinical record review identified that resident #012 was diagnosed with an injury on an identified date in 2017. Clinical record review indicated that an identified assessment was not completed by registered staff.

RN #100 stated that when there is a change in resident's condition that may affect resident's identified symptom the registered staff were to complete an assessment under the assessment tab in PCC. RN #100 acknowledged that resident was not assessed using an assessment tool when resident #012 was diagnosed with an injury.

B) A review of CIS report was submitted to the Director on an identified date in 2018, identified that resident #001 fell, sustained an injury and was transferred to hospital for further interventions.

Review of the clinical health record identified that resident #001 was transferred to hospital for treatment. Review of the progress note upon return, identified the resident reported identified symptoms and received treatment.

Review of the plan of care did not identify that the resident was assessed for the identified symptom after their returned from hospital.

In an interview with the RN #101, they stated residents were to be assessed using an identified assessment in PCC upon readmission and with any change in condition.

RN #101 confirmed that when the resident returned from hospital post treatment, that the identified assessment was not completed according to the licensee's policy. [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 any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record of everything provided for in clauses (b) and (d) and the date that the changes and improvements were implemented was promptly prepared.

Review of Resident Abuse Quality Program Evaluation signed in January 2018, indicated a list of objectives but did not contain the date that the changes were implemented. ED acknowledged that Resident Abuse Quality Program Evaluation did not contain the date that changes and improvements were implemented in the home.

The home failed to ensure that a written record of Resident Abuse Quality Program Evaluation was promptly prepared. [s. 99. (e)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee did not comply with the conditions to which the licence was subject.

The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN) under the Local Health Systems Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system.
Each resident's care and service needs shall be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the ARD of the previous assessment and will ensure that RAI-MDS tools are used correctly to produce an accurate assessment of the Health Care Service Provider's (HSP) residents (RAI-MDS Data) – 8.1(c)(ii) Any significant change in resident's condition, either decline or improvement, shall be reassessed along with RAPs by the interdisciplinary care team using the MDS Full Assessment by the 14th day following the determination that a significant change in status has occurred.

The licensee did not comply with the conditions to which the licence was subject.

A CIS report was submitted to the Director on an identified date in 2017, related to an incident that caused an injury to resident #012 for which the resident was taken to hospital and which resulted in a significant change in their health status.

Clinical record review identified that on an identified date in 2017, resident #012 was diagnosed with an injury. Subsequently, the resident was sent to the hospital for further assessment due to an identified condition. Resident #012 returned from the hospital with a significant change in the health condition. Clinical record review identified that the significant change was not completed in RAI-MDS.

RN #100 acknowledged that the significant change should have been completed in RAI-MDS when resident returned from the hospital and had a significant change in their health condition.

The licensee failed to comply with the LSSA agreement when resident #012 had a significant change in their health condition. [s. 101. (4)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that every licensee of a long-term care home shall ensure that, a written record was created and maintained for each resident of the home.

A review of a CIS report submitted to the Director on an identified date in 2018, identified that resident #010 sustained an injury and the cause was not determined.

Review of resident #010's plan of care, specifically PSW documentation, which identified the care that was provided daily and were to be documented on paper were not available in the resident's chart for an identified period of time.

During an interview with RN #101, they acknowledged that after an extensive search of the resident's chart they were unable to find the specific PSW documentation for the care provided on the identified dates.

RN #101 confirmed that the licensee did not maintain a written record for resident #010 related to PSW documentation. [s. 231. (a)]

Issued on this 22nd day of February, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARIA TRZOS (561), DIANNE BARSEVICH (581), YULIYA FEDOTOVA (632)
Inspection No. / No de l'inspection :	2019_543561_0002
Log No. / Registre no:	034049-16, 008917-17, 008918-17, 009452-17, 009745-17, 017073-17, 021826-17, 023151-17, 027711-17, 003857-18, 005258-18, 006359-18, 018389-18, 028486-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 22, 2019
Licensee / Titulaire de permis :	Halton Healthcare LTC Inc. 327 Reynolds Street, OAKVILLE, ON, L6J-3L7
LTC Home / Foyer de SLD :	Wyndham Manor Long Term Care Centre 291 Reynolds Street, OAKVILLE, ON, L6J-3L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Colleen Pittam

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,

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

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

Order / Ordre :

The licensee must be compliant with s. 6(11) of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure that resident #001 and any other resident in the home that has fallen and has sustained an injury is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan had not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care related to pain management and mobility.

The plan must include how the home will comply with the following:

1. Ensure all residents that sustain an injury post fall, strategies and interventions related to pain and mobility are evaluated for effectiveness and if these strategies are not effective different approaches are considered and tried in the revision of the plan of care. The analysis of the evaluation shall be documented in the plan of care.

2. Educate all registered staff on a scenario similar to this Critical Incident (CI), outlining the importance of assessment, reassessment and the evaluation of the strategies to ensure that when a resident falls and sustains injuries that their pain is well managed.
The home shall keep the training records and the attendance of the education.

3. Ensure all registered staff and PSWs in the home review the pain policy, specifically related to procedures for registered staff related to assessments of pain and what to do when the pain is not relieved with current interventions.

Please submit the written plan, quoting Inspection number 2019_543561_0002 and Inspector, Daria Trzos, by email to HamiltonSAO.moh@ontario.ca by March 8, 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

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

A review of a CIS report that was submitted to the Director on an identified date in 2018, identified that resident #001 fell was diagnosed with an injury and was transferred to hospital for treatment several days later.

A) Review of the clinical record identified that resident #001 fell on an identified date in 2018, and reported identified symptom and change in condition. The home completed an assessment which indicated a possibility of an injury and further assessment was required. Another test was performed several days later and identified there was a possible further injury and further assessment was required in several days. Several weeks later an identified test confirmed a change in status.

i. Review of identified assessments and electronic Medication Administration Records (EMARs) revealed the resident continued to complain of an identified symptom and was receiving medications as needed. The review of identified assessments indicated that the identified symptom was not relieved with current interventions.

ii. Review of the written plan of care included a care focus related to the resident's chronic condition with a goal to improve the condition and interventions in place. The written plan of care was not reviewed and revised related to the resident's increase in an identified symptom post fall with injury. There were no new goals or interventions documented in the written plan of care to manage the resident's symptom. RPN #101 confirmed that the resident's plan of care had not been reviewed or revised when the resident's care needs changed related to management of the condition post fall.

iii. Review of the plan of care did not include any revisions to the plan of care or that different approaches were considered, related to the identified symptom when the current management of it was not effective.

B) Review of the plan of care identified that the home was notified of the results of the second assessment which confirmed the injury that had deteriorated with significant changes.

i. Review of the PSW flow sheets for an identified period of time in 2018, identified that the resident was transferred daily from the bed to wheelchair with an identified level of assistance and received assistance with activities of daily living several weeks after the fall, at which time, it was documented that the

resident's mobility changed and the resident was later transferred to hospital for further interventions.

ii. PSW #122 was interviewed and stated that after the resident fell their mobility changed and resident reported identified symptoms. They acknowledged the resident was transferred with a device after the fall.

iii. Interview with RN #100 confirmed that PSW staff continued to transfer the resident and no interventions were put in place to stabilize the injury.

iv. Interview with Physiotherapist (PT) stated they received a referral post fall but did not assess the resident for transfers as was told by registered staff that the first assessment was not conclusive of an injury and the assessment needed to be repeated. PT stated they assumed that the resident's mobility status was changed after the fall.

C) On an identified date post fall an assessment identified the injury and further deterioration. Resident was sent to hospital for further interventions.

RN #100 confirmed that when the plan of care was being revised because care set out in the plan had not been effective, the licensee did not ensure that different approaches were considered in the revision of the plan of care, related to management of symptoms and mobility status.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 (isolated), as it was one out of three residents in the home. The home had a level 3 history of 1 or more non-compliance in last 36 months with s. 6 of the LTCHA, that included a previous voluntary plan of correction (VPC) issued in January 2018 (2017_543561_0018), and a written notification (WN) issued in June 2016 (2016_210169_0009). (581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 29, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 s.19 (1) of the LTCHA.

Specifically, the licensee must:
1. Ensure that resident #001 and any other resident in the home are not neglected by the licensee or staff.
2. Ensure that interdisciplinary assessments are completed to address the needs of residents exhibiting pain post fall and when the pain is not relieved ensure action is taken to address pain.
3. Ensure that interdisciplinary assessments are completed to address residents' mobility post fall, including a review of residents' ability to participate in activities of daily living with the least amount of pain possible.
4. Ensure that where follow up interventions are required they are completed in a timely manner. These interventions shall be audited and documentation of the audits kept in the home.

Grounds / Motifs :

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

The LTCHA, 2007, O. Reg 79/10, defines neglect as the failure to provide resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A CIS report was submitted to the Director on an identified date in 2018, related to a fall of resident #001 with injury and transfer to hospital for further

interventions.

Review of the clinical record identified that resident #001 fell on an identified date in 2018, and reported identified symptom and change in condition. The home completed an assessment which indicated a possibility of an injury and further assessment was required. Another test was performed several days later and identified there was a possible further injury and further assessment was required in several days. Several weeks later an identified test confirmed a further change in condition.

Review of identified assessments and EMARs revealed the resident continued to complain of an identified symptom and was receiving medications as needed. The review of identified assessments indicated that the identified symptom was not relieved with current interventions.

Review of the plan of care did not include any revisions to the plan of care or that different approaches were considered, related to management of the symptoms of the condition.

Review of an assessment, which identified the resident had constant symptoms of the condition and were not relieved with medication. It was documented that it was effecting all aspects of the resident's activities of daily living (ADLs). Review of physician order included an increase in medications.

The review of progress notes and identified assessments documented that resident #001 continued to have symptoms of the condition.

On an identified date, the home was notified of the results of the second assessment which confirmed the injury with significant deterioration.

The physician was notified and medication orders included a specified intervention.

On an identified date in 2018, the progress note identified that morning care was provided after medications were administered; however, an identified level of assistance was required due to the symptoms. The resident was transferred with a device and refused to eat. No further changes were made in the plan of care and resident continued to have the symptoms.

Review of the PSW flow sheets for an identified period of time in 2018, identified that the resident was transferred daily from the bed to wheelchair with an identified level of assistance and received assistance with activities of daily living several weeks after the fall, at which time, it was documented that the resident's mobility changed and the resident was later transferred to hospital for further interventions.

PSW #122 was interviewed and stated that after the resident fell their mobility changed and resident reported identified symptoms. They acknowledged the resident was transferred with a device after the fall.

Interview with RN #100 confirmed that PSW staff continued to transfer the resident and no interventions were put in place to stabilize the injury. During an interview with RN #101, after reviewing the clinical health record they acknowledged the Safe Lift and Transfer Assessment was not completed after the resident fell, sustained an injury and had a change in their condition. RN #101 confirmed that the licensee's policy, Safe Lifting with Care Program was not complied with.

Furthermore, interview with Physiotherapist (PT) stated they received a referral post fall but did not assess the resident for transfers as was told by registered staff that the first assessment was not conclusive of an injury and the assessment needed to be repeated. PT stated they assumed that the resident's mobility status was changed after the fall.

On an identified date in 2018, an assessment indicated that a comparison was made with previous assessments and identified the injury had deteriorated. There was significant change in the injury.

The home's inaction following resident #001's fall, related to transfer assessments, management of symptoms, and other assessments, jeopardized the health and well-being of the resident, resulting in ongoing symptom changes and worsening injury, until they were transferred to the hospital for further intervention.

The licensee failed to ensure that resident #001 was protected from neglect by anyone.

The severity of this issue was determined to be a level 3 as there was actual

harm to the resident. The scope of the issue was a level 1 (isolated), as it was one out of three residents in the home. The home had a level 3 history of 1 or more non-compliance in last 36 months with s. 19 (1) of the LTCHA, that included a previous voluntary plan of correction (VPC) issued in June 2016 (2016_210169_0009). (581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 29, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

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

Issued on this 22nd day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Daria Trzos

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