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 le Loi de 2007 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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
May 01, 2014;	2013_205129_0016 (A1) (Appeal\Dir#: DR6.0)	H-000649-13	Complaint

Licensee/Titulaire de permis
THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD, OAKVILLE, ON, L6M-3L1

Long-Term Care Home/Foyer de soins de longue durée
CREEK WAY VILLAGE
5200 Corporate Drive, BURLINGTON, ON, L7L-7G7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs
PHYLLIS HILTZ-BONTJE (129) - (A1)(Appeal\Dir#: DR6.0)

Amended Inspection Summary/Résumé de l'inspection modifié

As a result of a Director's Review of Complaint Inspection #2013_205129_0016/H-000649-13 the following changes have been made to the Complaint Inspection Report and the Complaint Inspection Order Report:

1. Portions of the grounds for Order #001 have been removed.

2. Portions of the grounds for Order #002 have been removed.

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 2 day of May 2014 (A1)(Appeal\Dir#: DR6.0)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
P. Hiltz-Bontje

Ministry of Health and Long-Term Care

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

CREEK WAY VILLAGE
5200 Corporate Drive, BURLINGTON, ON, L7L-7G7

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

PHYLLIS HILTZ-BONTJE (129) - (A1)(Appeal/Dir# DR6.0)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): November 25, 26, December 3 and 4, 2013

During the course of the inspection, the inspector(s) spoke with residents, regulated and unregulated nursing staff, the RIA-MDS coordinator, the Director of Care and the Administrator in relation to Log #H-000649-13.

During the course of the inspection, the inspector(s) observed residents, reviewed clinical records, training records and the home's policies and procedures related to the Falls Management Program and Pain Management.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Pain

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 LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that resident #001's right to be cared for in a manner consistent with their need was fully respected and promoted, in relation to the following: [3(1)4]
Resident #001 was identified on admission to the home as having a visual deficit and having a gait and mobility deficit as a result of a medical condition. Information provided by Community Care Access on admission also confirmed that the resident was at risk for falls and had a history of falling. Staff in the home did not provide care required by the resident to prevention falls or reduce the risk of injury from falling. The clinical record confirmed:
-Twenty five days after admission to the home, the resident fell, resulting in a possible head injury.

-The resident fell 10 more times (four times in 2010, six times in 2011). Clinical documentation indicated that five of these falls resulted in the possibility that the resident had sustained a head injury and one of the falls resulted in the resident sustaining a fracture which required surgical repair.

-The care plan developed 15 days after the last fall did not contain specific risks related to falling for this resident, did not provide any directions to staff related to the management of those risks and did not identify care to be provided to prevent further falls or reduce the risk of injury from falling for this resident.
-The resident continued to fall and documentation in the clinical record indicated the resident fell four times in 2012. One of those falls resulted in the resident sustaining a significant head injury and fractures and three of those falls resulting in the possibility that the resident had sustained a head injury. Clinical documentation also indicated the resident fell once in 2013 resulting in the resident sustaining a fracture.
- Incidents of falling identified in the resident's clinical notes indicated the resident was falling due to identified needs related to an unsteady gait, a visual deficits, mobility impairments related to a medical condition and staff not providing care as specified in the plan of care. The resident right to have care provided based on identified needs was not respected and promoted resulting in this resident continuing to fall and continuing to suffer from injuries related to falling. [s. 3. (1) 4.]

Additional Required Actions:

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

(A1)(Appeal/Dir# DR6.0)
The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

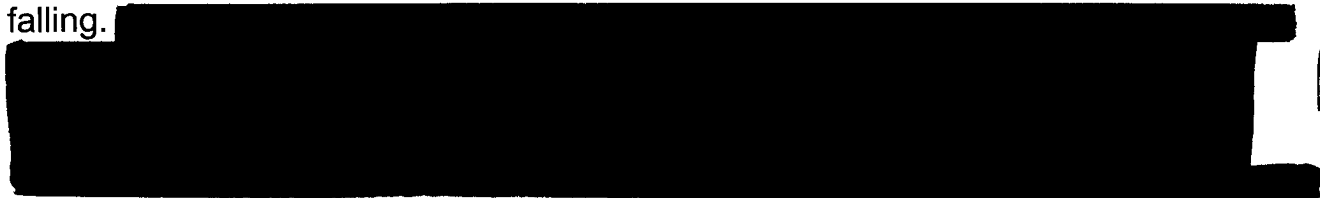
s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the risk of falls and pain, in relation to the following: [26(3) 10]

a) Resident #001 was experiencing falls and pain as a result of injuries sustained when falling, however the plan of care was not based on an interdisciplinary assessment of these needs and there were no care directions for staff in the resident's care plan related to the care to be provided to the resident.

-Clinical record documentation indicated the resident had a history of falls and it was recorded that this resident fell 18 times over a 42 month period of time. Eleven of those falls resulted in the possibility the resident had sustained a head injury, three of the falls resulted in other injuries, the resident was sent to hospital for assessment and treatment for five of those falls and the resident sustained three fractures as a result of falling.



PAB May 2, 2014

PHB May 2, 2014

- The Medication Administration (MAR) record indicated the resident received narcotic and non-narcotic analgesics over a two month period of time in 2013 to manage pain.

PHB May 2, 2014

The October 2013 MAR indicated the resident received treatment for pain, when a non-narcotic analgesic was administered once during the month and narcotic analgesics were administered 52 times during the last 13 days of the month. The November 2013 MAR indicated the resident received narcotic analgesics 29 times during the month.

b) Resident #002 was experiencing falls and pain as a result of injuries sustained when falling, however the plan of care was not based on an interdisciplinary assessment of these needs and there were no care directions for staff in the resident's care plan related to the care to be provided to the resident.

- It was identified in progress notes that this resident wandered expensively, had a disease condition that affected muscle strength and flexibility, staff documented that this resident had an unsteady gait while walking and the resident's Power of Attorney (POA) confirmed that the resident had a history of falling. The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) coordinator confirmed the risks for falling were not assessed by the interdisciplinary team and there were no care directions for staff with respect to steps that should be taken to reduce falls or minimize the risk of injury from falls. This resident fell three times over a 34 day period in 2013 which resulted in the resident sustaining three fractures.

-The Medication Administration (MAR) record indicated this resident received narcotic and non-narcotic analgesics over a two month period of time in 2013 to manage pain. The RAI-MDS coordinator confirmed that issues related to pain the resident was experiencing were not assessed by the interdisciplinary team and the document that the home used to identify the care required by the resident did not contain care directions for staff in relation to pain assessment, management of pain being experienced or direction for staff on reducing the risk of the resident experiencing increased pain during the provision of care. The September 2013 MAR confirmed the resident received treatment for pain, when a non-narcotic analgesic was administered three times a day for 20 days and a narcotic analgesic was administered four times during the month. The October 2013 MAR confirmed the resident received 26 doses of a narcotic analgesic. [s. 26. (3) 10.]

Additional Required Actions:

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

(A1)(Appeal/Dir# DR6.0)
The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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. (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 did not ensure that the care set out in the plan of care was provided to resident #001, in relation to the following: [6(7)]
Care specified in the plan of care was not provided to resident #001 on an identified date when a registered practical nurse directed a non-staff person to escort the resident back to their room. The plan of care indicated the resident's mobility was impaired related to a medical condition and two staff were required to physically assist the resident with ambulation. Clinical documentation also indicated that the resident had fallen many times as a result of poor gait. While being escorted down the hall by one non-staff person, the resident lost balance fell to the floor and sustained a fracture. [s. 6. (7)]

2. The licensee did not ensure residents were reassessed and the plan of care reviewed and revised when the care set out in the plan of care was not effective, in relation to the following: [6(1)(c)]
a) Documentation in resident #001's clinical record indicated the resident fell 11 times (five times in 2010 and six times in 2011). The RAI-MSD coordinator and the clinical record confirmed that during this period of time the resident was not reassessed and the plan of care was not reviewed or revised, despite the resident continuing to fall and sustain injuries from those falls. The plan of care related to falls was developed 15 days after the last fall in 2011 and identified the goal of care was that the resident would have no falls. The care identified in this plan of care was not effective and the resident continued to fall and fell four times in 2012 and once in 2013. The RAI-MDS coordinator confirmed that during this period of time the resident was not reassessed and the plan of care was not reviewed or revised in relation to the prevention and management of falls.
b) Documentation in resident #002's clinical record indicated that the resident fell three times over a two month period of time in 2013. The RAI-MDS coordinator and clinical documentation confirmed the resident was not reassessed throughout this period of time and the care plan was not reviewed or revised in relation to the prevention and management of falls. [s. 6. (10) (c)]

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 and ensuring that the care set out in the plan of care is provided to residents, to be implemented voluntarily.

WN #4: 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 did not 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 systems were complied with, in relation to the following:[8(1)b]
a) The licensee did not ensure staff in the home complied with the homes pain management program. The pain management program provided by the home at the time of this inspection directed that:
- Registered staff will document and implement an individual plan of care to include interventions specific to managing pain. Staff did not comply with this program when both resident #001 and resident #002 were treated with narcotic and non-narcotic analgesics over a two month period and these residents did not have individual plans of care that included interventions for the management of pain.
-The Administrator, Director of Resident Care and Managers of Resident Care were to ensure that the Resident Care Department utilized the program and monitored documentation in Point Click Care (PCC), including progress noted and care plans, to ensure that strategies developed where resident specific and included both non-pharmacological and pharmacological interventions. Staff did not comply with this program when the Administrator and Director of Care were not aware that resident #001 and resident #002 did not have an individual plan of care related to the management of pain.
b) The licensee did not ensure staff in the home complied with the home's policy [Falls Risk Assessment Procedure] identified as #19-01-02, included in the home's falls management program. This procedure directed that :
-For resident's identified to be at risk for falls and /or fall injuries, the interdisciplinary team will develop an individualized fall prevention plan within 24-48 hours that includes risk based fall and injury prevention interventions specific to the resident. Staff did not comply with this procedure when resident #001 and #002 experienced multiple falls resulting in injuries including fractures and the document the home used to identify care to be provided to the resident did not contain an individual plan that included the risks for falling and strategies for injury prevention.
- Individualized fall prevention plans will be documented in the care plan based on the risk assessment and individual fall prevention strategies. Staff in the home did not comply with this procedure when an individual falls prevention plan was not documented in the care plan for resident #001 and resident #002. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring 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 systems were complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the 24-hour admission care plan developed for resident #001 included risks of falling, in relation to the following: [24(2) 1]
Resident #001 was admitted to the home on an identified date in 2010. Information provided to the home and included in Community Care Access Centre (CCAC) assessment document indicated the resident had a history of falls within the last 90 days. The Administrator and the Director of Care confirmed that this resident had a history of falling when admitted to the home and there was not a 24 hour care plan developed related to preventing falls or minimizing the risk of injury to this resident. [s. 24. (2) 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 and ensuring that the 24-hour admission care plan developed for residents risks of falling, to be implemented voluntarily.

WN #6: 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 did not ensure that the organized falls prevention and management program was evaluated and updated annually, in relation to the following: [30(1)3]. Documents provided by the Administrator in response to a request that the home verify that an annual review of this program was completed indicated the percentages of resident who had fallen and data that indicated the cause, frequency, injury and time of falls was collected annually. The Administrator confirmed that this process did not include an evidenced based evaluation of the effectiveness of the home program in reducing falls and minimizing injury to residents who fall. The Administrator also confirmed that there was no evidence that the program was updated or changed in relation to the statistics collected. [s. 30. (1) 3.]

Issued on this 2 day of May 2014 (A1)(Appeal/Dir# DR6.0)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
P. Hiltz-Bontje

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Health System Accountability and Performance Division
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : PHYLLIS HILTZ-BONTJE (129) - (A1)(Appeal/Dir# DR6.0)

Inspection No. / No de l'inspection : 2013_205129_0016 (A1)(Appeal/Dir# DR6.0)

Appeal/Dir# / Appel/Dir#: DR6.0 (A1)

Log No. / Registre no. : H-000649-13 (A1)(Appeal/Dir# DR6.0)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : May 01, 2014;(A1)(Appeal/Dir# DR6.0)

Licensee / Titulaire de permis : THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD, OAKVILLE, ON, L6M-3L1

LTC Home / Foyer de SLD : CREEK WAY VILLAGE
5200 Corporate Drive, BURLINGTON, ON, L7L-7G7

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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.

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Patti Coates

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To THE REGIONAL MUNICIPALITY OF HALTON, 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. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or

refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee is to ensure that all staff participate in the assessment of resident who have a history of falling, who have identified risk factors placing them at greater risk for falling, that resident specific plans of care are developed and implemented, there is an ongoing evaluation of the effectiveness of care being provided to residents who fall and when the care being provided has not been successful the resident reassessed and the care plan is reviewed and revised based on the needs of the resident.

Grounds / Motifs :

(A1)(Appeal/Dir# DR6.0)
1. Previously identified non-compliant on August 14, 2012 as a VPC
2. Resident #001 was identified on admission to the home as having a visual deficit and having a gait and mobility deficit related to a medical condition. Information provided by Community Care Access on admission also confirmed that the resident was at risk for falls and had a history of falling. Staff in the home did not provide care required to the resident to prevention falls or reduce the risk of injury from falling for this resident. The clinical record confirmed:
-Twenty five days after admission to the home, the resident fell which resulted in a possible head injury.
-The resident fell 10 more times (four times in 2010 and six times in 2011). Clinical documenation indicated that five of these falls resulted in the possibilty that the resident sustained a head injury and one of the falls resulted in the resdient sustaining a fracture which required surgical repair.
-The care plan developed 15 days after the last fall did not contain specific risks related to falling for this resident, did not provide directions to staff related to the management of those risks and did not identify care to be provided to prevent further falls or reduce the risk of injury from falling for this resident.
-The resident continued to fall and documentation in the clinical record indicated the resident fell four times in 2012. One of these falls resulted in the resident sustaining a significand head injury and fractures and three of these falls resulted in the resident possibly sustaining a head injury. Clinical documenation also indicated the resident fell once in 2013 resulting in the resident sustaining a fracture.
- Incidents of falling identified in the residents clinical notes indicated the resident was falling due to identified needs related to an unsteady gait, a visual disability, mobility impairment related to a medical condition and staff not providing care as specified in the plan of care. The resident s right to have care provided based on identified needs was not respected and promoted resulting in this resident continuing to fall and continuing to suffer from injuries related to falling. (129)

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

Apr 14, 2014

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.

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. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee shall ensure that all residents, including resident #001 and # 002 who are identified as at risk for falling and who are experiencing pain are assessed by the interdisciplinary team and plans of care are developed and implemented following those assessments.

Grounds / Motifs :

(A1)(Appeal/Dir# DR6.0)
1. Two of three residents reviewed did not have plans of care developed based on an interdisciplinary assessment with respect to risk of falling and pain. Both of the residents identified experienced multiple falls with injury and experienced pain related to injuries from falling.
2. Resident #001 experienced falls and pain as a result of injuries sustained when falling, however the plan of care was not based on an interdisciplinary assessment of these needs and there were no care directions for staff in the resident's care plan related to the care to be provided to the resident.
-Clinical record documentation indicated the resident had a history of falls and it was recorded that this resident fell 18 times over a 42 month period of time. Eleven of those falls resulted in possible head injuries, three of the falls resulted in other injuries, the resident was sent to hospital for assessment and treatment for five of those falls and the resident sustained three fractures as a result of three of these falls
.
- The Medication Administration (MAR) record indicated the resident received narcotic and non-narcotic analgesics in October and November 2013 in order to manage pain. The October 2013 MAR indicated the resident received treatment for pain, when a non-narcotic analgesic was administered once during the month and narcotic analgesics were administered 52 times during the last 13 days of the month. The November 2013 MAR indicated the resident received narcotic analgesics 29 times during the month.
3. Resident #002 experienced falls and pain as a result of injuries sustained when falling, however the plan of care was not based on an interdisciplinary assessment of these needs and there were no care directions for staff in the resident's care plan related to the care to be provided to the resident.
- It was identified in progress notes that this resident wandered expensively, had a disease condition that affected muscle strength and flexibility, staff documented that this resident had an unsteady gait while walking and the resident's POA confirmed that the resident had a history of falling. The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) coordinator confirmed the risks for falling were not assessed by the interdisciplinary team and there were no care directions for staff with respect to steps that should be taken to reduce falls or minimize the risk of injury from falls. This resident fell three times over a 34 day period in 2013 which resulted in the resident sustaining three fractures.
-The Medication Administration (MAR) record indicated this resident received

narcotic and non-narcotic analgesics in September and October 2013 in order to manage pain. The RAI-MDS coordinator confirmed that issues related to pain the resident was experiencing were not assessed by the interdisciplinary team and the document that the home used to identify the care required by the resident did not contain care directions for staff in relation to pain assessment, management of pain being experienced or direction for staff on reducing the risk of the resident experiencing increased pain during the provision of care. The September 2013 MAR confirmed the resident received treatment for pain, when a non-narcotic analgesic was administered three times a day for 20 days and a narcotic analgesic was administered four times suring the last four days of the month. The October 2013 MAR confirmed the resident received 26 doses of a narcotic analgesic. (129)

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

Apr 14, 2014

REVIEW/APPEAL INFORMATION

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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.

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 and the Director

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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.

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 2 day of May 2014 (A1)(Appeal/Dir# DR6.0)

Signature of Inspector / Signature de l'inspecteur : P. Hiltz-Bontje

Name of Inspector / Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

Service Area Office / Bureau régional de services : Hamilton