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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 02, 2019	2019_788721_0016 (A1)	007689-18, 008523-18, 015265-18, 029486-18, 031961-18, 001072-19	Critical Incident System

Licensee/Titulaire de permis

Rykka Care Centres GP Inc.
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Arbour Creek Long-Term Care Centre
2717 King Street East HAMILTON ON L8G 1J3

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

Amended by MEAGAN MCGREGOR (721) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Compliance Due Date has been changed to September 30, 2019, for Compliance Orders #001, #002, #003 and #004.

Issued on this 2 nd day of July, 2019 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by MEAGAN MCGREGOR (721) - (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): May 6, 7, 8, 9, 10, 13, 14, 15 and 16, 2019.

The following Critical Incident (CI) reports were inspected during the course of this inspection:

CI #2930-000017-18/Log #029486-18 related to resident to resident physical abuse resulting in a fall;

CI #2930-000002-19/Log #001072-19 related to falls prevention and management;

CI #2930-000009-18/Log #007689-18 related to falls prevention and management;

CI #2930-000018-18/Log #031961-18 related to falls prevention and management;

CI #2930-000011-18/Log #015265-18 related to falls prevention and management; and

CI #2930-000010-18/Log #008523-18 related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Assistant Director of Care, the Business Services Manager, a Physician, six Registered Practical Nurses, four Personal Support Workers, and two Restorative Care Aides.

The inspector(s) also observed residents and the care provided to them and staff interactions with residents, observed resident common areas, reviewed clinical records and plans of care for identified residents and reviewed the home's relevant policies and procedures.

Inspector Yuliya Fedotova (#632) was also present on May 9, 10, 13, 14, 15 and

16, 2019, conducting a concurrent complaint inspection.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **7 WN(s)**
- **1 VPC(s)**
- **9 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

s. 6. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC), related to a fall by resident #004 which resulted in them being transferred to hospital. The CIS report stated that resident #004 had a bed alarm and crash mats to prevent falls.

A review of resident #004's progress notes in Point Click Care (PCC) showed that they had a crash mat in place on nine documented occurrences and a bed alarm in place on eight documented occurrences.

During an interview with a Personal Support Worker (PSW) they stated that they would find out what a resident's care needs were by looking at their printed Care Plan and Kardex within the physical chart at the nursing station. The PSW told Inspector #721 that resident #004 had a bed alarm and crash mat in place to reduce their risk of falling.

A review of resident #004's Care Plan in PCC did not show any documentation regarding them having a crash mat or bed alarm in place to prevent falls.

During an interview on a specific date, Assistant Director of Care (ADOC) #106 reviewed resident #004's clinical record with Inspector #721. When asked how staff would know what care was to be provided for a resident, ADOC #106 stated that this would be documented in their Care Plan and Kardex in PCC and any changes to their plan of care would be communicated to staff at the start of each shift. ADOC #106 stated that if there were any changes to a resident's plan of care this would be updated immediately in their Care Plan and Kardex and another copy would be printed for front line staff to access. ADOC #106 told Inspector #721 that resident #004 fell on a specific date and it was documented that they had a crash mat and bed alarm in place at the time of this fall. ADOC #106 stated that resident #004's Care Plan didn't indicate if they were supposed to have a crash mat or bed alarm in place.

The licensee has failed to ensure that there was a written plan of care for resident #004 that set out clear directions for falls preventions interventions to staff and others who provide direct care to the resident. (721)

B) The home submitted a CIS report to the MOHLTC, related to an incident where resident #002 was found lying on the floor and stated that they had been pushed by resident #003. The CIS report stated that after the incident one to one monitoring was in place for resident #003.

A review of resident #003's progress notes in PCC showed that they had one to one monitoring in place on 18 documented occurrences.

During an interview with a PSW they stated that if a resident was supposed to

have one to one monitoring in place this would be indicated on the staff deployment sheet that was posted in each unit.

During an interview with a Registered Practical Nurse (RPN) they stated that if a resident was supposed to have one to one monitoring in place this would be indicated in their Care Plan. They stated that all staff could access a resident's printed Care Plan and Kardex in their physical chart. The RPN told Inspector #721 that resident #003 had one to one monitoring in place as needed when their responsive behaviours were escalated.

A review of resident #003's Care Plan in PCC did not show any documentation regarding them having one to one monitoring in place.

During an interview on a specific date, ADOC #106 reviewed resident #003's clinical record with Inspector #721. ADOC #106 told Inspector #721 that following the incident which was reported in the CIS report, one to one monitoring was in place for resident #003. ADOC #106 stated that when one to one monitoring was implemented for a resident the staffing clerk would be notified to schedule the one to one monitoring on staff deployment sheets and nursing staff would also document this on the 24 hour shift report. They stated that staff were verbally informed when one to one monitoring was discontinued for a resident.

On a specific date, the Business Services Manager provided Inspector #721 with the homes staff deployment sheets from the month after the incident. The staff deployment sheets showed that a staff member was scheduled for one to one monitoring on the home area that resident #003 resided on the afternoon shift on five specific dates, night shift on five specific dates and day shift on three specific dates. The staff deployment sheets did not indicate which resident staff provided one to one monitoring for.

During an interview on a specific date, ADOC #106 reviewed the staff deployment sheets from the month after the incident with Inspector #435. ADOC #106 told Inspector #435 that the time of one to one monitoring was scheduled based on resident #003's behavioural needs. When asked how staff would know which resident one to one monitoring was scheduled for when it was not indicated on the staff deployment sheets, ADOC #106 stated that this was communicated verbally or on the shift change report.

The licensee has failed to ensure that there was a written plan of care for resident

#003 that set out clear directions for one to one monitoring to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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

The home submitted a CIS report to the MOHLTC, related to a fall by resident #004 which resulted in them being transferred to hospital. The CIS report stated that prior to the incident resident #004 had increased physical and verbal responsive behaviours.

A review of resident #004's Care Plan in PCC showed the following:
- "Registered staff to assess pain weekly and document" related to "[resident] will c/o pain and will get restless if in pain".

A review of resident #004's Assessments section in PCC showed that pain assessments were completed on two specific dates during the identified period before the incident. Resident #004's physical chart and Assessments section in PCC did not include any documented pain assessments on one of the identified weeks prior to the incident.

During an interview on a specific date, ADOC #106 reviewed resident #004's clinical record with Inspector #721. ADOC #106 told Inspector #721 that registered staff were expected to assess and document resident #004's pain weekly. ADOC #106 stated that there were pain assessments completed for resident #004 on two specific dates, and that there were no weekly pain assessments completed on one of the identified weeks prior to the incident, as stated in their Care Plan.

The licensee failed to ensure that weekly pain assessments were completed for resident #004 as stated in their plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care were documented.

A) The home submitted a CIS report to the MOHLTC, related to a fall by resident #006 which resulted in hospitalization and a significant change in the resident's health condition. The CIS report documented that resident #006 had sustained a

fall on a specific date, at which time the resident was found by a staff member to be lying on the floor in front of their washroom with dried blood noted on the resident and on the floor. The physician assessed the resident and the resident was then transported to hospital for further assessment.

A review of resident #006's plan of care at the time of the fall identified that resident #006 was to be checked every one hour to ensure their safety for falls prevention and management.

During an interview with ADOC #106, when asked where staff were expected to document resident's every one hour safety checks, ADOC #106 stated that it was documented on a flow sheet. When asked where Inspectors would find these documents, ADOC #106 stated that the documented safety checks could be found in resident #006's paper copy chart.

Inspector #435 reviewed resident #006's paper copy chart and was unable to find documentation for resident #006's every one hour safety check for falls prevention and management. Inspector #435 verified with ADOC #106 that they were unable to find the one hour safety check flow sheets in resident #006's paper copy chart as informed and ADOC #106 stated that if they were completed they would be found in the chart provided. When asked when the last time resident #006 was checked prior to being found on the floor of their washroom, ADOC #106 was unable to provide this information.

During an interview with an RPN, when asked where staff look to find the information that they need to provide care to residents, the RPN stated that staff use the Kardex and Care Plan. When asked where staff document that they have provided every one hour safety checks for falls prevention, if identified as an intervention in a resident's Care Plan, the RPN stated that this was not documented.

The licensee failed to ensure that the provision of the every one hour safety checks, the outcomes of the every one hour safety checks, and the effectiveness of the every one hour safety checks were documented for resident #006. (435)

B) The home submitted a CIS report to the MOHLTC, related to an incident in which resident #008 had sustained a hip fracture of unknown cause resulting in a significant change in the residents health status and transfer to hospital on a specific date.

A review of resident #008's plan of care at the time of the incident, documented that resident #008 was to be checked on every 30 minutes for safety as an intervention as the resident was identified to be at risk for falls.

During an interview with ADOC #106, when asked where staff were expected to document a resident's safety checks as identified in their plan of care, ADOC #106 stated that it was documented on a flow sheet. When asked where Inspectors would find these documents, ADOC #106 stated that the documented safety checks could be found in resident #008's paper copy chart.

Inspector #435 reviewed resident #008's paper copy chart and was unable to find documentation for resident #008's every 30 minute safety check for falls prevention and management. Inspector #435 verified with ADOC #106 that they were unable to find the every 30 minute safety check flow sheets in resident #008's paper copy chart as informed and ADOC #106 stated that if they were completed they would be found in the chart provided.

During an interview with a PSW, when asked where staff document care provided, the PSW stated that it was documented on flow sheets. When asked where staff would look to find what interventions were in place for a residents care needs, the PSW stated they refer to the Care Plan. When asked where it would be documented that staff checked on a resident if they required every 30 minute safety checks, the PSW referred to the Personal Care Aid (PCA) flow sheet which did not include times that residents were checked.

During an interview with an RPN, when asked where staff look to find the information that they need to provide care to residents, the RPN stated that staff use the Kardex and Care Plan. When asked where staff document that they have provided every one hour safety checks for falls prevention, if identified as an intervention in a resident's Care Plan, the RPN stated that this was not documented.

The licensee failed to ensure that the provision of the every 30 minute safety checks, the outcomes of the every 30 minute safety checks and the effectiveness of the 30 minute safety checks were documented for resident #008. [s. 6. (9)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time

when the resident's care needs changed.

A) The home submitted a CIS report to the MOHLTC, related to an incident in which resident #008 had sustained a hip fracture of unknown cause resulting in a significant change in the residents health status and transfer to hospital on a specific date.

A review of resident #008's progress notes in PCC documented that the home was notified by the hospital four days after the incident that resident #008 had a hip fracture but would not be a candidate for surgery and was to be on bed rest for six weeks. In another progress it was documented that the resident returned to the home from hospital five days after the incident with a hip fracture and was non-weight bearing.

During an interview with a PSW and RPN, when asked where they would look to find out what a residents care needs were, the PSW and RPN stated they looked in the Care Plan. When asked how resident #008 ambulated after their return from hospital on an identified date, the PSW and RPN stated that resident #008 did not ambulate as they were on bed rest. When asked how the resident was toileted after their return from hospital on the identified date, the PSW and RPN stated that the resident used a brief and a bed pan for toileting. When asked how resident #008 ambulated prior to their hospitalization, PSW #104 stated that the resident was independent with their walker for ambulation and was independent with toileting.

A review of resident #008's Care Plan upon their return from hospital on a specific date, documented that the resident toileted independently with an initiated date of approximately five months prior to their return from hospital, and resolved date of approximately two weeks after their return from hospital.

During an interview with ADOC #106, when asked what resident #008's toileting needs were upon their return from hospital on an identified date, as found in the residents plan of care, ADOC #106 stated that resident #008's plan of care for toileting was last updated approximately five months prior to the identified date.

The licensee failed to ensure that resident #008's plan of care was reviewed and revised when resident #008's toileting care needs changed upon their return from hospital with a fractured hip, ordered bed rest, and non-ambulatory on a specific date. (435)

B) The home submitted a CIS report to the MOHLTC, related to an incident in which resident #008 had sustained a hip fracture of unknown cause resulting in a significant change in the residents health status and transfer to hospital on a specific date. The CIS report documented that resident #008 had previously fallen two weeks prior to this incident, resulting in transfer to hospital for further assessment and they returned to the home without a fracture or change in ambulation status. The CIS report also stated that the home would trial a bed alarm and crash mat as fall precaution interventions in the resident's plan of care.

A review of a Risk Management incident documented that resident #008 had sustained a fall on a specific date prior to their fall reported in the CIS report, but this fall was on a different date than what was documented in the CIS report. The incident report continued to state that staff were to encourage resident #008 to call for help before using the washroom and that staff members were to check them every hour to make sure the resident's bed was in the lowest position and a bed alarm was on the bed as fall precaution interventions.

During an interview with a PSW, when asked what falls prevention and management strategies were in place for resident #008, the PSW stated that the resident used a crash mat and hip protectors. When asked if resident #008 used a bed alarm, the PSW stated no.

During an interview with an RPN, when asked if resident #008 had any falls prevention strategies changed or updated in their plan of care between the time of their fall two weeks prior and the time of the fall that was reported in the CIS report, the RPN stated that nothing had changed in the resident's plan of care as resident #008 was walking and not complaining of pain. When asked if resident #008 was at risk for falls at that time, the RPN said yes.

During an interview with ADOC #106, when asked if resident #008 was at high risk for falls, ADOC #106 stated yes. When asked if resident #008 had a fall mat or bed alarm implemented in their plan of care as falls prevention interventions, ADOC #106 stated no. When asked what interventions were identified in the CIS report submitted to the MOHLTC as long term actions that were planned to prevent recurrence of the incident, ADOC #106 stated that the CIS report documented that the home would trial a bed alarm and crash mats. When asked what actions for staff were documented in the Risk Management report on an identified date, ADOC #106 stated that resident #008 was to have a bed alarm on

their bed. When asked if the falls prevention and management interventions as described in the CIS report and the Risk Management report were implemented, ADOC #106 stated that they were not implemented.

The licensee failed to ensure that resident #008's plan of care was reviewed and revised to include the bed alarm and crash mats when they were assessed to require this change in their plan of care. (435)

C) The home submitted a CIS report to the MOHLTC, related to a fall by resident #004 on a specific date, which resulted in them being transferred to hospital. The CIS report stated that resident #004 sustained a hip fracture and returned to the home four days later, following surgery with orders for comfort measures.

A review of the resident #004's Minimum Data Set (MDS) Annual assessment completed prior to their fall, and Significant change in status assessment completed upon their return from hospital after the fall, showed the following:
- "Supervision" and "Set-up help only" with transfer prior to the fall, and "Total Dependence" and "Two+ persons physical assist" with transfer after the fall.
- "Supervision" and "Set-up help only" with walking in their room prior to the fall, and "Activity Did Not Occur" and "ADL activity did not occur during entire 7 days" with walking in their room after the fall.
- "Limited Assistance" and "One-person physical assist" with walking on the unit prior to the fall, and "Activity Did Not Occur" and "ADL activity did not occur during entire 7 days" with walking on the unit after the fall.
- "Limited Assistance" and "One-person physical assist" with locomotion on the unit prior to the fall, and "Activity Did Not Occur" and "ADL activity did not occur during entire 7 days" with locomotion on the unit after the fall.
- "Limited Assistance" and "One-person physical assist" with locomotion off the unit prior to the fall, and "Activity Did Not Occur" and "ADL activity did not occur during entire 7 days" with locomotion off the unit after the fall.
- Modes of locomotion were "Cane, walker or crutch" prior to the fall, and Modes of locomotion were "NONE OF ABOVE" after the fall.
- Modes of transfer were "NONE OF ABOVE" prior to the fall, and Modes of transfer were "Bed rails used for bed mobility and transfer" and "Lifted Manually" after the fall.

A review of resident #004's progress notes in PCC showed the following:
- A note from a specific date and time, stating that the home spoke with resident #004's family member regarding their condition and discussed getting a

wheelchair for them upon return to home.
- A note from a specific date and time, stating that the home spoke with resident #004's family member regarding goals of care upon their return to the home and orders given for palliative care.
- A note from a specific date and time, stating that they were found climbing out of bed.
- A note from a specific date and time, stating that they were awake sitting in a wheelchair with a lap belt most of the night for safety as they were trying to climb out of bed.
- A note from a specific date and time, stating that they were on palliative care following hip fracture and physiotherapy program was discontinued.
- A note from a specific date and time, stating that they were deemed palliative and bed rails had been requested by resident #004's family member due to bed exiting habits.
- A note from a specific date and time, stating that they were attempting to get out of bed and re-directed to bed by staff.
- A note from a specific date and time, stating that they were awake in their wheelchair all night.
- A note from a specific date and time, stating that they were attempting to climb out of bed and placed in a wheelchair with a lap belt for safety and slept in the wheelchair through the night.

A review of resident #004's Care Plan in PCC, upon their return from hospital, showed the following:
- "[Resident] walks independently on the unit using [walker]" related to "Mobility/Ambulation impaired d/t impaired cognition, weakness from not eating/drinking. Resident to ambulate with 1 staff supervision."
- "Staff will encourage [resident] to walk with [their] walker with short steps, safely and take break and big breath when feeling tired" related to "ambulation impaired r/t decrease in strength ,weakness, dementia and unsteady gait balance [resident] use walker for ambulation."
- "TRANSFERS without assistance but requires staff to provide assistive devices/aides/equipment" and "Resident can weight bear" related to "Transferring; ability impaired related to decrease weakness of lower limbs due to not eating or drinking."

During an interview with a PSW they stated that they would find out what a resident's care needs were by looking at their printed Care Plan and Kardex within their physical chart at the nursing station. The PSW told Inspector #721 that

prior to their fall, resident #004 ambulated with a walker and was independent sometimes requiring limited assistance with transfers. The PSW stated that when resident #004 returned to the home after their fall on an identified date, they were bedridden and that if they did get out of bed they were in a wheelchair.

During an interview with an RPN, when asked how front line staff would know what a resident's ambulation status and transfer needs were, the RPN stated that they would look in the resident's printed Care Plan on the unit. The RPN stated that when a resident's care needs change registered staff will update their Care Plan in PCC and the printed Care Plan in the binder on each unit and this will also be noted on the 24 hour shift report. The RPN told Inspector #721 that prior to their fall on an identified date, resident #004 ambulated independently with a walker and was mostly independent with some supervision for transfers. The RPN stated that when resident #004 returned to the home after their fall on an identified date, they required two person assistance and were non weight bearing with transfers and they couldn't remember them walking.

During an interview on a specific date, ADOC #106 reviewed resident #004's clinical record with Inspector #721. When asked how staff would know what care was to be provided for a resident, ADOC #106 stated that this would be documented in their Care Plan and Kardex in PCC and any changes to their plan of care would be communicated to staff at the start of each shift. ADOC #106 stated that if there were any changes to a resident's plan of care that this would be updated immediately in their Care Plan and Kardex and another copy would be printed for front line staff to access. ADOC #106 told Inspector #721 that prior to their fall on an identified date, resident #004 was walking independently with a walker and receiving physical assistance with transfers as needed. ADOC #106 stated that after their fall on an identified date, resident #004 was palliative and bed ridden, and required two person physical assistance with transfers. ADOC #106 told Inspector #721 that after the fall on an identified date, resident #004's Care Plan was not updated to reflect their change in ambulation and transfer status.

The licensee failed to ensure that when resident #004's care needs changed related to a change in their ambulation and transfer status a result of a fall, that their plan of care was revised to reflect their needs. (721)

D) The home submitted a CIS report to the MOHLTC, related to an incident on on a specific date where resident #002 was found lying on the floor and stated that

they had been pushed by resident #003.

A review of the Risk Management section in PCC showed that resident #003 had initiated physical aggression towards other residents on eight identified occurrences prior to the incident identified in the CIS report.

A review of resident #003's progress notes in PCC showed documentation from a specific date, stating that they were physically aggressive towards another resident that entered their room and that a wander strip was to be applied so that other residents couldn't enter their room.

A review of resident #003's Care Plan in PCC did not show any documentation regarding them having a wander strip in place.

During an interview with a PSW they stated that when behavioural interventions such as a wander strip were implemented for a resident, this would be indicated in their Care Plan and Kardex and on the 24 hour shift report. The PSW stated that resident #003 exhibited physically aggressive behaviours and would use their walker to hit other residents. The PSW told Inspector #721 that resident #003 had a wander strip across their door at some point.

During an interview with an RPN they stated that if a resident was supposed to have a wander strip in place this would be indicated in their Care Plan in PCC. The RPN told Inspector #721 that resident #003's behaviours were unpredictable and of sudden onset and that they would try to hit other residents who wandered with their walker. They stated resident #003 had a wander strip prior to their hospital stay during a specific period of time.

During an interview on a specific date, ADOC #106 reviewed resident #003's clinical record with Inspector #721. ADOC #106 told Inspector #721 that resident #003's progress notes stated they had a wander strip applied to their door after they were involved in a physical altercation on an identified date. When asked how staff knew that resident #003 was supposed to have a wander strip in place, ADOC #106 stated that it should be documented somewhere and maybe it was done verbally. ADOC #106 told Inspector #721 that staff were expected to go over a resident's progress notes. When asked if all staff had access to resident's progress notes, ADOC #106 stated that registered staff could access a resident's progress notes and they would be responsible for communicating this information to PSW staff at shift report. ADOC #106 stated that it was not documented in

resident #003's plan of care that they had a wander strip in place at this time.

The licensee failed to ensure that when resident #003's care needs changed related to an increase in physically aggression, that their plan of care was revised to reflect their needs. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002, 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 001,002,003,004

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home submitted a CIS report to the MOHLTC, related to an incident on a specific date, where resident #002 was found lying on the floor and stated that they had been pushed by resident #003.

The home's policy titled "Abuse and Neglect Policy", in place at the time of the incident, stated that:
- “Any alleged, suspected or witnessed incident of abuse or neglect of a resident is to be reported to the Executive Director/designate of the Home".
- As part of their investigation the Executive Director and their designates are to assemble an investigation team and “the investigation team is to analyze the evidence obtained, make conclusions based on the evidence and prepare a report. The report should: i. summarize the complaint, ii. identify any interim steps taken pending the completion of the investigation, iii. summarize the evidence obtained, iv. identify any inconsistencies, v. assess credibility and weigh competing evidence to attempt to reach factual conclusions and vi. explain the reason for any conclusions reached".

A review of resident #003's progress notes and Risk Management section in PCC showed ten documented incidents where resident #003 had been physically abusive towards other residents, which included the incident documented in the CIS report and nine additional incidents which occurred in the three months prior to this incident.

During an interview on a specific date, ADOC #106 reviewed resident #003’s clinical record with Inspector #721. ADOC #106 told Inspector #721 that when staff witness or become aware of an allegation of resident abuse they are expected to inform the charge nurse and the charge nurse will inform management. They stated that staff are expected to document under the Risk Management section in PCC when there is any incident of abuse and when residents exhibit verbally and physically aggressive behaviours. ADOC #106 stated that they reviewed documented incidents on the Risk Management section in PCC daily.

During an interview on a specific date, Executive Director (ED) #100 reviewed resident #003’s clinical record with Inspector #721. When asked what process staff were expected to follow when they became aware of an incident of abuse, ED #100 stated that they were expected to notify them verbally in person, via email, or through the dashboard in PCC. ED #100 told Inspector #721 that if they became aware of allegations of abuse, they would meet with the Director of Care (DOC), ADOC and charge nurse to discuss what occurred and that each person would take the lead on a piece of the investigation and document accordingly. ED #100 and Inspector #721 discussed ten identified incidents documented in

resident #003's progress notes where they allegedly physically abused other residents. ED #100 told Inspector #721 that they would consider the ten identified incidents to be abuse.

In response to a request for documentation of the home's investigation into the allegations of physical abuse that were reported in the CIS report, ED #100 informed Inspector #721 via email that investigation notes were primarily documented in progress notes and that conversations would occur between the interdisciplinary team and be recorded in PCC. ED #100 stated that if there was an investigation conducted they would also have statements from employees, residents or residents families. The home was unable to provide Inspectors with documentation of the home's investigation into the allegations of physical abuse that were documented in the CIS report and the nine other identified incidents where resident #003 was alleged to have physically abused other residents.

The licensee failed to ensure that the home's Abuse and Neglect Policy was complied with when they failed to follow their process for investigating allegations of abuse by resident #003, including analyzing the evidence obtained, making conclusions based on the evidence and preparing a report. [s. 20. (1)]

Additional Required Actions:

CO # - 005 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

On a specific date the home submitted a CIS report to the MOHLTC, related to an incident that occurred one to day prior, in which resident #002 was found lying on the floor and stated that they had been pushed by resident #003.

The home's policy titled "Abuse and Neglect Policy", in place at the time of the incident, stated that:
- "Where a staff member has reason to believe that a resident has suffered harm or is at risk of harm due to abuse or neglect, improper or incompetent treatment or care, or unlawful conduct, they must immediately report their suspicion and the information upon which it is based, to the Home, and to the Director appointed under the Long-Term Care Homes Act, 2007".
- "Staff must adhere to the mandatory reporting obligations set out in the LTCHA".
- "As set out in the LTCHA, any person who has reasonable grounds to suspect that any of the following has occurred, or may occur, shall immediately report the suspicion and the information upon which it was based to the Director of Long-

Term Care Homes: abuse of a resident by anyone, or neglect of a resident by the licensee or staff member that resulted in harm or a risk of harm to the Resident".

A review of resident #003's progress notes and Risk Management section in PCC showed nine documented incidents where resident #003 had been physically abusive towards other residents, which included the incident documented in the CIS report and eight additional incidents which occurred in the three months prior to this incident.

During an interview on a specific date, ADOC #106 reviewed resident #003's clinical record with Inspector #721. ADOC #106 told Inspector #721 that when staff witness or become aware of an allegation of resident abuse they are expected to inform the charge nurse and the charge nurse will inform management. They stated that staff are expected to document under the Risk Management section in PCC when there is any incident of abuse and when residents exhibit verbally and physically aggressive behaviours. ADOC #106 stated that they reviewed documented incidents on the Risk Management section in PCC daily.

A review of the MOHLTC Critical Incident reporting system showed that no CIS reports were submitted related to eight of the documented incidents where resident #003 allegedly abused other residents.

During an interview on a specific date, ED #100 reviewed resident #003's clinical record with Inspector #721. When asked what process staff were expected to follow when they became aware of an incident of abuse, ED #100 stated that they were expected to notify them verbally in person, via email, or through the dashboard in PCC. ED #100 reviewed nine identified incidents documented in resident #003's progress notes where they allegedly hit other residents. ED #100 told Inspector #721 that they would consider the nine identified incidents to be abuse. When asked when they became aware of the nine identified incidents where resident #003 had abused other residents, ED #100 stated that they couldn't recall when they were made aware but that they were usually notified the same day. ED #100 told Inspector #721 it was their expectation that the nine identified incidents where resident #003 abused other residents should have been immediately reported to the MOHLTC. ED #100 stated that the incidents which occurred on eight identified dates were not reported to the MOHLTC and that the incident which occurred on one identified date, was not reported to the MOHLTC until one day after the incident occurred.

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse by resident #003 that resulted in harm or a risk of harm to a resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Additional Required Actions:

CO # - 006 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. 31. Restraining by physical devices

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was restrained by a physical device as described in paragraph 3 of subsection 30(1), that the restraining of the resident was included in the resident's plan of care and that the provisions and requirements for restraining a resident by a physical device were satisfied.

The home submitted a CIS report to the MOHLTC, related to a fall by resident #004 on a specific date, which resulted in them being transferred to hospital. The CIS report stated that resident #004 sustained a hip fracture and returned to the home on a specific date, following surgery with orders for comfort measures.

A review of resident #004's progress notes in PCC showed the following:
- A note from a specific date stating that they were awake and sitting in a wheelchair with a lap belt most of the night for safety as they were trying to climb out of bed.
- A note from a specific date stating that they were deemed palliative and full bed

rails had been requested by a family member.
- A note from a specific date stating that they were attempting to climb out of bed and placed in a wheelchair with a lap belt for safety and slept in the wheelchair through the night.

A review of the resident #004's MDS assessment completed after the time of their fall, related to a significant change in status, indicated the following:
- "Bed rails used for bed mobility or transfer".
- "Other types of side rails used (e.g. half rail, 1 side)" were "Used daily".
- "Full bed rails on all open sides of bed" and "Trunk restraint" were "Not used".

The home's policy titled "Restraints", in place at the time of the incident, was reviewed and stated the following:
- "A physical restraint is any physical device that is used to protect the resident from serious bodily harm to self and/or others. It is considered a restraint only when the resident is unable to undo or remove it due to physical and cognitive deficit".
- "Physical devices which are approved for use in the home and defined as restraints are: seat belts (front and side closure ONLY), bed rails (2 or 1 bed rail), lap trays, recliner chairs, any physical device that the resident is physically and cognitively unable to remove or undo".
- The procedure for restraining by a physical device includes "The interdisciplinary team initiates the assessment process when a situation presents itself that could result in the use of a restraint. The causal factors are assessed, and appropriate interventions/treatment will be implemented by the care team. Document these in the care plan, and electronic progress notes" and "Informed consent will be discussed and obtained, prior to the application of a physical restraint (except in an emergency situation) from the resident if deemed competent or from the substitute decision maker if resident has been assessed as competent for the purpose of making this informed decision at the time the restraint is required".
- The procedure for initiation of a physical restraint use includes "A physician, RN (EC) or the Director of Nursing and Personal Care or a Registered Nurse has recommended the restraining." and "A physician or RN (EC) must order a physical device".

During an interview with a PSW they stated that if a resident was supposed to have a lap belt or bed rails in place this would be indicated on their printed Care Plan and Kardex within their physical chart and on the 24 hour shift report at the nursing station. The PSW stated they couldn't remember if resident #004 had a

lap belt or bed rails in place when they returned from hospital on a specific date. When asked if they considered a lap belt to be a restraint, they stated absolutely. When asked if resident #004 would have been able to undo a lap belt at this time, they stated they didn't know if they could because they had really declined.

During an interview with an RPN they stated that prior to implementing a lap belt or bed rails for a resident they would tell their family, would look at alternative things to use and would only use them as a last resource. When asked if there were any assessments they would complete before implementing a restraint, the RPN stated they didn't think they had assessments. The RPN told Inspector #721 that if a resident had a lap belt or bed rails in place this would be stated in their Care Plan and Kardex.

A review of resident #004's physical chart and clinical record in PCC did not include any documented assessments, consent or orders for the use of a lap belt and bed rails. Resident #004's Care Plan and Kardex did not show any documentation indicating they were to have a lap belt or bed rails in place.

During an interview on a specific date, ADOC #106 reviewed resident #004's clinical record with Inspector #721. When asked if they considered lap belts and bed rails to be restraints, ADOC #106 stated they would be restraints if a resident was unable to remove them. ADOC #106 told Inspector #721 that nursing staff can use lap belts on residents for a period of time provided that they have an order. ADOC #106 stated that prior to implementing a restraint, staff would document an assessment and consent for the use of the restraint in PCC or in their physical chart. ADOC #106 reviewed resident #004's progress notes with Inspector #721 present, which indicated that a lap belt was applied to resident #004's wheelchair on two identified dates. They also reviewed resident #004's MDS assessment completed after their fall, which indicated that resident #004 had bed rails in place. ADOC #106 told Inspector #721 that resident #004 did not have any documented assessments, consent or orders for the use of a lap belt and bed rails in their physical chart or in PCC and that the use of a lap belt and bed rails were not indicated in their plan of care.

The licensee failed to ensure that when resident #004 was restrained by a physical device as described in paragraph 3 of subsection 30 (1), that this was included in the resident's plan of care, was ordered by a physician, registered nurse in the extended class or other person provided for in the regulations, was consented for by the resident or their substitute decision-maker and that the plan

of care provided for the requirements under subsection (3). [s. 31.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 where the Act or Regulation required them to have, institute or otherwise put in place any policy or procedure, that the policy and procedure were complied with.

In accordance with Ontario Regulation 79/10, s. 52, required the licensee to ensure there was a program in place to manage pain. The home's policy and procedure titled "Pain Management", revised on a specific date, was reviewed and identified that upon initiation of a new pain management medication or an adjustment to dosage and/or frequency, a Pain Flow Sheet shall be initiated. The policy also stated if a resident's pain is not relieved with initial interventions, notify physician for alternate pain control measure and a pain management assessment in PCC is to be completed.

A) On a specific date, the home submitted a CIS report to the MOHLTC, related to a fall by resident #001 which resulted in hospitalization and a significant change in the resident's health condition.

During a review of resident #001's progress notes in PCC it was noted that on a specific date, they received as needed (PRN) Tylenol, at a specific dosage, for leg pain and were yelling from their room at a specific time. Another progress note documented by a physician on the following day stated that the resident was reported to be calling out during the night and as the PRN Tylenol appeared to be affective in settling the resident, the physician adjusted the Tylenol to a specific dosage at two times of day and a specific dosage at a third time of day. The physician note also stated that resident #001's calling out may have been due to inadequate control of the resident's pain. A progress note dated this same day, documented that the resident was unsettled with verbal responsive behaviours at a specific time of day and upon assessment the writer noted swelling to the resident's leg which was warm to the touch and pain medication was administered. A progress note dated two days after the initial pain was reported, documented that the resident was reported to be screaming in pain during care with movement and on assessment the resident denied pain. This progress note continued to document that scheduled Tylenol was administered and the physician was notified and advised to increase resident #001's Tylenol to a specific dosage three times daily. A progress note dated four days after the initial pain was reported, documented that the resident remained in bed and complained of pain to their leg with repositioning, or any movement and Tylenol was administered. A progress note dated five days after the initial pain was reported, documented that the resident remained in bed and reported that they had pain to their leg. Another progress note dated five days after the initial pain was reported, documented that an x-ray noted a fracture and resident #001 was sent to the hospital.

During an interview with DOC #101, when asked what the process would be when a resident is exhibiting worsening symptoms of pain, DOC #101 stated that a pain assessment would be completed and the physician notified. When asked where this assessment would be documented, DOC #101 stated that there would be a pain assessment and pain evaluation and these would be documented in PCC. When asked if a pain assessment was completed for resident #001 when they first complained of pain, DOC #101 stated no and that they would expect it to have been completed when the resident's status changed, when the resident's

Tylenol was increased, and that this was not completed until 13 days later.

A review of resident #001's clinical record showed that no pain assessments were documented from a specific date, when they were first documented to be in pain, to a specific date, which was five days later, when they were transferred to hospital. Additionally, no Pain Flow Sheets were noted to be documented in the resident #001's paper copy chart or in PCC. When asked where Inspectors would find the Pain Flow Sheets that were to be completed as per the homes pain management policy at the time when resident #001's pain medication was adjusted, ADOC #106 stated that resident's pain was documented as a numerical scale on PCC and no documented flow sheets were provided to Inspector #435 when requested.

The licensee failed to ensure that the home's policy and procedure titled, "Pain Management", was followed for resident #001 when management could not provide pain flow sheets and no pain management assessments using a clinically appropriate assessment tool had been completed in PCC on two separate occasions when the physician increased resident #001's Tylenol order for unrelieved pain. (435)

B) The home submitted a CIS report to the MOHLTC, related to a fall by resident #006 on a specific date, which resulted in hospitalization and a significant change in the resident's health condition.

During a review of resident #006's progress notes in PCC, it was noted that they first complained of pain to their trunk on a specific date. A progress note dated three days later, noted that resident #006 was restless and showed signs of increased pain when staff attempted to reposition them in their chair. The progress note continued to state that the writer faxed the physician to notify of resident #006's increased pain and orders were received for Dilaudid at a specific dosage and frequency as needed. Another progress note dated this same day, stated that resident #006 was administered the ordered Dilaudid at a specific dosage and frequency as needed for pain.

During an interview with DOC #101, when asked what process the home would follow when a resident was exhibiting worsening symptoms of pain, DOC #101 stated that a pain assessment would be completed and the physician notified. When asked where this assessment would be documented, DOC #101 stated that there would be a pain assessment and pain evaluation and these would be

documented in PCC.

During an interview with ADOC #106, when asked when a pain assessment would be completed for a resident, ADOC #106 stated that pain assessments were completed on admission, readmission, quarterly, and upon identified changes in resident's condition. When asked what assessments were completed when resident #006 first complained of pain on an identified date, ADOC #106 stated that resident #006 had a fall assessment completed on a specific date, and a lift and transfer assessment completed on this same day.

A review of resident #006's clinical record showed that no pain assessments were documented from an identified date, when the resident was first documented to be in pain, to an identified date, when the resident was discharged. Additionally, no pain flow sheets were noted to be documented in the resident #006's paper copy chart or in PCC. When asked where Inspectors would find the pain flow sheets that were to be completed as per the home's pain management policy at the time when resident #006's PRN Dilaudid was initiated, ADOC #106 stated that resident's pain was documented as a numerical scale on PCC and no documented flow sheets were provided to Inspector #435 when requested.

The licensee failed to ensure that the home's policy and procedure titled, "Pain Management", was followed for resident #006 when management could not provide pain flow sheets and no pain management assessments using a clinically appropriate assessment tool had been completed in PCC on a specific date, when resident #006 first complained of pain and on a specific date, when resident #006 was administered a new order of Dilaudid for pain. (435)

C) The home submitted a CIS report to the MOHLTC, related to a fall by resident #004 on a specific date, which resulted in them being transferred to hospital. The CIS report stated that prior to the incident resident #004 had increased physical and verbal responsive behaviours and would run into things while ambulating.

A review of resident #004's progress notes in PCC showed the following:
- A note from a specific date and time stating they were complaining of neck pain and was often seen with their face down while wandering causing them to bump into furniture. A specific topical analgesic was applied to their lower back and neck.
- A note from a specific date and time stating they had continued to wander the unit while looking down.

- A note from a specific date and time stating they were looking down when ambulating and running over chairs, tables and co-residents.
- A from a specific date and time stating that staff had been advised to increase monitoring for resident #004 as they had been banging into walls, chairs, tables, and co-residents.
- A note from a specific date and time stating they were exhibiting responsive behaviours when staff re-directed them from running into walls and tables and also complained of back pain.
- A note from a specific date and time stating they complained of neck and back pain, were confused and often walking with their head leaning down bumping into walls.
- A note from a specific date and time stating they were leaning their head while ambulating and bumping into furniture and they were exhibiting verbal and physical aggressive behaviours.
- A note from a specific date and time stating they were bumping into things and exhibiting responsive behaviours.
- A note from a specific date and time stating they continued to look down and exhibited responsive behaviours.
- A note from a specific date and time stating they continued to exhibit responsive behaviours and were looking down and bumping into walls.
- A note from a specific date and time stating they continued to wander bumping into walls, chairs and tables and were exhibiting responsive behaviours when staff would re-direct.
- A note from a specific date and time stating they continued to wander with their head down and were complaining of pain and discomfort in their neck.
- A note from a specific date and time stating that they had been walking with their head down and when asked to keep their head up they complained of neck pain, they had been complaining of neck pain for two to three days. A specific topical analgesic was to be trialled four times daily for 14 days for neck pain.
- A note from a specific date and time stating they complained of neck and back pain.
- A note from the physician on a specific date and time stating they were wandering with their neck stooped and had noticeable neck tension/tightness when examined. Specific medications were discontinued and a new medication was prescribed for treatment of a specific medical condition that may have contributed to their neck pain.
- A note from a specific date and time stating their neck pain was possibly suggestive of a specific medical condition, a specific topical analgesic was prescribed four times daily, specific medications were discontinued and a specific

medication was to be trialled to treat a specific medical condition that may have contributed to their neck pain.
- A note from a specific date and time stating they continued to look down to the floor and were seen bumping on walls and chairs.
- A note from a specific date and time stating they continued to exhibit responsive behaviours when staff when attempted to re-direct from hitting a table, chair or wall.
- A note from a specific date and time stating they continued to exhibit responsive behaviours when staff tried to re-direct from bumping into the wall.
- A note from a specific date and time stating they were exhibiting responsive behaviours and complaining about neck and back pain.
- A note from a specific date and time stating they continued to exhibit responsive behaviours when staff attempted to re-direct them from bumping into walls and tables.
- A note from a specific date and time stating they attempted to walk but were unable to see where they were going, and were exhibiting responsive behaviours.
- A note from a specific date and time stating they had a witnessed fall that morning and were complaining of neck pain. They were noted to be holding their neck rigid during the fall and strained their neck. Moist heat was applied to their neck to ease the pain.
- A note from a specific date and time stating they complained of neck and back pain and were exhibiting responsive behaviours.
- A note from a specific date and time stating they were bumping into walls, chairs and tables and would become agitated as if someone was hurting them when staff tried to re-direct. They fell and were transferred to hospital.

A review of resident #004's Medication Administration Record and Treatment Administration Record in PCC showed the following:
- A specific topical analgesic four times daily for neck pain was ordered three days after they first complained of neck pain. This was administered as ordered on three consecutive dates, without documented effect.
- A specific topical analgesic as needed for lower back was ordered five months prior to when they first complained of neck pain. This was not documented as administered.
- Tylenol four times daily was ordered 19 months prior to when they first complained of neck pain. This was administered as ordered until resident was transferred to hospital on specific date, without documented effect.
- A specific medication identified to treat a specific medical condition that may have contributed to neck pain was ordered twice daily for seven days five months

prior to when they first complained of neck pain. This was administered as ordered on the date of their fall, without documented effect.

During an interview with an RPN they stated that pain assessments would be completed for all residents on admission, monthly and when they complained of new pain and that this would be documented under the Assessments section in PCC. The RPN told Inspector #721 that resident's pain levels and response to medications are documented for all scheduled and as needed medications such as Tylenol. They stated that when resident's medications are changed the physician will tell registered staff when to re-assess. When asked what actions they would take when a residents pain medications were changed, the RPN stated that front line staff would document on paper behavioural flow sheets and they would document the residents response to the changes in their progress notes.

During an interview with an RPN they told Inspector #435 that pain flow sheets would be completed for all residents monthly, on the first three days when someone is started on a pain medication and with as needed pain medications. The RPN stated that in the past pain flow sheets were completed on paper and kept in a pain flow sheet binder at each nursing station and that these are now completed on PCC.

A review of resident #004's Assessments section in PCC showed that Pain Assessments were completed two days prior to the date when they first complained of neck pain and five days after the date when they first complained of neck pain, which didn't include any documented of neck pain. Resident #004's Assessments section in PCC did not include any documented Pain Assessments from the four day period when they complained of ongoing neck pain.

A review of resident #004's Pain Level Summary in PCC showed three documented numerical pain levels on a specific date, five days after they first complained of neck pain. The Pain Level Summary did not include any documented pain levels from the date when they they first complained of neck pain or the four consecutive days following, when they complained of ongoing neck pain.

A review of resident #004's physical chart did not include any documented pain assessments or pain flow sheets from the date when they first complained of neck pain or the five consecutive days following, when they complained of ongoing

neck pain.

During an interview on a specific date, ADOC #106 reviewed resident #004's clinical record with Inspector #721. ADOC #106 stated that resident #004 first complained of neck pain on an identified date. ADOC #108 told Inspector #721 that they would expect a numerical pain level to be documented when a PRN pain medication was given and a pain assessment to be completed when any unusual pain was noted. ADOC #106 told Inspector #721 that no pain assessments or numerical pain levels were documented when resident #004 first complained of neck pain on a specific date, and thereafter when they complained of ongoing neck pain on the four consecutive days following. ADOC #106 stated that resident #004 was seen by the physician regarding their neck pain two days after they initially complained of neck pain, and a trial of a specific topical analgesic was initiated for a specific period of time. When asked if resident #004's response to the specific topical analgesic was documented, ADOC #106 stated that resident #004 had a weekly pain assessment completed five days after they initially complained of neck pain, and that their neck pain was not assessed during this assessment. They also stated that resident #004's numerical pain levels were not documented until five days after they initially complained of neck pain, and that it wasn't identified where the location of their pain was.

The licensee failed to ensure that the home's policy and procedure titled, "Pain Management", was followed for resident #004 when pain flow sheets and pain management assessments using a clinically appropriate assessment tool were not completed in PCC during a five day period, when they complained of unrelieved pain and on a specific date, when the physician initiated new medications for resident #004's unrelieved pain. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to were kept closed and locked, equipped with a door access control system that is kept on at all times, and were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and was connected to the resident-staff communication and response system, or was connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and had a manual reset switch at each door.

During an observation on a specific date and time on the fourth floor of the home, Inspector #435 observed a balcony door propped open by a chair off of the main hallway leading to the elevators. Inspector #435 was able to walk onto the balcony without using a key and no alarm sounded. No staff were observed to be in view of the balcony door at that time. Inspector #435 observed two staff members later walking past the opened balcony door. Two residents were

observed walking into the nearby dining room on their own.

On this specific date, Inspector #435 asked a Restorative Care Aide (RCA) if the fourth floor balcony door that was observed was usually open and they stated that it is open sometimes. When asked if residents could walk onto this balcony, the RCA stated yes. When asked if the balcony door was locked, the RCA stated no. When asked if there were residents capable of walking on their own on the fourth floor, the RCA said yes but there was always staff around. The RCA continued to walk past the balcony door to assist residents with getting ready for meal service.

On this specific date, Inspector #435 observed a PSW walk past the fourth floor balcony door. Inspector #435 asked the PSW if the balcony door was usually closed and they stated that the door was usually closed and a resident must have been out there. The PSW proceeded to close the balcony door at this time. Inspector #435 was then able to open the balcony door without a key or alarm sounding after the PSW closed the door.

On this specific date, Inspector #721 observed the doors leading to the outside balconies off of the main hall near resident common areas on the second and third floor of the home to be unlocked. Inspector #721 was able to open the door to the balconies with no key or alarm sounding.

During an interview on this specific date, when asked if the fourth floor had any wandering residents, DOC #101 stated that there were no residents at risk for elopement on the fourth floor. When asked what the legislative requirement was for doors to a home that lead to outside non-enclosed balconies or terraces, DOC #101 stated that doors would have to be locked, secured and enclosed. When asked if this was in place for all doors leading to the non-enclosed balconies on the second, third and fourth floors, DOC #101 stated that RPN's and Recreation staff have keys to the balcony doors and residents who were able to, could use the balcony. DOC #101 continued to state that staff would need to know if a resident was on the balcony. Inspector #435 took DOC #101 to the fourth floor balcony that was observed to be propped open by a chair earlier that day. When asked if they would expect that the door be propped open by a chair, DOC #101 stated no. When asked if they would expect the door to be unlocked, they stated no and acknowledged that Inspector #435 could open the door without a key or alarm sounding and enter the balcony. When Inspector #435 identified a chair pushed up against the glass barrier at the edge of the balcony and asked if DOC #101 thought there was a risk that a resident would be able to enter the balcony

without a key and be able to stand on the chair and climb over the glass barrier, DOC #101 stated yes, anything is possible. When asked if the door leading to the balcony was equipped with an alarm, DOC #101 stated no.

During observations at two separate times on the consecutive day following, Inspector #435 checked the balcony doors on the second, third and fourth floors and identified that the third floor balcony door was unlocked and they were able to enter the balcony without a key or alarm sounding.

During additional observations at three separate times on a third consecutive date, the third floor balcony door was observed to be unlocked and Inspector #435 was able to enter the balcony without a key or an alarm sounding.

During an interview on a specific date, when asked why the balcony doors were kept locked, an RPN stated that the door was kept locked for safety. When asked if this meant that residents could not walk out on to the balcony unsupervised, the RPN stated yes.

The licensee failed to ensure that doors leading to balconies that didn't preclude exit and were located off of resident care areas were locked to restrict unsupervised access on the second floor, third floor and fourth floor on seven identified occurrences during a three day time period. [s. 9. (1) 1.]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition within one business day.

A) On a specific date, the home submitted a CIS report to the MOHLTC, related to a fall by resident #001, which resulted in hospitalization and a significant change in the resident's health condition. The CIS report noted that resident #001 had a fall on a specific date, which was 15 days prior to the date that the CIS report was submitted, at which time the resident was reported to have no ill effects. The resident was transferred to hospital on a specific date, which was five days prior to the date that the CIS report was submitted, at which time an x-ray was taken and indicated a fracture.

During an interview with DOC #101 they stated that resident #001 presented with a change in condition on a specific date, when the home was made aware that they had a fracture. When asked when the MOHLTC was first notified of this incident, DOC #101 stated it was submitted on a specific date which was five

days after they were made aware that they had a fracture. DOC #101 stated that they were not present in the home on the specific date that the home was made aware resident #001 had a fracture or the three consecutive days following, and that they submitted the CIS report upon their return on the fifth consecutive day following. When asked if other staff members were able to submit CIS reports to the MOHLTC in their absence, DOC #101 said yes.

The licensee failed to ensure that the Director was informed within one business day when it was identified that resident #001 had a change in condition on a specific date, with transfer to hospital and surgical repair of their fracture. The incident was first reported to the MOHLTC on a specific date, five days later. (435)

B) On a specific date, the home submitted a CIS report to the MOHLTC, related to a fall by resident #006 on a specific date, which was 31 days prior to the date that the CIS report was submitted, which resulted in them being transferred to hospital and a significant change in the resident's health condition. The CIS report stated that on this specific date, resident #006 was found by housekeeping staff to be lying on the floor in front of their washroom. The physician assessed the resident and they were transported to hospital for further assessment. It was noted that resident #006 returned from hospital on the following day, with no change in health status. The report continued to state that the resident #006's health declined on a specific date, which was six days after the fall, and they passed away on a specific date, which was eight days after the fall.

During an interview with ADOC #106, when asked when the home was first aware of resident #006's change in condition and hospitalization, ADOC #106 stated that they had a change in condition when the resident was sent to the hospital on a specific date. When asked when the resident passed away, ADOC #106 stated the resident passed away on a specific date which was ten days after the fall, and not eight days after the fall as was documented in the CIS report. When asked what the reporting requirements were for an incident in which a resident has a significant change in health status with hospitalization, ADOC #106 stated that they would report the next business day or call the after-hours line. When asked why this incident was not reported to the MOHLTC when the resident first presented with a significant change in health status and hospitalization, ADOC #106 stated they could not speak to that.

The licensee failed to ensure that the Director was informed within one business

day when resident #006 had a change in condition with hospitalization on a specific date, and subsequent decline in health six days later, which was first reported to the MOHLTC on a specific date, 28 days later. (435)

C) On a specific date, the home submitted a CIS report to the MOHLTC, related to an incident in which resident #008 had sustained a hip fracture of unknown cause resulting in a significant change in the their health status and transfer to hospital. The CIS report documented that staff had found resident #008 lying in bed on a specific date, which was five days prior to the date that the CIS report was submitted, at which point they were complaining of pain and holding their hip, resistive to movement and transferred to hospital. The report continued to document that the residents Power of Attorney (POA) had informed the home the next day after they were transferred to hospital, that the resident was diagnosed with a hip fracture. The hospital phoned the home on a specific date, which was four days after they were transferred to hospital, to inform that resident #008 had a hip fracture and would require bed rest for six weeks.

During an interview with ADOC #106, when asked when resident #008 first had a change in condition, ADOC #106 stated on a specific date, when the resident was first complaining of pain and holding their hip. ADOC #106 also stated that when found resident #008 was not responding as usual. When asked when the MOHLTC was first notified of this incident, ADOC #106 stated on a specific date, which was five days after they had a change in condition. ADOC #106 was unable to provide Inspector #435 with an answer when they asked why the MOHLTC was notified five days later.

The licensee failed to ensure that the Director was informed within one business day when resident #008 had a change in condition with hospitalization on a specific date, which was first reported to the MOHLTC on a specific date, five days later. (435)

D) On a specific date, the home submitted a CIS report to the MOHLTC, related to a fall by resident #004 on a specific date, which was 18 days prior to the date that the CIS report was submitted and resulted in them being transferred to hospital. The CIS report stated that on the day after they fell, the home was notified by resident #004's family that they had sustained a fracture and would undergo surgery. Resident #004 returned to the home following surgery with orders for comfort measures on a specific date, which was 14 days prior to the date that the CIS report was submitted.

A review of resident #004's progress notes in PCC showed the following:
- A note from a specific date and time stating that resident #004 was found by staff to be lying on their side complaining of pain and that they were sent to hospital for further assessment.
- A note from the next consecutive date following stating that resident #004's family member contacted the home and told them that resident #004 broke their hip and would undergo surgery.
- A note from the second consecutive date following stating that resident #004's family member contacted the home and told them that resident #004 had surgery the previous day and was "not doing well".
- A note from the fourth consecutive date following stating that resident 004's family member contacted the home and told them that resident #004's behaviour had worsened and they would require a wheelchair upon return to the home.
- A note from the fourth consecutive date following stating that resident #004 was discharged from hospital post hip fracture and surgery.
- A note from the fourth consecutive date following stating that the home had a discussion with resident #004's family and orders were given for palliative care.

A review of the resident #004's MDS Assessment completed on a specific date, which was five days after they fell and were transferred to hospital, related to a significant change in status, indicated that their overall level of self-sufficiency had deteriorated.

During an interview on a specific date, ADOC #106 reviewed resident #004's clinical record with Inspector #721. ADOC #106 told Inspector #721 that on a specific date, which was one day after the incident where resident #004 fell and was transferred to hospital, the home was made aware by resident #004's family that they had broken their hip and would undergo surgery. When asked if this fall resulted in a significant change in resident #004's status, ADOC #106 stated it caused a significant change in their status as it affected their ability. ADOC #106 told Inspector #721 that this incident was not reported to the MOHLTC until a specific date, which was 18 days after the incident in which they fell and were transferred to hospital, and that they expected this should have been reported within one business day of the specific date, when it was known that resident #004's status had changed.

The licensee failed to ensure that the Director was informed within one business day when the home was aware resident #004 had a change in condition with

hospitalization on a specific date, which was first reported to the MOHLTC on a specific date, 17 days later. [s. 107. (3) 4.]

2. The licensee has failed to ensure that when required to inform the Director of an incident under subsection (3), within 10 days of becoming aware of the incident, or sooner if required by the Director, a report in writing is made to the Director with a description of the incident, including the events leading up with to the incident.

The home submitted a CIS report to the MOHLTC, related to a fall by resident #004 on a specific date and time which resulted in them being transferred to hospital. The CIS report provided a fall history for resident #004 from the last quarter, which stated they had one fall incident in the last quarter on a specific date.

A review of the homes Risk Management section in PCC showed that resident #004 had fallen on six separate occasions in the quarter prior to their fall which occurred on the specific date and time documented in the CIS report.

During an interview on a specific date, ADOC #106 reviewed resident #004's clinical record with Inspector #721. ADOC #106 told Inspector #721 that resident #004 had a history of falls and that they had previously fallen on six occasions, prior to their fall that was reported in the CIS report. When asked if a fall history for resident #004 during the last quarter was provided in the CIS report submitted to the MOHLTC, ADOC #106 stated that just the fall on one specific date, was listed in the CIS report.

The licensee failed to ensure that when required to inform the Director of a fall by resident #004 resulting in a significant change in status, that a report was made in writing to the Director with a description of the incident, including the residents fall history from the last quarter. [s. 107. (4) 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 Director is informed of any incident in the home under subsection (4) no later than one business day after the occurrence of the incident, followed by the report; that when required to inform the Director of an incident under subsection (1), (3) or (3.1) they shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident, to be implemented voluntarily.

Issued on this 2 nd day of July, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MEAGAN MCGREGOR (721) - (A1)
Inspection No. / No de l'inspection :	2019_788721_0016 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	007689-18, 008523-18, 015265-18, 029486-18, 031961-18, 001072-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 02, 2019(A1)
Licensee / Titulaire de permis :	Rykka Care Centres GP Inc. 3760 14th Avenue, Suite 402, MARKHAM, ON, L3R-3T7
LTC Home / Foyer de SLD :	Arbour Creek Long-Term Care Centre 2717 King Street East, HAMILTON, ON, L8G-1J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Paladino

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Rykka Care Centres GP 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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee must be compliant with s.6(10) of the LTCHA.

Specifically, the licensee must:
a) Ensure that when any resident's care needs change or the care set out in the plan of care is no longer necessary related to a change in their ambulation and transfer status as a result of a fall or an increase in responsive behaviours, their plan of care is reviewed and revised.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC), related to a fall by resident #004 which resulted in them being transferred to hospital. The CIS report stated that resident #004 had a bed alarm and crash mats to prevent falls.

A review of resident #004's progress notes in Point Click Care (PCC) showed that they had a crash mat in place on nine documented occurrences and a bed alarm in

place on eight documented occurrences.

During an interview with a Personal Support Worker (PSW) they stated that they would find out what a resident's care needs were by looking at their printed Care Plan and Kardex within the physical chart at the nursing station. The PSW told Inspector #721 that resident #004 had a bed alarm and crash mat in place to reduce their risk of falling.

A review of resident #004's Care Plan in PCC did not show any documentation regarding them having a crash mat or bed alarm in place to prevent falls.

During an interview on a specific date, Assistant Director of Care (ADOC) #106 reviewed resident #004's clinical record with Inspector #721. When asked how staff would know what care was to be provided for a resident, ADOC #106 stated that this would be documented in their Care Plan and Kardex in PCC and any changes to their plan of care would be communicated to staff at the start of each shift. ADOC #106 stated that if there were any changes to a resident's plan of care this would be updated immediately in their Care Plan and Kardex and another copy would be printed for front line staff to access. ADOC #106 told Inspector #721 that resident #004 fell on a specific date and it was documented that they had a crash mat and bed alarm in place at the time of this fall. ADOC #106 stated that resident #004's Care Plan didn't indicate if they were supposed to have a crash mat or bed alarm in place.

The licensee has failed to ensure that there was a written plan of care for resident #004 that set out clear directions for falls preventions interventions to staff and others who provide direct care to the resident. (721)

B) The home submitted a CIS report to the MOHLTC, related to an incident where resident #002 was found lying on the floor and stated that they had been pushed by resident #003. The CIS report stated that after the incident one to one monitoring was in place for resident #003.

A review of resident #003's progress notes in PCC showed that they had one to one monitoring in place on 18 documented occurrences.

During an interview with a PSW they stated that if a resident was supposed to have

one to one monitoring in place this would be indicated on the staff deployment sheet that was posted in each unit.

During an interview with a Registered Practical Nurse (RPN) they stated that if a resident was supposed to have one to one monitoring in place this would be indicated in their Care Plan. They stated that all staff could access a resident's printed Care Plan and Kardex in their physical chart. The RPN told Inspector #721 that resident #003 had one to one monitoring in place as needed when their responsive behaviours were escalated.

A review of resident #003's Care Plan in PCC did not show any documentation regarding them having one to one monitoring in place.

During an interview on a specific date, ADOC #106 reviewed resident #003's clinical record with Inspector #721. ADOC #106 told Inspector #721 that following the incident which was reported in the CIS report, one to one monitoring was in place for resident #003. ADOC #106 stated that when one to one monitoring was implemented for a resident the staffing clerk would be notified to schedule the one to one monitoring on staff deployment sheets and nursing staff would also document this on the 24 hour shift report. They stated that staff were verbally informed when one to one monitoring was discontinued for a resident.

On a specific date, the Business Services Manager provided Inspector #721 with the homes staff deployment sheets from the month after the incident. The staff deployment sheets showed that a staff member was scheduled for one to one monitoring on the home area that resident #003 resided on the afternoon shift on five specific dates, night shift on five specific dates and day shift on three specific dates. The staff deployment sheets did not indicate which resident staff provided one to one monitoring for.

During an interview on a specific date, ADOC #106 reviewed the staff deployment sheets from the month after the incident with Inspector #435. ADOC #106 told Inspector #435 that the time of one to one monitoring was scheduled based on resident #003's behavioural needs. When asked how staff would know which resident one to one monitoring was scheduled for when it was not indicated on the staff deployment sheets, ADOC #106 stated that this was communicated verbally or on the shift change report.

The licensee has failed to ensure that there was a written plan of care for resident #003 that set out clear directions for one to one monitoring to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 1 as it related to two of six (33%) residents reviewed. The home had a level 3 compliance history as they had one or more related non-compliance in the last 36 months that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued January 11, 2017, (2016_570528_0025);
- WN and VPC issued February 8, 2018, (2018_573581_0001); and
- WN and VPC issued July 13, 2018, (2018_560632_0014). (721)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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 :

(A1)
The licensee must be compliant with s.6(10) of the LTCHA.

Specifically, the licensee must:
a) Ensure that when any resident's care needs change or the care set out in the plan of care is no longer necessary related to a change in their ambulation and transfer status as a result of a fall or an increase in responsive behaviours, their plan of care is reviewed and revised.

Grounds / Motifs :

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

The home submitted a CIS report to the MOHLTC, related to a fall by resident #004 which resulted in them being transferred to hospital. The CIS report stated that prior to the incident resident #004 had increased physical and verbal responsive behaviours.

A review of resident #004's Care Plan in PCC showed the following:
- "Registered staff to assess pain weekly and document" related to "[resident] will c/o pain and will get restless if in pain".

A review of resident #004's Assessments section in PCC showed that pain assessments were completed on two specific dates during the identified period before the incident. Resident #004's physical chart and Assessments section in PCC did not include any documented pain assessments on one of the identified weeks prior to the incident.

During an interview on a specific date, ADOC #106 reviewed resident #004's clinical record with Inspector #721. ADOC #106 told Inspector #721 that registered staff were expected to assess and document resident #004's pain weekly. ADOC #106 stated that there were pain assessments completed for resident #004 on two specific dates, and that there were no weekly pain assessments completed on one of the identified weeks prior to the incident, as stated in their Care Plan.

The licensee failed to ensure that weekly pain assessments were completed for resident #004 as stated in their plan of care. [s. 6. (7)]

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the resident. The scope of the issue was a level 1 as it related to one of six (16%) residents reviewed. The home had a level 3 compliance history as they had one or more related non-compliance in the last 36 months that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued January 11, 2017, (2016_570528_0025);
- WN and VPC issued February 8, 2018, (2018_573581_0001); and
- WN and VPC issued July 13, 2018, (2018_560632_0014). (721)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère 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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (9) The licensee shall ensure that the following are documented:

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

Order / Ordre :

(A1)
The licensee must be compliant with s.6(10) of the LTCHA.

Specifically, the licensee must:
a) Ensure that when any resident's care needs change or the care set out in the plan of care is no longer necessary related to a change in their ambulation and transfer status as a result of a fall or an increase in responsive behaviours, their plan of care is reviewed and revised.

Grounds / Motifs :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care were documented.

A) The home submitted a CIS report to the MOHLTC, related to a fall by resident #006 which resulted in hospitalization and a significant change in the resident's health condition. The CIS report documented that resident #006 had sustained a fall on a specific date, at which time the resident was found by a staff member to be lying on the floor in front of their washroom with dried blood noted on the resident and on the floor. The physician assessed the resident and the resident was then transported to hospital for further assessment.

A review of resident #006's plan of care at the time of the fall identified that resident #006 was to be checked every one hour to ensure their safety for falls prevention and management.

During an interview with ADOC #106, when asked where staff were expected to document resident's every one hour safety checks, ADOC #106 stated that it was documented on a flow sheet. When asked where Inspectors would find these documents, ADOC #106 stated that the documented safety checks could be found in resident #006's paper copy chart.

Inspector #435 reviewed resident #006's paper copy chart and was unable to find documentation for resident #006's every one hour safety check for falls prevention and management. Inspector #435 verified with ADOC #106 that they were unable to find the one hour safety check flow sheets in resident #006's paper copy chart as informed and ADOC #106 stated that if they were completed they would be found in the chart provided. When asked when the last time resident #006 was checked prior to being found on the floor of their washroom, ADOC #106 was unable to provide this information.

During an interview with an RPN, when asked where staff look to find the information that they need to provide care to residents, the RPN stated that staff use the Kardex and Care Plan. When asked where staff document that they have provided every one hour safety checks for falls prevention, if identified as an intervention in a resident's Care Plan, the RPN stated that this was not documented.

The licensee failed to ensure that the provision of the every one hour safety checks, the outcomes of the every one hour safety checks, and the effectiveness of the every one hour safety checks were documented for resident #006. (435)

B) The home submitted a CIS report to the MOHLTC, related to an incident in which resident #008 had sustained a hip fracture of unknown cause resulting in a significant change in the residents health status and transfer to hospital on a specific date.

A review of resident #008's plan of care at the time of the incident, documented that resident #008 was to be checked on every 30 minutes for safety as an intervention as the resident was identified to be at risk for falls.

During an interview with ADOC #106, when asked where staff were expected to document a resident's safety checks as identified in their plan of care, ADOC #106 stated that it was documented on a flow sheet. When asked where Inspectors would find these documents, ADOC #106 stated that the documented safety checks could be found in resident #008's paper copy chart.

Inspector #435 reviewed resident #008's paper copy chart and was unable to find documentation for resident #008's every 30 minute safety check for falls prevention and management. Inspector #435 verified with ADOC #106 that they were unable to find the every 30 minute safety check flow sheets in resident #008's paper copy chart as informed and ADOC #106 stated that if they were completed they would be found in the chart provided.

During an interview with a PSW, when asked where staff document care provided, the PSW stated that it was documented on flow sheets. When asked where staff would look to find what interventions were in place for a residents care needs, the PSW stated they refer to the Care Plan. When asked where it would be documented that staff checked on a resident if they required every 30 minute safety checks, the PSW referred to the Personal Care Aid (PCA) flow sheet which did not include times that residents were checked.

During an interview with an RPN, when asked where staff look to find the information that they need to provide care to residents, the RPN stated that staff use the Kardex and Care Plan. When asked where staff document that they have provided every one hour safety checks for falls prevention, if identified as an intervention in a resident's Care Plan, the RPN stated that this was not documented.

The licensee failed to ensure that the provision of the every 30 minute safety checks, the outcomes of the every 30 minute safety checks and the effectiveness of the 30 minute safety checks were documented for resident #008. [s. 6. (9)]

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 1 as it related to two of six (33%) residents reviewed. The home had a level 3 compliance history as they had one or more related non-compliance in the last 36 months that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued January 11, 2017, (2016_570528_0025);

- WN and VPC issued February 8, 2018, (2018_573581_0001); and
- WN and VPC issued July 13, 2018, (2018_560632_0014). (435)

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

Order # / Ordre no : 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. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be compliant with s.6(10) of the LTCHA.

Specifically, the licensee must:
a) Ensure that when any resident's care needs change or the care set out in the plan of care is no longer necessary related to a change in their ambulation and transfer status as a result of a fall or an increase in responsive behaviours, their plan of care is reviewed and revised.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A) The home submitted a CIS report to the MOHLTC, related to an incident in which resident #008 had sustained a hip fracture of unknown cause resulting in a significant change in the residents health status and transfer to hospital on a specific date.

A review of resident #008's progress notes in PCC documented that the home was notified by the hospital four days after the incident that resident #008 had a hip fracture but would not be a candidate for surgery and was to be on bed rest for six

weeks. In another progress it was documented that the resident returned to the home from hospital five days after the incident with a hip fracture and was non-weight bearing.

During an interview with a PSW and RPN, when asked where they would look to find out what a residents care needs were, the PSW and RPN stated they looked in the Care Plan. When asked how resident #008 ambulated after their return from hospital on an identified date, the PSW and RPN stated that resident #008 did not ambulate as they were on bed rest. When asked how the resident was toileted after their return from hospital on the identified date, the PSW and RPN stated that the resident used a brief and a bed pan for toileting. When asked how resident #008 ambulated prior to their hospitalization, PSW #104 stated that the resident was independent with their walker for ambulation and was independent with toileting.

A review of resident #008's Care Plan upon their return from hospital on a specific date, documented that the resident toileted independently with an initiated date of approximately five months prior to their return from hospital, and resolved date of approximately two weeks after their return from hospital.

During an interview with ADOC #106, when asked what resident #008's toileting needs were upon their return from hospital on an identified date, as found in the residents plan of care, ADOC #106 stated that resident #008's plan of care for toileting was last updated approximately five months prior to the identified date.

The licensee failed to ensure that resident #008's plan of care was reviewed and revised when resident #008's toileting care needs changed upon their return from hospital with a fractured hip, ordered bed rest, and non-ambulatory on a specific date. (435)

B) The home submitted a CIS report to the MOHLTC, related to an incident in which resident #008 had sustained a hip fracture of unknown cause resulting in a significant change in the residents health status and transfer to hospital on a specific date. The CIS report documented that resident #008 had previously fallen two weeks prior to this incident, resulting in transfer to hospital for further assessment and they returned to the home without a fracture or change in ambulation status. The CIS report also stated that the home would trial a bed alarm and crash mat as fall precaution interventions in the resident's plan of care.

A review of a Risk Management incident documented that resident #008 had sustained a fall on a specific date prior to their fall reported in the CIS report, but this fall was on a different date than what was documented in the CIS report. The incident report continued to state that staff were to encourage resident #008 to call for help before using the washroom and that staff members were to check them every hour to make sure the resident's bed was in the lowest position and a bed alarm was on the bed as fall precaution interventions.

During an interview with a PSW, when asked what falls prevention and management strategies were in place for resident #008, the PSW stated that the resident used a crash mat and hip protectors. When asked if resident #008 used a bed alarm, the PSW stated no.

During an interview with an RPN, when asked if resident #008 had any falls prevention strategies changed or updated in their plan of care between the time of their fall two weeks prior and the time of the fall that was reported in the CIS report, the RPN stated that nothing had changed in the resident's plan of care as resident #008 was walking and not complaining of pain. When asked if resident #008 was at risk for falls at that time, the RPN said yes.

During an interview with ADOC #106, when asked if resident #008 was at high risk for falls, ADOC #106 stated yes. When asked if resident #008 had a fall mat or bed alarm implemented in their plan of care as falls prevention interventions, ADOC #106 stated no. When asked what interventions were identified in the CIS report submitted to the MOHLTC as long term actions that were planned to prevent recurrence of the incident, ADOC #106 stated that the CIS report documented that the home would trial a bed alarm and crash mats. When asked what actions for staff were documented in the Risk Management report on an identified date, ADOC #106 stated that resident #008 was to have a bed alarm on their bed. When asked if the falls prevention and management interventions as described in the CIS report and the Risk Management report were implemented, ADOC #106 stated that they were not implemented.

The licensee failed to ensure that resident #008's plan of care was reviewed and revised to include the bed alarm and crash mats when they were assessed to require this change in their plan of care. (435)

C) The home submitted a CIS report to the MOHLTC, related to a fall by resident #004 on a specific date, which resulted in them being transferred to hospital. The CIS report stated that resident #004 sustained a hip fracture and returned to the home four days later, following surgery with orders for comfort measures.

A review of the resident #004's Minimum Data Set (MDS) Annual assessment completed prior to their fall, and Significant change in status assessment completed upon their return from hospital after the fall, showed the following:
- "Supervision" and "Set-up help only" with transfer prior to the fall, and "Total Dependence" and "Two+ persons physical assist" with transfer after the fall.
- "Supervision" and "Set-up help only" with walking in their room prior to the fall, and "Activity Did Not Occur" and "ADL activity did not occur during entire 7 days" with walking in their room after the fall.
- "Limited Assistance" and "One-person physical assist" with walking on the unit prior to the fall, and "Activity Did Not Occur" and "ADL activity did not occur during entire 7 days" with walking on the unit after the fall.
- "Limited Assistance" and "One-person physical assist" with locomotion on the unit prior to the fall, and "Activity Did Not Occur" and "ADL activity did not occur during entire 7 days" with locomotion on the unit after the fall.
- "Limited Assistance" and "One-person physical assist" with locomotion off the unit prior to the fall, and "Activity Did Not Occur" and "ADL activity did not occur during entire 7 days" with locomotion off the unit after the fall.
- Modes of locomotion were "Cane, walker or crutch" prior to the fall, and Modes of locomotion were "NONE OF ABOVE" after the fall.
- Modes of transfer were "NONE OF ABOVE" prior to the fall, and Modes of transfer were "Bed rails used for bed mobility and transfer" and "Lifted Manually" after the fall.

A review of resident #004's progress notes in PCC showed the following:
- A note from a specific date and time, stating that the home spoke with resident #004's family member regarding their condition and discussed getting a wheelchair for them upon return to home.
- A note from a specific date and time, stating that the home spoke with resident #004's family member regarding goals of care upon their return to the home and orders given for palliative care.
- A note from a specific date and time, stating that they were found climbing out of bed.

- A note from a specific date and time, stating that they were awake sitting in a wheelchair with a lap belt most of the night for safety as they were trying to climb out of bed.
- A note from a specific date and time, stating that they were on palliative care following hip fracture and physiotherapy program was discontinued.
- A note from a specific date and time, stating that they were deemed palliative and bed rails had been requested by resident #004's family member due to bed exiting habits.
- A note from a specific date and time, stating that they were attempting to get out of bed and re-directed to bed by staff.
- A note from a specific date and time, stating that they were awake in their wheelchair all night.
- A note from a specific date and time, stating that they were attempting to climb out of bed and placed in a wheelchair with a lap belt for safety and slept in the wheelchair through the night.

A review of resident #004's Care Plan in PCC, upon their return from hospital, showed the following:
- "[Resident] walks independently on the unit using [walker]" related to "Mobility/Ambulation impaired d/t impaired cognition, weakness from not eating/drinking. Resident to ambulate with 1 staff supervision."
- "Staff will encourage [resident] to walk with [their] walker with short steps, safely and take break and big breath when feeling tired" related to "ambulation impaired r/t decrease in strength ,weakness, dementia and unsteady gait balance [resident] use walker for ambulation."
- "TRANSFERS without assistance but requires staff to provide assistive devices/aides/equipment" and "Resident can weight bear" related to "Transferring; ability impaired related to decrease weakness of lower limbs due to not eating or drinking."

During an interview with a PSW they stated that they would find out what a resident's care needs were by looking at their printed Care Plan and Kardex within their physical chart at the nursing station. The PSW told Inspector #721 that prior to their fall, resident #004 ambulated with a walker and was independent sometimes requiring limited assistance with transfers. The PSW stated that when resident #004 returned to the home after their fall on an identified date, they were bedridden and that if they did get out of bed they were in a wheelchair.

During an interview with an RPN, when asked how front line staff would know what a resident's ambulation status and transfer needs were, the RPN stated that they would look in the resident's printed Care Plan on the unit. The RPN stated that when a resident's care needs change registered staff will update their Care Plan in PCC and the printed Care Plan in the binder on each unit and this will also be noted on the 24 hour shift report. The RPN told Inspector #721 that prior to their fall on an identified date, resident #004 ambulated independently with a walker and was mostly independent with some supervision for transfers. The RPN stated that when resident #004 returned to the home after their fall on an identified date, they required two person assistance and were non weight bearing with transfers and they couldn't remember them walking.

During an interview on a specific date, ADOC #106 reviewed resident #004's clinical record with Inspector #721. When asked how staff would know what care was to be provided for a resident, ADOC #106 stated that this would be documented in their Care Plan and Kardex in PCC and any changes to their plan of care would be communicated to staff at the start of each shift. ADOC #106 stated that if there were any changes to a resident's plan of care that this would be updated immediately in their Care Plan and Kardex and another copy would be printed for front line staff to access. ADOC #106 told Inspector #721 that prior to their fall on an identified date, resident #004 was walking independently with a walker and receiving physical assistance with transfers as needed. ADOC #106 stated that after their fall on an identified date, resident #004 was palliative and bed ridden, and required two person physical assistance with transfers. ADOC #106 told Inspector #721 that after the fall on an identified date, resident #004's Care Plan was not updated to reflect their change in ambulation and transfer status.

The licensee failed to ensure that when resident #004's care needs changed related to a change in their ambulation and transfer status a result of a fall, that their plan of care was revised to reflect their needs. (721)

D) The home submitted a CIS report to the MOHLTC, related to an incident on on a specific date where resident #002 was found lying on the floor and stated that they had been pushed by resident #003.

A review of the Risk Management section in PCC showed that resident #003 had

initiated physical aggression towards other residents on eight identified occurrences prior to the incident identified in the CIS report.

A review of resident #003's progress notes in PCC showed documentation from a specific date, stating that they were physically aggressive towards another resident that entered their room and that a wander strip was to be applied so that other residents couldn't enter their room.

A review of resident #003's Care Plan in PCC did not show any documentation regarding them having a wander strip in place.

During an interview with a PSW they stated that when behavioural interventions such as a wander strip were implemented for a resident, this would be indicated in their Care Plan and Kardex and on the 24 hour shift report. The PSW stated that resident #003 exhibited physically aggressive behaviours and would use their walker to hit other residents. The PSW told Inspector #721 that resident #003 had a wander strip across their door at some point.

During an interview with an RPN they stated that if a resident was supposed to have a wander strip in place this would be indicated in their Care Plan in PCC. The RPN told Inspector #721 that resident #003's behaviours were unpredictable and of sudden onset and that they would try to hit other residents who wandered with their walker. They stated resident #003 had a wander strip prior to their hospital stay during a specific period of time.

During an interview on a specific date, ADOC #106 reviewed resident #003's clinical record with Inspector #721. ADOC #106 told Inspector #721 that resident #003's progress notes stated they had a wander strip applied to their door after they were involved in a physical altercation on an identified date. When asked how staff knew that resident #003 was supposed to have a wander strip in place, ADOC #106 stated that it should be documented somewhere and maybe it was done verbally. ADOC #106 told Inspector #721 that staff were expected to go over a resident's progress notes. When asked if all staff had access to resident's progress notes, ADOC #106 stated that registered staff could access a resident's progress notes and they would be responsible for communicating this information to PSW staff at shift report. ADOC #106 stated that it was not documented in resident #003's plan of care that they had a wander strip in place at this time.

The licensee failed to ensure that when resident #003's care needs changed related to an increase in physically aggression, that their plan of care was revised to reflect their needs. [s. 6. (10) (b)]

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 2 as it related to three of six (50%) residents reviewed. The home had a level 4 compliance history as despite MOHLTC action, non-compliance continues with original area of non-compliance that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued January 11, 2017, (2016_570528_0025);
- WN and VPC issued February 8, 2018, (2018_573581_0001); and
- WN and VPC issued July 13, 2018, (2018_560632_0014). (721)

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s.20(1) of the LTCHA.

Specifically, the licensee must:
a) Ensure that the home's policy to promote zero tolerance of abuse and neglect of residents is complied with, specific but not limited to the process for investigating allegations of abuse, analyzing the evidence obtained, making conclusions based on the evidence and preparing a report.
b) Ensure there is a documented record maintained of their investigation into each allegation of abuse.

Grounds / Motifs :

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

The home submitted a CIS report to the MOHLTC, related to an incident on a specific date, where resident #002 was found lying on the floor and stated that they had been pushed by resident #003.

The home's policy titled "Abuse and Neglect Policy", in place at the time of the incident, stated that:
- "Any alleged, suspected or witnessed incident of abuse or neglect of a resident is to be reported to the Executive Director/designate of the Home".

- As part of their investigation the Executive Director and their designates are to assemble an investigation team and "the investigation team is to analyze the evidence obtained, make conclusions based on the evidence and prepare a report. The report should: i. summarize the complaint, ii. identify any interim steps taken pending the completion of the investigation, iii. summarize the evidence obtained, iv. identify any inconsistencies, v. assess credibility and weigh competing evidence to attempt to reach factual conclusions and vi. explain the reason for any conclusions reached".

A review of resident #003's progress notes and Risk Management section in PCC showed ten documented incidents where resident #003 had been physically abusive towards other residents, which included the incident documented in the CIS report and nine additional incidents which occurred in the three months prior to this incident.

During an interview on a specific date, ADOC #106 reviewed resident #003's clinical record with Inspector #721. ADOC #106 told Inspector #721 that when staff witness or become aware of an allegation of resident abuse they are expected to inform the charge nurse and the charge nurse will inform management. They stated that staff are expected to document under the Risk Management section in PCC when there is any incident of abuse and when residents exhibit verbally and physically aggressive behaviours. ADOC #106 stated that they reviewed documented incidents on the Risk Management section in PCC daily.

During an interview on a specific date, Executive Director (ED) #100 reviewed resident #003's clinical record with Inspector #721. When asked what process staff were expected to follow when they became aware of an incident of abuse, ED #100 stated that they were expected to notify them verbally in person, via email, or through the dashboard in PCC. ED #100 told Inspector #721 that if they became aware of allegations of abuse, they would meet with the Director of Care (DOC), ADOC and charge nurse to discuss what occurred and that each person would take the lead on a piece of the investigation and document accordingly. ED #100 and Inspector #721 discussed ten identified incidents documented in resident #003's progress notes where they allegedly physically abused other residents. ED #100 told Inspector #721 that they would consider the ten identified incidents to be abuse.

In response to a request for documentation of the home's investigation into the

allegations of physical abuse that were reported in the CIS report, ED #100 informed Inspector #721 via email that investigation notes were primarily documented in progress notes and that conversations would occur between the interdisciplinary team and be recorded in PCC. ED #100 stated that if there was an investigation conducted they would also have statements from employees, residents or residents families. The home was unable to provide Inspectors with documentation of the home's investigation into the allegations of physical abuse that were documented in the CIS report and the nine other identified incidents where resident #003 was alleged to have physically abused other residents.

The licensee failed to ensure that the home's Abuse and Neglect Policy was complied with when they failed to follow their process for investigating allegations of abuse by resident #003, including analyzing the evidence obtained, making conclusions based on the evidence and preparing a report. [s. 20. (1)]

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 3 as it related to ten of ten (100%) incidents reviewed. The home had a level 2 compliance history as they had one or more unrelated non-compliance in the last 36 months that included:
- Written Notification (WN), Voluntary Plan of Correction (VPC) and Compliance Order (CO) issued January 11, 2017, (2016_570528_0025);
- WN and VPC issued May 1, 2017, (2017_539120_0022);
- WN, VPC and CO issued February 8, 2018, (2018_573581_0001);
- WN and VPC issued August 2, 2018, (2018_539120_0032);
- WN and VPC issued July 13, 2018, (2018_560632_0014); and
- WN and VPC issued March 19, 2019, (2019_539120_0012). (721)

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

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

Ministère 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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be compliant with s.24(1) of the LTCHA.

Specifically, the licensee must:
a) Ensure that when anyone working in the home has reasonable grounds to suspect that abuse of any resident by anyone that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

On a specific date the home submitted a CIS report to the MOHLTC, related to an incident that occurred one to day prior, in which resident #002 was found lying on the floor and stated that they had been pushed by resident #003.

The home's policy titled "Abuse and Neglect Policy", in place at the time of the incident, stated that:
- "Where a staff member has reason to believe that a resident has suffered harm or is at risk of harm due to abuse or neglect, improper or incompetent treatment or care, or unlawful conduct, they must immediately report their suspicion and the information upon which it is based, to the Home, and to the Director appointed under the Long-Term Care Homes Act, 2007".
- "Staff must adhere to the mandatory reporting obligations set out in the LTCHA".
- "As set out in the LTCHA, any person who has reasonable grounds to suspect that any of the following has occurred, or may occur, shall immediately report the suspicion and the information upon which it was based to the Director of Long-Term Care Homes: abuse of a resident by anyone, or neglect of a resident by the licensee or staff member that resulted in harm or a risk of harm to the Resident".

A review of resident #003's progress notes and Risk Management section in PCC showed nine documented incidents where resident #003 had been physically abusive towards other residents, which included the incident documented in the CIS report and eight additional incidents which occurred in the three months prior to this incident.

During an interview on a specific date, ADOC #106 reviewed resident #003's clinical record with Inspector #721. ADOC #106 told Inspector #721 that when staff witness or become aware of an allegation of resident abuse they are expected to inform the charge nurse and the charge nurse will inform management. They stated that staff are expected to document under the Risk Management section in PCC when there is any incident of abuse and when residents exhibit verbally and physically aggressive behaviours. ADOC #106 stated that they reviewed documented incidents on the Risk Management section in PCC daily.

A review of the MOHLTC Critical Incident reporting system showed that no CIS reports were submitted related to eight of the documented incidents where resident #003 allegedly abused other residents.

During an interview on a specific date, ED #100 reviewed resident #003's clinical record with Inspector #721. When asked what process staff were expected to follow when they became aware of an incident of abuse, ED #100 stated that they were

expected to notify them verbally in person, via email, or through the dashboard in PCC. ED #100 reviewed nine identified incidents documented in resident #003's progress notes where they allegedly hit other residents. ED #100 told Inspector #721 that they would consider the nine identified incidents to be abuse. When asked when they became aware of the nine identified incidents where resident #003 had abused other residents, ED #100 stated that they couldn't recall when they were made aware but that they were usually notified the same day. ED #100 told Inspector #721 it was their expectation that the nine identified incidents where resident #003 abused other residents should have been immediately reported to the MOHLTC. ED #100 stated that the incidents which occurred on eight identified dates were not reported to the MOHLTC and that the incident which occurred on one identified date, was not reported to the MOHLTC until one day after the incident occurred.

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse by resident #003 that resulted in harm or a risk of harm to a resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

The severity of this issue was determined to be a level 1 as there was potential for actual harm to the residents. The scope of the issue was a level 3 as it related to nine of ten (90%) incidents reviewed. The home had a level 2 compliance history as they had one or more unrelated non-compliance in the last 36 months that included:
- Written Notification (WN), Voluntary Plan of Correction (VPC) and Compliance Order (CO) issued January 11, 2017, (2016_570528_0025);
- WN and VPC issued May 1, 2017, (2017_539120_0022);
- WN, VPC and CO issued February 8, 2018, (2018_573581_0001);
- WN and VPC issued August 2, 2018, (2018_539120_0032);
- WN and VPC issued July 13, 2018, (2018_560632_0014); and
- WN and VPC issued March 19, 2019, (2019_539120_0012). (721)

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

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

Ministère 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

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Order / Ordre :

The licensee must be compliant with s.31 of the LTCHA.

Specifically, the licensee must:
a) Ensure that when any resident is restrained by a physical device as described in paragraph 3 of subsection 30(1), that the restraining of the resident is included in the resident's plan of care and that the provisions and requirements for restraining of a resident by a physical device are satisfied.
b) Training shall be provided to all registered nursing staff members on the home's restraint policy, specific but not limited to the procedure for completing an assessment and obtaining consent and an order prior to the application of a physical device. The home must keep a documented record of the education provided.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident was restrained by a physical device as described in paragraph 3 of subsection 30(1), that the restraining of the resident was included in the resident's plan of care and that the provisions and requirements for restraining a resident by a physical device were satisfied.

The home submitted a CIS report to the MOHLTC, related to a fall by resident #004 on a specific date, which resulted in them being transferred to hospital. The CIS report stated that resident #004 sustained a hip fracture and returned to the home on a specific date, following surgery with orders for comfort measures.

A review of resident #004's progress notes in PCC showed the following:
- A note from a specific date stating that they were awake and sitting in a wheelchair with a lap belt most of the night for safety as they were trying to climb out of bed.

- A note from a specific date stating that they were deemed palliative and full bed rails had been requested by a family member.
- A note from a specific date stating that they were attempting to climb out of bed and placed in a wheelchair with a lap belt for safety and slept in the wheelchair through the night.

A review of the resident #004's MDS assessment completed after the time of their fall, related to a significant change in status, indicated the following:
- "Bed rails used for bed mobility or transfer".
- "Other types of side rails used (e.g. half rail, 1 side)" were "Used daily".
- "Full bed rails on all open sides of bed" and "Trunk restraint" were "Not used".

The home's policy titled "Restraints", in place at the time of the incident, was reviewed and stated the following:
- "A physical restraint is any physical device that is used to protect the resident from serious bodily harm to self and/or others. It is considered a restraint only when the resident is unable to undo or remove it due to physical and cognitive deficit".
- "Physical devices which are approved for use in the home and defined as restraints are: seat belts (front and side closure ONLY), bed rails (2 or 1 bed rail), lap trays, recliner chairs, any physical device that the resident is physically and cognitively unable to remove or undo".
- The procedure for restraining by a physical device includes "The interdisciplinary team initiates the assessment process when a situation presents itself that could result in the use of a restraint. The causal factors are assessed, and appropriate interventions/treatment will be implemented by the care team. Document these in the care plan, and electronic progress notes" and "Informed consent will be discussed and obtained, prior to the application of a physical restraint (except in an emergency situation) from the resident if deemed competent or from the substitute decision maker if resident has been assessed as competent for the purpose of making this informed decision at the time the restraint is required".
- The procedure for initiation of a physical restraint use includes "A physician, RN (EC) or the Director of Nursing and Personal Care or a Registered Nurse has recommended the restraining." and "A physician or RN (EC) must order a physical device".

During an interview with a PSW they stated that if a resident was supposed to have a lap belt or bed rails in place this would be indicated on their printed Care Plan and

Kardex within their physical chart and on the 24 hour shift report at the nursing station. The PSW stated they couldn't remember if resident #004 had a lap belt or bed rails in place when they returned from hospital on a specific date. When asked if they considered a lap belt to be a restraint, they stated absolutely. When asked if resident #004 would have been able to undo a lap belt at this time, they stated they didn't know if they could because they had really declined.

During an interview with an RPN they stated that prior to implementing a lap belt or bed rails for a resident they would tell their family, would look at alternative things to use and would only use them as a last resource. When asked if there were any assessments they would complete before implementing a restraint, the RPN stated they didn't think they had assessments. The RPN told Inspector #721 that if a resident had a lap belt or bed rails in place this would be stated in their Care Plan and Kardex.

A review of resident #004's physical chart and clinical record in PCC did not include any documented assessments, consent or orders for the use of a lap belt and bed rails. Resident #004's Care Plan and Kardex did not show any documentation indicating they were to have a lap belt or bed rails in place.

During an interview on a specific date, ADOC #106 reviewed resident #004's clinical record with Inspector #721. When asked if they considered lap belts and bed rails to be restraints, ADOC #106 stated they would be restraints if a resident was unable to remove them. ADOC #106 told Inspector #721 that nursing staff can use lap belts on residents for a period of time provided that they have an order. ADOC #106 stated that prior to implementing a restraint, staff would document an assessment and consent for the use of the restraint in PCC or in their physical chart. ADOC #106 reviewed resident #004's progress notes with Inspector #721 present, which indicated that a lap belt was applied to resident #004's wheelchair on two identified dates. They also reviewed resident #004's MDS assessment completed after their fall, which indicated that resident #004 had bed rails in place. ADOC #106 told Inspector #721 that resident #004 did not have any documented assessments, consent or orders for the use of a lap belt and bed rails in their physical chart or in PCC and that the use of a lap belt and bed rails were not indicated in their plan of care.

The licensee failed to ensure that when resident #004 was restrained by a physical

device as described in paragraph 3 of subsection 30 (1), that this was included in the resident's plan of care, was ordered by a physician, registered nurse in the extended class or other person provided for in the regulations, was consented for by the resident or their substitute decision-maker and that the plan of care provided for the requirements under subsection (3). [s. 31.]

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 1 as it related to one of three (33%) residents reviewed. The home had a level 4 compliance history as despite MOHLTC action, non-compliance continues with original area of non-compliance that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued January 11, 2017, (2016_570528_0025). (721)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 04, 2019

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

Ministère 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

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s.8(1).

Specifically, the licensee must:
a) Ensure the home's pain management policy is fully implemented and complied with.
b) Training shall be provided to all registered nursing staff members on the home's pain management policy, specific but not limited to the procedure for completing pain assessments. The home must keep a documented record of the education provided.

Grounds / Motifs :

1. The licensee has failed to ensure where the Act or Regulation required them to have, institute or otherwise put in place any policy or procedure, that the policy and procedure were complied with.

In accordance with Ontario Regulation 79/10, s. 52, required the licensee to ensure there was a program in place to manage pain. The home's policy and procedure titled "Pain Management", revised on a specific date, was reviewed and identified that upon initiation of a new pain management medication or an adjustment to dosage and/or frequency, a Pain Flow Sheet shall be initiated. The policy also stated if a resident's pain is not relieved with initial interventions, notify physician for

alternate pain control measure and a pain management assessment in PCC is to be completed.

A) On a specific date, the home submitted a CIS report to the MOHLTC, related to a fall by resident #001 which resulted in hospitalization and a significant change in the resident's health condition.

During a review of resident #001's progress notes in PCC it was noted that on a specific date, they received as needed (PRN) Tylenol, at a specific dosage, for leg pain and were yelling from their room at a specific time. Another progress note documented by a physician on the following day stated that the resident was reported to be calling out during the night and as the PRN Tylenol appeared to be affective in settling the resident, the physician adjusted the Tylenol to a specific dosage at two times of day and a specific dosage at a third time of day. The physician note also stated that resident #001's calling out may have been due to inadequate control of the resident's pain. A progress note dated this same day, documented that the resident was unsettled with verbal responsive behaviours at a specific time of day and upon assessment the writer noted swelling to the resident's leg which was warm to the touch and pain medication was administered. A progress note dated two days after the initial pain was reported, documented that the resident was reported to be screaming in pain during care with movement and on assessment the resident denied pain. This progress note continued to document that scheduled Tylenol was administered and the physician was notified and advised to increase resident #001's Tylenol to a specific dosage three times daily. A progress note dated four days after the initial pain was reported, documented that the resident remained in bed and complained of pain to their leg with repositioning, or any movement and Tylenol was administered. A progress note dated five days after the initial pain was reported, documented that the resident remained in bed and reported that they had pain to their leg. Another progress note dated five days after the initial pain was reported, documented that an x-ray noted a fracture and resident #001 was sent to the hospital.

During an interview with DOC #101, when asked what the process would be when a resident is exhibiting worsening symptoms of pain, DOC #101 stated that a pain assessment would be completed and the physician notified. When asked where this assessment would be documented, DOC #101 stated that there would be a pain assessment and pain evaluation and these would be documented in PCC. When

asked if a pain assessment was completed for resident #001 when they first complained of pain, DOC #101 stated no and that they would expect it to have been completed when the resident's status changed, when the resident's Tylenol was increased, and that this was not completed until 13 days later.

A review of resident #001's clinical record showed that no pain assessments were documented from a specific date, when they were first documented to be in pain, to a specific date, which was five days later, when they were transferred to hospital. Additionally, no Pain Flow Sheets were noted to be documented in the resident #001's paper copy chart or in PCC. When asked where Inspectors would find the Pain Flow Sheets that were to be completed as per the homes pain management policy at the time when resident #001's pain medication was adjusted, ADOC #106 stated that resident's pain was documented as a numerical scale on PCC and no documented flow sheets were provided to Inspector #435 when requested.

The licensee failed to ensure that the home's policy and procedure titled, "Pain Management", was followed for resident #001 when management could not provide pain flow sheets and no pain management assessments using a clinically appropriate assessment tool had been completed in PCC on two separate occasions when the physician increased resident #001's Tylenol order for unrelieved pain. (435)

B) The home submitted a CIS report to the MOHLTC, related to a fall by resident #006 on a specific date, which resulted in hospitalization and a significant change in the resident's health condition.

During a review of resident #006's progress notes in PCC, it was noted that they first complained of pain to their trunk on a specific date. A progress note dated three days later, noted that resident #006 was restless and showed signs of increased pain when staff attempted to reposition them in their chair. The progress note continued to state that the writer faxed the physician to notify of resident #006's increased pain and orders were received for Dilaudid at a specific dosage and frequency as needed. Another progress note dated this same day, stated that resident #006 was administered the ordered Dilaudid at a specific dosage and frequency as needed for pain.

During an interview with DOC #101, when asked what process the home would

follow when a resident was exhibiting worsening symptoms of pain, DOC #101 stated that a pain assessment would be completed and the physician notified. When asked where this assessment would be documented, DOC #101 stated that there would be a pain assessment and pain evaluation and these would be documented in PCC.

During an interview with ADOC #106, when asked when a pain assessment would be completed for a resident, ADOC #106 stated that pain assessments were completed on admission, readmission, quarterly, and upon identified changes in resident's condition. When asked what assessments were completed when resident #006 first complained of pain on an identified date, ADOC #106 stated that resident #006 had a fall assessment completed on a specific date, and a lift and transfer assessment completed on this same day.

A review of resident #006's clinical record showed that no pain assessments were documented from an identified date, when the resident was first documented to be in pain, to an identified date, when the resident was discharged. Additionally, no pain flow sheets were noted to be documented in the resident #006's paper copy chart or in PCC. When asked where Inspectors would find the pain flow sheets that were to be completed as per the home's pain management policy at the time when resident #006's PRN Dilaudid was initiated, ADOC #106 stated that resident's pain was documented as a numerical scale on PCC and no documented flow sheets were provided to Inspector #435 when requested.

The licensee failed to ensure that the home's policy and procedure titled, "Pain Management", was followed for resident #006 when management could not provide pain flow sheets and no pain management assessments using a clinically appropriate assessment tool had been completed in PCC on a specific date, when resident #006 first complained of pain and on a specific date, when resident #006 was administered a new order of Dilaudid for pain. (435)

C) The home submitted a CIS report to the MOHLTC, related to a fall by resident #004 on a specific date, which resulted in them being transferred to hospital. The CIS report stated that prior to the incident resident #004 had increased physical and verbal responsive behaviours and would run into things while ambulating.

A review of resident #004's progress notes in PCC showed the following:

- A note from a specific date and time stating they were complaining of neck pain and was often seen with their face down while wandering causing them to bump into furniture. A specific topical analgesic was applied to their lower back and neck.
- A note from a specific date and time stating they had continued to wander the unit while looking down.
- A note from a specific date and time stating they were looking down when ambulating and running over chairs, tables and co-residents.
- A from a specific date and time stating that staff had been advised to increase monitoring for resident #004 as they had been banging into walls, chairs, tables, and co-residents.
- A note from a specific date and time stating they were exhibiting responsive behaviours when staff re-directed them from running into walls and tables and also complained of back pain.
- A note from a specific date and time stating they complained of neck and back pain, were confused and often walking with their head leaning down bumping into walls.
- A note from a specific date and time stating they were leaning their head while ambulating and bumping into furniture and they were exhibiting verbal and physical aggressive behaviours.
- A note from a specific date and time stating they were bumping into things and exhibiting responsive behaviours.
- A note from a specific date and time stating they continued to look down and exhibited responsive behaviours.
- A note from a specific date and time stating they continued to exhibit responsive behaviours and were looking down and bumping into walls.
- A note from a specific date and time stating they continued to wander bumping into walls, chairs and tables and were exhibiting responsive behaviours when staff would re-direct.
- A note from a specific date and time stating they continued to wander with their head down and were complaining of pain and discomfort in their neck.
- A note from a specific date and time stating that they had been walking with their head down and when asked to keep their head up they complained of neck pain, they had been complaining of neck pain for two to three days. A specific topical analgesic was to be trialled four times daily for 14 days for neck pain.
- A note from a specific date and time stating they complained of neck and back pain.

- A note from the physician on a specific date and time stating they were wandering with their neck stooped and had noticeable neck tension/tightness when examined.

Specific medications were discontinued and a new medication was prescribed for treatment of a specific medical condition that may have contributed to their neck pain.
- A note from a specific date and time stating their neck pain was possibly suggestive of a specific medical condition, a specific topical analgesic was prescribed four times daily, specific medications were discontinued and a specific medication was to be trialled to treat a specific medical condition that may have contributed to their neck pain.
- A note from a specific date and time stating they continued to look down to the floor and were seen bumping on walls and chairs.
- A note from a specific date and time stating they continued to exhibit responsive behaviours when staff when attempted to re-direct from hitting a table, chair or wall.
- A note from a specific date and time stating they continued to exhibit responsive behaviours when staff tried to re-direct from bumping into the wall.
- A note from a specific date and time stating they were exhibiting responsive behaviours and complaining about neck and back pain.
- A note from a specific date and time stating they continued to exhibit responsive behaviours when staff attempted to re-direct them from bumping into walls and tables.
- A note from a specific date and time stating they attempted to walk but were unable to see where they were going, and were exhibiting responsive behaviours.
- A note from a specific date and time stating they had a witnessed fall that morning and were complaining of neck pain. They were noted to be holding their neck rigid during the fall and strained their neck. Moist heat was applied to their neck to ease the pain.
- A note from a specific date and time stating they complained of neck and back pain and were exhibiting responsive behaviours.
- A note from a specific date and time stating they were bumping into walls, chairs and tables and would become agitated as if someone was hurting them when staff tried to re-direct. They fell and were transferred to hospital.

A review of resident #004's Medication Administration Record and Treatment Administration Record in PCC showed the following:
- A specific topical analgesic four times daily for neck pain was ordered three days after they first complained of neck pain. This was administered as ordered on three consecutive dates, without documented effect.
- A specific topical analgesic as needed for lower back was ordered five months prior

to when they first complained of neck pain. This was not documented as administered.
- Tylenol four times daily was ordered 19 months prior to when they first complained of neck pain. This was administered as ordered until resident was transferred to hospital on specific date, without documented effect.
- A specific medication identified to treat a specific medical condition that may have contributed to neck pain was ordered twice daily for seven days five months prior to when they first complained of neck pain. This was administered as ordered on the date of their fall, without documented effect.

During an interview with an RPN they stated that pain assessments would be completed for all residents on admission, monthly and when they complained of new pain and that this would be documented under the Assessments section in PCC. The RPN told Inspector #721 that resident's pain levels and response to medications are documented for all scheduled and as needed medications such as Tylenol. They stated that when resident's medications are changed the physician will tell registered staff when to re-assess. When asked what actions they would take when a residents pain medications were changed, the RPN stated that front line staff would document on paper behavioural flow sheets and they would document the residents response to the changes in their progress notes.

During an interview with an RPN they told Inspector #435 that pain flow sheets would be completed for all residents monthly, on the first three days when someone is started on a pain medication and with as needed pain medications. The RPN stated that in the past pain flow sheets were completed on paper and kept in a pain flow sheet binder at each nursing station and that these are now completed on PCC.

A review of resident #004's Assessments section in PCC showed that Pain Assessments were completed two days prior to the date when they first complained of neck pain and five days after the date when they first complained of neck pain, which didn't include any documented of neck pain. Resident #004's Assessments section in PCC did not include any documented Pain Assessments from the four day period when they complained of ongoing neck pain.

A review of resident #004's Pain Level Summary in PCC showed three documented numerical pain levels on a specific date, five days after they first complained of neck pain. The Pain Level Summary did not include any documented pain levels from the

date when they they first complained of neck pain or the four consecutive days following, when they complained of ongoing neck pain.

A review of resident #004's physical chart did not include any documented pain assessments or pain flow sheets from the date when they first complained of neck pain or the five consecutive days following, when they complained of ongoing neck pain.

During an interview on a specific date, ADOC #106 reviewed resident #004's clinical record with Inspector #721. ADOC #106 stated that resident #004 first complained of neck pain on an identified date. ADOC #108 told Inspector #721 that they would expect a numerical pain level to be documented when a PRN pain medication was given and a pain assessment to be completed when any unusual pain was noted. ADOC #106 told Inspector #721 that no pain assessments or numerical pain levels were documented when resident #004 first complained of neck pain on a specific date, and thereafter when they complained of ongoing neck pain on the four consecutive days following. ADOC #106 stated that resident #004 was seen by the physician regarding their neck pain two days after they initially complained of neck pain, and a trial of a specific topical analgesic was initiated for a specific period of time. When asked if resident #004's response to the specific topical analgesic was documented, ADOC #106 stated that resident #004 had a weekly pain assessment completed five days after they initially complained of neck pain, and that their neck pain was not assessed during this assessment. They also stated that resident #004's numerical pain levels were not documented until five days after they initially complained of neck pain, and that it wasn't identified where the location of their pain was.

The licensee failed to ensure that the home's policy and procedure titled, "Pain Management", was followed for resident #004 when pain flow sheets and pain management assessments using a clinically appropriate assessment tool were not completed in PCC during a five day period, when they complained of unrelieved pain and on a specific date, when the physician initiated new medications for resident #004's unrelieved pain. [s. 8. (1) (a),s. 8. (1) (b)]

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 3 as it related to three of four (75%) residents reviewed. The home had a level 4 compliance history

as despite MOHLTC action, non-compliance continues with original area of non-compliance that included:
- Written Notification (WN) issued January 11, 2017, (2016_570528_0025); and
- WN and Voluntary Plan of Correction (VPC) issued February 8, 2018, (2018_573581_0001). (721)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 04, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 009

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s.9(1).

Specifically, the licensee must:
a) Ensure that doors leading to balconies on the second, third and fourth floors of the home, which don't preclude exit by a resident and are located off of resident care areas, are kept closed and locked, equipped with a door access control system that is kept on at all times, and equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident-staff communication and response system or to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
b) Ensure all staff members are made aware that doors leading to balconies on the second, third and fourth floors of the home, which don't preclude exit by a resident and are located off of resident care areas, are to be kept closed and locked when unsupervised. The home must keep a documented record of this communication including staff signatures to acknowledge that they are aware these doors are to be kept closed and locked.

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to were kept closed and locked, equipped with a door access control system that is kept on at all times, and were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and was connected to the resident-staff communication and response system, or was connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and had a manual reset switch at each door.

During an observation on a specific date and time on the fourth floor of the home, Inspector #435 observed a balcony door propped open by a chair off of the main hallway leading to the elevators. Inspector #435 was able to walk onto the balcony without using a key and no alarm sounded. No staff were observed to be in view of the balcony door at that time. Inspector #435 observed two staff members later walking past the opened balcony door. Two residents were observed walking into the nearby dining room on their own.

On this specific date, Inspector #435 asked a Restorative Care Aide (RCA) if the fourth floor balcony door that was observed was usually open and they stated that it is open sometimes. When asked if residents could walk onto this balcony, the RCA stated yes. When asked if the balcony door was locked, the RCA stated no. When asked if there were residents capable of walking on their own on the fourth floor, the RCA said yes but there was always staff around. The RCA continued to walk past the balcony door to assist residents with getting ready for meal service.

On this specific date, Inspector #435 observed a PSW walk past the fourth floor balcony door. Inspector #435 asked the PSW if the balcony door was usually closed and they stated that the door was usually closed and a resident must have been out there. The PSW proceeded to close the balcony door at this time. Inspector #435 was then able to open the balcony door without a key or alarm sounding after the PSW closed the door.

On this specific date, Inspector #721 observed the doors leading to the outside balconies off of the main hall near resident common areas on the second and third floor of the home to be unlocked. Inspector #721 was able to open the door to the balconies with no key or alarm sounding.

During an interview on this specific date, when asked if the fourth floor had any wandering residents, DOC #101 stated that there were no residents at risk for elopement on the fourth floor. When asked what the legislative requirement was for doors to a home that lead to outside non-enclosed balconies or terraces, DOC #101 stated that doors would have to be locked, secured and enclosed. When asked if this was in place for all doors leading to the non-enclosed balconies on the second, third and fourth floors, DOC #101 stated that RPN's and Recreation staff have keys to the balcony doors and residents who were able to, could use the balcony. DOC #101 continued to state that staff would need to know if a resident was on the balcony. Inspector #435 took DOC #101 to the fourth floor balcony that was observed to be propped open by a chair earlier that day. When asked if they would expect that the door be propped open by a chair, DOC #101 stated no. When asked if they would expect the door to be unlocked, they stated no and acknowledged that Inspector #435 could open the door without a key or alarm sounding and enter the balcony. When Inspector #435 identified a chair pushed up against the glass barrier at the edge of the balcony and asked if DOC #101 thought there was a risk that a resident

would be able to enter the balcony without a key and be able to stand on the chair and climb over the glass barrier, DOC #101 stated yes, anything is possible. When asked if the door leading to the balcony was equipped with an alarm, DOC #101 stated no.

During observations at two separate times on the consecutive day following, Inspector #435 checked the balcony doors on the second, third and fourth floors and identified that the third floor balcony door was unlocked and they were able to enter the balcony without a key or alarm sounding.

During additional observations at three separate times on a third consecutive date, the third floor balcony door was observed to be unlocked and Inspector #435 was able to enter the balcony without a key or an alarm sounding.

During an interview on a specific date, when asked why the balcony doors were kept locked, an RPN stated that the door was kept locked for safety. When asked if this meant that residents could not walk out on to the balcony unsupervised, the RPN stated yes.

The licensee failed to ensure that doors leading to balconies that didn't preclude exit and were located off of resident care areas were locked to restrict unsupervised access on the second floor, third floor and fourth floor on seven identified occurrences during a three day time period. [s. 9. (1) 1.]

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 2 as it related to eight of 32 (38%) occurrences reviewed. The home had a level 2 compliance history as they had one or more unrelated non-compliance in the last 36 months that included:
- Written Notification (WN), Voluntary Plan of Correction (VPC) and Compliance Order (CO) issued January 11, 2017, (2016_570528_0025);
- WN and VPC issued May 1, 2017, (2017_539120_0022);
- WN, VPC and CO issued February 8, 2018, (2018_573581_0001);
- WN and VPC issued August 2, 2018, (2018_539120_0032);
- WN and VPC issued July 13, 2018, (2018_560632_0014); and
- WN and VPC issued March 19, 2019, (2019_539120_0012). (435)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 2 nd day of July, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by MEAGAN MCGREGOR (721) - (A1)

Ontario

Ministry of Health and Long-Term Care

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