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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 16, 2014	2014_215123_0001	H-000748-13	Complaint

Licensee/Titulaire de permis

HOLLAND CHRISTIAN HOMES INC
7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7

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

GRACE MANOR
45 Kingknoll Drive, BRAMPTON, ON, L6Y-5P2

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

MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 10, 13, 15, 16, 17, 20, 21, 22, 23, and 24, 2014

Concurrent inspection H-000899-13

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), human resources staff, registered staff members and Personal Support Workers (PSWs).

During the course of the inspection, the inspector(s) reviewed the home's records including policies and procedures, reviewed residents' records, observed residents and the available equipment and supplies in the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 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 home failed to ensure that 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, (b) is complied with.

(1.) The home's policy and procedure "Head Injury-Routine #30-04-03" was reviewed and included; the staff are to monitor blood pressure, pulse, respirations, pupils and hand-grips every 15 minutes for the first hour. If stable, monitor and record vital signs every hour for the next three hours. If vital signs remain stable, monitor and record every four hours for 24 hours. Watch for abnormal shaking movement of limbs. Record all findings on Neurological Record.

The record of identified resident #002 and the home's records were reviewed and the resident was assessed after they fell in August, 2013. However, the first documented assessment in the Neurological Assessment Record of resident #002 was five hours after the resident was initially assessed. The documentation in the resident's Neurological Assessment Record included two assessments which were fifteen minutes apart, one assessment an hour later, an assessment two hours later and another assessment an hour later. One assessment of limb movement was documented on the resident's Neurological Assessment Record approximately 16 hours after they fell in August, 2013.

The registered staff who was working at the time when resident #002 fell in August, 2013 was interviewed and reported that they assessed resident #002 after the fall and that the resident was stable. The results of the assessments were recorded on a piece of paper then later onto the Neurological Assessment Record.
The home's policy and procedures were not followed related to the frequency of the neurological assessments of resident #002 nor related to the recording of the results of the assessments of resident #002.

(2.) The home's policy and procedure "In-service Education Program #60-04-07" was reviewed and included: The in-service Education Program will be based on a formalized annual written needs assessment to determine the learning needs of the nursing staff; that an In-service Education Report is to be completed by the Staff Development Program Coordinator at the end of each session. Evaluation of the session will include input from attendees. Ensure In-service Education Report is filed in In-service Education Binder.
Inspector requested the annual written needs assessment and it was not produced by the home.

The home's education records were reviewed and no In-service Education Reports were found for education sessions delivered in 2013. The home was requested to provide In-service Education Reports for education provided to staff and the reports were not provided. The Assistant Director of Care (ADOC) reported that the reports were not available. Also, that the home does not currently have a Staff Development Program Coordinator. The home did not conduct formalized needs assessments to determine the learning needs of staff as per the home's policy and procedure. The home did not complete and In-service Education Report at the end of each education session as per the home's policies and procedures.

(3.)The home's policy and procedure "Orientation Program-Nursing Personnel #61-04-03" was reviewed and included: An Orientation Checklist for new registered staff or Health Care Aides/Personal Support Worker (PSW) is followed and each item is signed by the orientator upon being completed. The completed checklist becomes a part of the employee's files after it is checked by the ADRC/DRC. The records of registered staff including an identified staff member who worked in the home as a Registered Practical Nurse (RPN) though they did not have a certificate of registration with the College of Nurses of Ontario (CNO) were reviewed with the ADOC and the records of the identified staff member and others did not contain records of orientation as per the home's policy and procedure. The ADOC reported that the Orientation Checklists were not available. The home did not follow it's policy and procedures related to the Orientation Checklist.
The home failed to ensure that the Head Injury-Routine, the In-service Education and the Nursing Orientation policies and procedures were complied with. [s. 8. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 46. Every licensee of a long-term care home shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario. O. Reg. 79/10, s. 46.

Findings/Faits saillants :

1. The licensee failed to ensure that every member of the staff who performs duties in the capacity of Registered Nurse, Registered Practical Nurse or Registered Nurse in the Extended Class has the appropriate current certificate of registration with the College of Nurses of Ontario.

The home's records were reviewed and the documentation revealed that an identified staff member was promoted from working as a Personal Support Worker (PSW) to working as a Temporary License Registered Practical Nurse (RPN) in May, 2013 by the previous Director of Care (DOC). The identified staff member worked as a RPN for 60 hours in the home until August, 2013. The staff member was removed from the home's staffing roster in November, 2013. The staff member passed the College of Nurses of Ontario (CNO) Practical Nurse Registration Examination in September, 2013 and passed the CNO Registered Nurse (RN)/Registered Practical Nurse (RPN) Jurisprudence Examination in December, 2013. No proof of 2013 Registered Practical Nurse certificate of registration with the College of Nurses of Ontario for the identified staff was found in the home's records. There was no evidence found in the records to indicate that the identified staff member's application for Certificate of Registration in the Temporary Class was submitted to the College of Nurses of Onatrio (CNO).

The Director of Care (DOC) was interviewed and reported that the home does not have a Certificate of Registration with the College of Nurses of Ontario (CNO) for the identified employee as the staff member did not have a certificate of registration with the CNO while employed by the home. The home hires only Registered Practical Nurses (RPN) who are certified with the CNO and does not have policies and procedures related to RPN with Certificates of Registration in the Temporary Class. The staff worked as a casual RPN in the home and their last shift worked was in August, 2013. They were removed from the home's staffing roster in November, 2013 as the DOC did not see evidence of a current certificate of registration with the College of Nurses of Ontario in the records and they were unavailable for shifts. The College of Nurses of Ontario is involved in this matter.
The home failed to ensure that every member of the staff who performed duties in the capacity of a Registered Practical Nurse had a current certificate of registration with the College of Nurses of Ontario. [s. 46.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs.
(1.)The record of identified resident #002 was reviewed and the progress notes indicated that the resident has experienced pain in multiple locations related to chronic health conditions between March and July, 2013. The resident's pain was assessed and they received medication for the pain at least twice daily. The progress note documentation noted that the resident's Power of Attorney (POA) gave instructions to the home which included that pain medications are to be given. It was noted that the resident's POA was aware that a note would be posted at the nursing station and that they agreed to that. It was also noted in the resident's record that the resident denied pain at times when asked even when they were experiencing pain as evidenced by facial grimacing. The care plan of identified resident #002 was reviewed and pain was not identified as a problem in their plan of care and there were no goals or interventions to address the pain of resident #002. Pain is mentioned under the focus of resistive to treatment care where interventions included; as per family, do not tell resident that medication is for pain, as they will then deny pain and not take medication.
The home failed to ensure that the plan of care of resident #002 was based on an interdisciplinary assessment with respect to the resident's health conditions including pain.

(2.)During the review of the record of resident #002 it was noted in the progress notes that the resident spent the day sitting in their armchair in their room and that they had

a poor posture of sleeping and leaning forward which was not safe. Progress note documentation indicated that the resident #002 was kept in the recliner chair in the lounge for positioning and comfort. The resident was not happy with using the positioning aids. In June, 2013 documentation in the progress notes of resident #002 indicated that the resident threw all the positioning aids from the chair and refused to use them.
The record of resident #002 was reviewed and it did not contain any evidence of interdisciplinary assessment of the resident's poor posture of sleeping and leaning forward when in a chair as above or of the resident's sitting balance. The resident's plan of care did not include a focus, goals, or interventions specific to their poor posture when in chair and leaning forward.
The home failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including other special needs specifically, the poor posture and leaning forward when sitting or the sitting balance of resident #002. [s. 26. (3) 10.]

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 plans of care of all residents are based on interdisciplinary assessments of their health conditions including pain and other special needs such as sitting balance, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations. (1) Abuse recognition and prevention.

The home's records including: the 2013 Training Sessions; the Training Attended in 2013 and the Nursing Department Listing were reviewed. The home has 34 RPNs working in the home. The "Training Attended in 2013 List" identified 19 RPN working and of those only one attended the elder abuse training.

The Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator were interviewed and confirmed the information in the home's records related to staff education. The DOC and Administrator also reported that the home is planning to use an external service provider to deliver staff education.
The home failed to ensure that staff who provide direct care to residents received annual training in abuse recognition and prevention. [s. 76. (7) 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 all staff who provide direct care to residents receive annual education in abuse recognition and prevention, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:(1) Falls prevention and management; Skin and wound care; Continence care and bowel management; Pain management, including pain recognition of specific and non-specific signs of pain; For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices; For staff who apply Personal Assistance Services devices (PASDs), or monitor residents with PASDs, training in the application, use and potential dangers of PASDs.

The Assistant Director of Care (ADOC) was interviewed and reported that the Registered staff who worked the hours shift and who attended to resident #002 immediately after they fell, had a lack of knowledge related to the home's Head Injury-Routine. Also that the registered staff who worked on the following shift told the ADOC that they were not familiar with the home's Fall Management and Prevention policies and procedures as they did not review them during their orientation to the home.

The home's record of Training Attended in 2013 was reviewed. None of the 12 Personal Support Workers (PSW) listed in the Training Attended in 2013 record were noted to have attended training in any of the six required areas above and two identified staff members did not attend any training in 2013. Eight of the 17 Registered Practical Nurses (RPN) attended training related to Falls Prevention in 2013. None of the 17 RPNs are noted as having attended training in any the other five areas required above.

The home's In-service record was reviewed. The In-service Attendance Sheet for Recognizing Pain in Behavior and Cognitively Impaired in October, 2013 noted the names of 16 staff members who were present.

The In-Service attendance record for Review of Incontinence Products October, 2013 noted the names of 16 staff members who were present. No documentation was found indicating that the licensee provided training in all the required areas listed above to all staff who provide direct care to residents.

The Director of Care (DOC), the Assistant Director of Care (ADOC) and the Human Resources staff member were interviewed and confirmed that the above is all the documentation available of training provided to direct care staff in the home during 2013.
The home failed to ensure that annual training was provided to all staff who provide direct care to residents in: Falls Prevention and Management; Skin and wound care; Continence care and bowel management; Pain Management; Restraints and Personal Assistance Services Devices (PASDs). [s. 221. (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 all staff who provide direct care to residents are provided training in: Falls prevention and management; Skin and wound care; Continence care and bowel management; Pain management; Restraints and Personal Assistance Services devices (PASDs), to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

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

The home's records including: the incident investigation notes; the August, 2013 registered staff meeting suggestions; the August, 2013 Personal Support Workers Meeting record and written and signed statement of the ADOC January, 2014 were reviewed. Documentation indicated that during the registered staff meeting in August, 2013 there was a review of the Fall Protocol and the standardized procedure for calling family even if it is midnight whether the resident is stable or unstable. The documentation also included that the staff were to know how to relay information to other staff, for example, the family of identified resident #002, special instructions were, to call anytime of the day and night.

The record of resident #002 was reviewed including the plan of care and progress notes. Interventions for various identified care concerns included: the resident's POA would like to be informed so they may come in; the POA would like to be notified immediately so as to come in and sit with them; the home is to keep family informed and call friends if resident has an acute problem. However, the plan of care specific to falls risk did not include any information related to the POA's request to be notified at any time if the resident fell.
The Assistant Director of Care (ADOC) was interviewed and reported that the family of identified resident #002 were very involved in their care and that the resident's Power of Attorney wanted to be informed at any time of the day if the resident had a fall.
The home failed to ensure that the written plan of care for resident #002 provided clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect to each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this regulation: (1) There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources related to falls where required.

The home's policies and procedures: "Falls Protocol #30-06-13"; "Resident Fall With No or Minor Injury #30-06-11"; "Resident Fall with Severe Injury #30-06-12" and "Head Injury Routine #30-04-03" were reviewed and they did not contain protocols for the referral of residents to specialized resources where required. The Director of Care (DOC) was interviewed and confirmed that the policies and procedures do not include protocols for referral of residents to specialized resources where required.
The home failed to ensure that the written description of the Fall Prevention and Management program includes protocols for the referral of residents to specialized resources where required. [s. 30. (1) 1.]

2. The home failed to ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: (3.) The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The Director of Care (DOC) and the Administrator were interviewed and they were unable to provide information related to the home's 2013 annual evaluation of the Fall Prevention and Management program including the changes made as a result of the evaluation.
The home failed to ensure that the Fall Prevention and Management program is evaluated and updated annually. [s. 30. (1) 3.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Nursing and Personal Support staffing plans are evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's records including employee time schedules for registered staff and personal support workers and policies and procedures including: "Staffing Patterns #60-02-06"; "Organizational Structure-Nursing Services #60-02-04" and "Registered Nurse Coverage #60-02-08B" were reviewed. The "Organizational Structure-Nursing Services #60-02-04" policy and procedure identified the position of Resource Nurse reporting directly to the Assistant Director of Resident Care (ADOC).
The ADOC and Director of Care (DOC) were interviewed and reported that the home does not currently have a Resource Nurse position. The Resource Nurse was referred to in other policies and procedures of the home including: The "Registered Nurse Coverage #60-02-08B" and the "Orientation Program for Registered Staff #60-04-04" policies and procedures.

The scope/special instructions section of policy and procedure "Staffing Patterns #60-02-06" noted that; the staffing pattern will be based on the requirements of the contract between the Ministry of Health and the home. Procedures identifies that; the Director of Resident Care(DOC) will prepare the plan in conjunction with the Executive Director/Administrator using hours of care required by each resident as the workload measurement.

The Director of Care (DOC) and Administrator were interviewed and were unable to provide information related to the home's 2013 annual evaluation of the organized nursing and personal support services staffing plans including the changes made as a result of the evaluations.
The home failed to ensure that the Nursing and Personal Support staffing plans were evaluated and updated annually. [s. 31. (3) (e)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The records of identified residents #003 and #004 were reviewed. Resident #003 was noted to be at a high risk for falls and fell in October, 2013. Resident #004 was identified as being at a high risk for falls and fell in January, 2014. No record of a post-fall assessment using a clinically appropriate instrument was found in the records of either resident #003 or resident #004.

The Assistant Director of Care (ADOC)was interviewed and was requested to provide post-fall assessments related to the the above falls. The ADOC reported that there were no available documentation of post-fall assessments for resident #003 or resident #004 related to the above falls, using an assessment tool specifically designed for falls.
The home failed to ensure that when residents #003 and #004 fell, post-fall assessments were conducted using an assessment instrument specifically designed for falls. [s. 49. (2)]

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

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of the incident, followed by the report required under subsection(4) of 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.

The home's records and the record of resident #002 were reviewed and the documentation revealed that the identified resident #002 fell in August, 2013. The resident was taken to the hospital on that day due to injuries sustained as a result of the fall which resulted in a significant change to the their condition. The Director was notified by the home of the occurrence of the incident two days later.

The Assistant Director of Care (ADOC) was interviewed and confirmed that: the incident involving resident #002 being found on the floor took place in August, 2013 at approximately midnight; that they completed the report to the Director two days later and that they noted in the report that the resident was found on the floor approximately four and a half hours later than the actual time that the resident was found on the floor.
The home failed to ensure that the Director was informed of no later than one business day after the occurrence 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 status. [s. 107. (3) 4.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

The home's records and the records of identified resident #002 were reviewed and the documentation revealed that the identified staff member who was not a Registered Practical Nurse (RPN) worked as a (RPN) in the home and that they administered medications to residents in the home.

The Director of Care (DOC) and the Assistant Director of Care (ADOC) were interviewed and confirmed that: the staff member was not a RPN; that they worked in the home as a RPN and that they administered medications to residents.
The home failed to ensure that a person who administered a drug to a resident in the home was a Registered Practical Nurse. [s. 131. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that, when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

The record of identified resident #002 was reviewed including the Physician Medication Review July, 2013 to September, 2013 and the physician ordered that the resident receive an identified medication. The documentation in the resident's progress notes indicated that the resident was given the medication as ordered by the physician. It was documented that the effects were pending at the end of the shift. There was no further documentation in the resident's progress notes related to the evaluation of the effectiveness of the medication administered above. The resident's Medication Administration Record was reviewed and there was no documentation of the administration of the medication noted above or of the evaluation of the effectiveness of the medication.
The home failed to ensure that resident's response to and the effectiveness of their medication was documented. [s. 134. (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, at least annually, the program is evaluated and updated in accordance with evidence based practices and, if there are not, in accordance with prevailing practices.

The home's documentation of the 2013 and 2012 Training Attended by Registered Practical Nurses was reviewed. The home's policies and procedures including: "Education and Safety Coordinator #73-02-15"; "Orientation and Staff Development Standards #60-04-00"; "Orientation and Staff Development, In-service Education Program #60-04-07"; "Orientation and Staff Development, Orientation Program for Registered Staff # 60-04-04" and "Orientation and Staff Development, Orientation Program - Nursing Personnel #61-04-03" were reviewed.

On multiple occasions, the inspector requested that the home provide information specific to the the home's process related to the 2013 annual evaluation and update of the Training and Orientation program. The home did not produce the information related to the home's 2013 evaluation and update of the Training and Orientation program.
The home failed to ensure that the Training and Orientation program was evaluated and updated annually. [s. 216. (2)]

Issued on this 16th day of April, 2014

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

M. GRAY

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELODY GRAY (123)
Inspection No. / No de l'inspection :	2014_215123_0001
Log No. / Registre no:	H-000748-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 16, 2014
Licensee / Titulaire de permis :	HOLLAND CHRISTIAN HOMES INC 7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7
LTC Home / Foyer de SLD :	GRACE MANOR 45 Kingknoll Drive, BRAMPTON, ON, L6Y-5P2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PETER DYKSTRA

To HOLLAND CHRISTIAN HOMES INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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 is to prepare, submit and implement a plan to ensure that the home's policies and procedures related to the Head Injury-Routine, the nursing department In-service Education Program and the Orientation Program for nursing department staff are complied with.

Grounds / Motifs :

1. The home failed to ensure that 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, (b) is complied with.

(1.) The home's policy and procedure "Head Injury-Routine #30-04-03" included; the staff are to monitor blood pressure, pulse, respirations, pupils and hand-grips every 15 minutes for the first hour. If stable, monitor and record vital signs every hour for the next three hours. If vital signs remain stable, monitor and record every four hours for 24 hours. Watch for abnormal shaking movement of limbs. Record all findings on Neurological Record.

The record of identified resident #002 and the home's records were reviewed and the resident was assessed after they fell in August, 2013. The first documented assessment in the Neurological Assessment Record of resident #002 was approximately five hours later. The documentation in the resident's

Neurological Assessment Record included; two assessments fifteen minutes apart, one assessment an hour later, an assessment two hours later and another assessment an hour later. One assessment of limb movement was documented on the resident's Neurological Assessment Record approximately 16 hours after the resident fell.

The registered staff who working at the time that resident #002 fell in August, 2013 was interviewed and reported that they assessed resident #002 after the fall and that the resident was stable. The results of the assessments were recorded on a piece of paper then later onto the Neurological Assessment Record.
The home's policy and procedures were not followed related to the frequency of the neurological assessments of resident #002 nor related to the recording of the results of the assessments of resident #002.

(2.) The home's policy and procedure "In-service Education Program #60-04-07" included: The in-service Education Program will be based on a formalized annual written needs assessment to determine the learning needs of the nursing staff; that an In-service Education Report is to be completed by the Staff Development Program Coordinator at the end of each session. Evaluation of the session will include input from attendees. Ensure In-service Education Report is filed in In-service Education Binder.
Inspector requested the annual written needs assessment and it was not produced by the home.

The home's education records were reviewed and no In-service Education Reports were found for education sessions delivered in 2013. The home was requested to provide In-service Education Reports for education provided to staff and the reports were not provided. The Assistant Director of Care (ADOC) reported that the reports were not available. Also, that the home does not currently have a Staff Development Program Coordinator. The home did not conduct formalized needs assessments to determine the learning needs of staff as per the home's policy and procedure. The home did not complete and In-service Education Report at the end of each education session as per the home's policies and procedures.

(3.)The home's policy and procedure "Orientation Program-Nursing Personnel #61-04-03" included: An Orientation Checklist for new registered staff or Health Care Aides/Personal Support Worker (PSW) is followed and each item is signed

by the orientator upon being completed. The completed checklist becomes a part of the employee's files after it is checked by the ADRC/DRC. The records of registered staff including an identified staff member who worked in the home as a Registered Practical Nurse (RPN) though they did not have a certificate of registration with the College of Nurses of Ontario (CNO) were reviewed with the ADOC and the records of the identified staff member and others did not contain records of orientation as per the home's policy and procedure. The ADOC reported that the Orientation Checklists were not available. The home did not follow it's policy and procedures related to the Orientation Checklist.
The home failed to ensure that the Head Injury-Routine, the In-service Education and the Nursing Orientation policies and procedures were complied with. (123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 46. Every licensee of a long-term care home shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario. O. Reg. 79/10, s. 46.

Order / Ordre :

The licensee is to ensure that every member of the staff who performs duties in the capacity of Registered Nurse, Registered Practical Nurse or Registered Nurse in the Extended Class has the appropriate current certificate of registration with the College of Nurses of Ontario.

Grounds / Motifs :

1. The licensee failed to ensure that every member of the staff who performs duties in the capacity of Registered Nurse, Registered Practical Nurse or Registered Nurse in the Extended Class has the appropriate current certificate of registration with the College of Nurses of Ontario.

The home's records were reviewed and the documentation revealed that an identified staff member was promoted from working as a Personal Support Worker (PSW) to working as a Temporary License Registered Practical Nurse (RPN) in May, 2013 by the previous Director of Care (DOC). The identified staff member worked as a RPN for 60 hours in the home until August, 2013. The staff member was removed from the home's staffing roster in November, 2013. The staff member passed the College of Nurses of Ontario (CNO) Practical Nurse Registration Examination in September, 2013 and passed the CNO Registered Nurse (RN)/Registered Practical Nurse (RPN) Jurisprudence Examination in December, 2013. No proof of 2013 Registered Practical Nurse certificate of registration with the College of Nurses of Ontario for the identified staff was found in the home's records. There was no evidence found in the records to indicate that the identified staff member's application for Certificate of Registration in the Temporary Class was submitted to the College of Nurses of Onatrio (CNO).

The Director of Care (DOC) was interviewed and reported that the home does not have a Certificate of Registration with the College of Nurses of Ontario (CNO) for the identified employee as the staff member did not have a certificate of registration with the CNO while employed by the home. The home hires only Registered Practical Nurses (RPN) who are certified with the CNO and does not have policies and procedures related to RPN with Certificates of Registration in the Temporary Class. The staff worked as a casual RPN in the home and their last shift worked was in August, 2013. They were removed from the home's staffing roster in November, 2013 as the DOC did not see evidence of a current certificate of registration with the College of Nurses of Ontario in the records and they were unavailable for shifts. The College of Nurses of Ontario is involved in this matter.
(123)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board

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

and the Director

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

Issued on this 16th day of April, 2014

Signature of Inspector / Signature de l'inspecteur : M. GRAY

Name of Inspector / Nom de l'inspecteur : MELODY GRAY

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