Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 21, 2020	2020_661683_0002	022710-19, 023337-19, 000311-20	Complaint

Licensee/Titulaire de permis

St. Joseph's Health System
50 Charlton Avenue East Room M146 HAMILTON ON L8N 4A6

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

St. Joseph's Villa, Dundas
56 Governor's Road DUNDAS ON L9H 5G7

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

LISA BOS (683), STACEY GUTHRIE (750)

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 7, 8, 9, 10, 13, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 29, 30 and 31, 2020.

This inspection was completed concurrently with critical incident inspection #2020_661683_0001 and director order follow up inspection #2020_661683_0003.

The following intakes were completed during this complaint inspection:
Log #022710-19 was related to falls prevention and management and the prevention of abuse and neglect
Log #023337-19 was related to nutrition and hydration and responsive behaviours
Log #000311-20 was related to medication administration

PLEASE NOTE:
A Written Notification (WN) and Compliance Order (CO) related to O. Reg. 79/10 s. 131 (2) and s. 135 (1) were identified in this inspection and have been issued in inspection report #2020_661683_0001, which was conducted concurrently with this inspection.

A WN and Voluntary Plan of Correction (VPC) related to O. Reg. 79/10 s. 8 (1) (b) identified in concurrent inspection #2020_661683_0001 were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Quality, Performance Systems and Food Services, the Director(s) of Care (DOC), the Assistant Director(s) of Care (ADOC), the Resident Care Managers (RCM), the Education, Quality and Clinical Support Lead, the Resident Assessment Instrument (RAI) Coordinator(s), the Physician, the Physiotherapist (PT), the Registered Dietitian (RD), registered staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) reviewed resident clinical records, reviewed policies and procedures, reviewed investigation notes, reviewed training records, reviewed internal audits and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Nutrition and Hydration
Pain
Responsive Behaviours

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

3 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised at least every six months and any other time when care set out in the plan was not effective.

A critical incident (CI) report and a complaint were submitted to the Director related to a fall for resident #001 which resulted in a significant change in condition.

On an identified date, resident #001 had a fall and the initial post fall assessment indicated that they complained of pain in an identified area.

i) Initial assessment by Physiotherapist (PT) #116, noted that they were unable to assess a specific area due to pain on movement, and there was a change in their mobility. The resident’s transfer status was changed, a diagnostic test was ordered and pain medication was given routinely and as needed for pain.

Two days after their fall the resident was reassessed by PT #116 and they indicated that they were unable to complete the assessment due to the same pain and there was no improvement in their mobility. PT #116 indicated that the resident would benefit from one to one PT intervention. Five days later, PT #116 reassessed the resident and there was no noted improvement in the resident’s condition.

A review of the resident’s written plan of care including review of the Physiotherapy Resident Log did not include documentation that the resident received the one to one PT intervention. There was no improvement in the resident's mobility after the fall and they continued to complain of pain in an identified area, receiving pain medication with temporary relief. The resident was not reassessed until 16 days later, at which time, the PT noted that they were still complaining of pain.

In an interview with DOC #101, they acknowledged that after the resident’s fall they experienced a significant change in condition. They indicated that they reviewed resident #001’s care plan and they did not note any revisions to the resident’s plan of care between identified dates, despite the resident being reassessed by the PT and there being no improvement in their condition.

Resident #001 experienced a significant change in condition after their fall. The resident was reassessed by PT #116, and there was no improvement in their condition, worsened

pain, and they did not receive physiotherapy interventions. The resident's mobility did not improve and there were no improvements in their transfer status. When the resident was reassessed by PT #116, their plan of care was not revised when the interventions in place were ineffective.

ii) A review of the progress notes indicated that resident #001's condition continued to deteriorate and they continued to complain of pain. On an identified date, the resident indicated that they had pain in an identified area. The NP assessed the resident and a diagnostic test was ordered, as well as pain medication as needed for several days and then the resident was to be reassessed. The results of the diagnostic test were received by the home and the report recommended a repeat test if clinical concern persisted.

Resident #001's electronic medication administration record (eMAR) and progress notes were reviewed between identified dates and they indicated that the resident continued to complain of pain. Although they received as needed pain medication, it was only temporarily effective.

Despite the signs of pain, there were no repeat diagnostic tests taken, no reassessments documented and there were no changes made to the resident's medications until an identified individual expressed concerns about pain management.

Resident Care Manager (RCM) #117 documented in a progress note that they were alerted to the resident's increased pain, changes in their mobility and the status of their physiotherapy interventions. An interdisciplinary risk rounds progress note indicated that the resident expressed pain regardless if care was being provided or not. The resident's plan of care was not reviewed and revised when the home was aware that the resident was in pain, with only temporary relief from pain medication, and there were changes in their mobility.

A review of the progress notes and interview with the NP suggested that they ordered diagnostic tests on two occasions, and no other progress notes suggested that they assessed the resident.

In an interview with the resident's Physician, they indicated that they were not involved in the care of the resident after their fall and neither the NP nor the staff at the home notified them of the resident's pain until an identified date.

In an interview with DOC #101, they acknowledged that there were no revisions to the

resident’s plan of care and no reassessment of their condition between identified dates, despite documentation that the resident was in pain.

Resident #001 was not reassessed and their plan of care was not reviewed and revised when their condition continued to worsen and their pain management strategies were only temporarily effective. [s. 6. (10) (c)]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

A) In accordance with O. Reg. 79/10, s. 48 (1) 4, and in reference to O. Reg. 79/10, s. 52 (1) 4, the licensee was required to have a pain management program that included monitoring of the residents' responses to, and the effectiveness of, the pain management strategies.

Specifically, staff did not comply with the licensee's policy number POL/12, titled "Pain Management," last revised March 2018, which was part of the licensee's pain management program. The policy identified that residents who received routine or as

needed pain medication would receive a weekly pain assessment by a Registered Nurse (RN)/Registered Practical Nurse (RPN) using the UDA-Pain Tool in the electronic health record and subsequently, these residents were also to receive a weekly assessment utilizing the Numerical Rating Tool (NRT) or Pain Ad (assessment checklist for persons with cognitive impairment or a limited ability to communicate).

A CI report and a complaint were submitted to the Director related to a fall for resident #001 which resulted in a significant change in condition.

A review of the resident's clinical record in place at the time of the incident indicated that they had pain and directed staff to complete pain assessments as indicated in the eMAR and to follow the home's policy.

A review of resident #001's eMAR identified that they were receiving routine administration of pain medication. Resident #001 also had an order for pain medication as needed, which was administered to the resident on eight days after their fall.

A review of the resident's clinical record did not identify any weekly pain assessments using a clinically appropriate assessment instrument for their routine pain medication for an identified time period.

The home did not ensure that weekly pain assessments were completed by registered staff using the UDA-Pain Tool for resident #001 when they were on routine pain medication or when they were provided pain medication as needed for the identified time period.

B) In accordance with O. Reg. 79/10 s. 68, the licensee was required to ensure that the nutrition care program included a weight monitoring system to measure and record the weight of each resident at admission and monthly thereafter.

Specifically, staff did not comply with the licensee's policy titled "Vital Signs, Height, Weight and Assessment," last revised December 2019, which was part of the licensee's nutrition care and dietary service program. The policy identified that the Personal Support Worker (PSW) was to review the current monthly weight and the previous monthly weight and if there was a weight change of 2.0 kilograms (kg), the PSW was to immediately reweigh the resident and record the reweigh on the monthly weight record. The registered staff were to enter the monthly weights and reweighs into the vitals section of Point Click Care (PCC) and they were to review the resident's weight and any

weight changes.

A complaint was submitted to the Director in relation to the care of resident #011, which included a concern related to weight loss.

A review of the clinical record for resident #011 indicated that in an identified month, the resident's weight was recorded as greater than 2.0 kg lower than the previous month. Registered Dietitian (RD) #139 assessed the resident for weight loss and identified that they were meeting their nutrition and hydration requirements and requested a re-weigh. Later than month, RD #139 documented that a reweigh was not completed for the resident.

In an interview with RN #124, they identified that for residents who required re-weighs, they were told to enter both weights into PCC.

In interviews with RD #139, they indicated that they communicated to management staff that they required re-weighs for residents in the identified month, and they acknowledged that if a resident was re-weighed, there would be a second weight listed under the weights section in PCC.

In an interview with DOC #101, they acknowledged that they reviewed the clinical record for resident #011 and they did not see a re-weigh for the resident in the identified month, and there should have been one.

The home did not ensure that when resident #011 was weighed and their weight was greater than 2.0 kg lower than the previous month, that they were re-weighed as per their "Vital Signs, Height, Weight and Assessment" policy.

C) In accordance with O. Reg. 79/10 s. 114, the licensee was required to have an interdisciplinary medication management system that included written policies and protocols for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs in the home.

Specifically, staff did not comply with the licensee's policy titled "Narcotics and Controlled Substances," last revised August 2017, which was part of the licensee's medication management system. The policy outlined that at the beginning of each shift, the narcotic supply was to be counted by two registered staff and the Narcotic Count Sheet signed.

A CI report was submitted to the Director related to a missing/unaccounted for narcotic.

The home's medication incident report indicated that as per their internal investigation, the registered staff admitted to completing the narcotic count without a second registered staff. The staff member was unable to confirm the whereabouts of the dose as per the report.

In an interview with RPN #143, they explained that it was the home's practice when the narcotic count was off, registered staff who found the discrepancy were to notify management and management was to complete an investigation. RPN #143 acknowledged that two registered staff were to complete the narcotic count at the beginning of their shift, typically the outgoing registered staff counted with the oncoming registered staff. RPN #143 confirmed that they did not count with the outgoing registered staff at the beginning of their shift on the identified date.

In an interview with DOC #101, they confirmed that staff did not comply with the home's "Narcotics and Controlled Substances" policy.

D) In accordance with O. Reg. 79/10 s. 114, the licensee was required to have an interdisciplinary medication management system that included written policies and protocols for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs in the home.

Specifically, staff did not comply with the licensee’s policy titled "Medication Administration Rounds," last revised November 2019, which was part of the licensee’s medication management system. The policy outlined that registered staff were to sign the eMAR that corresponded with the date and time the medication was administered.

A complaint was submitted to the Director regarding concerns about the management of medication orders in the home resulting in possible medication omissions.

i) A review of the physician orders indicated that resident #012 had an order to increase an identified medication.

Resident #012's eMAR and progress notes were reviewed and an order was identified for a specific medication. There was a blank box in resident #012's eMAR for a dose of the

medication for an identified date.

In an interview with RPN #128, they confirmed that they worked on the identified date and they recalled that they administered the medication to resident #012 as ordered. They noted that they processed the order and made an associated progress note in PCC.

In an interview with RCM #127, they confirmed that the eMAR was blank and that RPN #128 should have documented on the eMAR or in a progress note that the medication was administered to resident #012 on the identified date.

The home failed to ensure that registered staff documented the administration of an ordered medication in the eMAR for resident #012, as per their “Medication Administration Rounds” policy.

ii) Resident #013's eMAR was reviewed and identified the resident was receiving an ordered medication twice daily from an identified date. Later that month, there was an order to increase the dose of the medication. There was no documentation that the resident was administered the medication on an identified date.

In an interview with RPN #128, they indicated that they worked on an identified date, and they administered the old dose of medication as the new dose was not processed at the time of administration. RPN #128 noted that they would have documented in progress notes. No note was found regarding the administration of the ordered medication on the identified date.

In an interview with RCM #127, they confirmed that the eMAR was blank for the ordered dose of the medication on the identified date, and that RPN #128 should have documented on the eMAR or in a progress note that the medication was administered to resident #013.

The home failed to ensure that registered staff documented the administration of an ordered medication to resident #013 as per their “Medication Administration Rounds” policy.

iii) A review of resident #002's eMAR indicated that they had an order for an identified medication. There was no documentation in their eMAR or progress notes that they received their ordered dose of the medication on two dates.

In an interview with RPN #140, they acknowledged that they worked on one of the identified dates and confirmed that they administered the medication to resident #002 as noted in the physician order as it wasn't confirmed in PCC at the time of administration and therefore was not available to sign.

In an interview with RPN #141, they acknowledged that they worked on the other identified date, and confirmed that they administered the medication to resident #002.

During an interview with DOC #101 they acknowledged that staff who administered any ordered medication were to sign the eMAR or write a progress note. DOC #101 confirmed that registered staff did not document the administration of a medication for resident #002 on two dates.

The home failed to ensure that registered staff documented indicating that they administered medication as ordered for resident #002 on two dates, as per their “Medication Administration Rounds” policy. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was not neglected by the licensee or staff.

O. Reg 79/10 s. 5 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A CI report and a complaint were submitted to the Director related to a fall for resident #001 which resulted in a significant change in condition.

Resident #001 had a fall and the initial post fall assessment indicated that they complained of pain in an identified area.

Initial assessment by Physiotherapist (PT) #116, noted that they were unable to assess a specific area due to pain on movement, and there was a change in their mobility. The resident’s transfer status was changed, a diagnostic test was ordered and pain medication was given routinely and as needed for pain.

Two days after their fall the resident was reassessed by PT #116 and they indicated that they were unable to complete the assessment due to the same pain and there was no improvement in their mobility. PT #116 indicated that the resident would benefit from one to one PT intervention. Five days later, PT #116 reassessed the resident and there was no noted improvement in the resident’s condition.

A review of the resident’s written plan of care including review of the Physiotherapy Resident Log did not include documentation that the resident received the one to one PT intervention. There was no improvement in the resident's mobility after the fall and they continued to complain of pain in an identified area, receiving pain medication with temporary relief. The resident was not reassessed until 16 days later, at which time, the PT noted that they were still complaining of pain.

A review of the progress notes indicated that the resident continued to complain of pain during transfers and a note was left in the physician’s book to assess the resident. The following day, the resident expressed pain in an identified area. The NP assessed the resident and a diagnostic test was ordered, as well as pain medication as needed for

several days and then the resident was to be reassessed. The results of the diagnostic test were received by the home and the report recommended a repeat test if clinical concern persisted.

Resident #001's eMAR and progress notes were reviewed between identified dates and they indicated that the resident continued to complain of pain. As needed pain medication was administered 20 times during this period.

Despite the signs of pain, there were no repeat diagnostic tests, no reassessments documented and there were no changes made to the resident’s medications until an identified individual expressed concerns about pain management.

RCM #117 documented in a progress note that they were alerted to the resident’s increased pain, changes in their mobility and the status of their physiotherapy interventions. An interdisciplinary risk rounds progress note indicated that the resident expressed pain regardless if care was being provided or not. The resident's plan of care was not reviewed and revised when the home was aware that the resident was in pain, with only temporary relief from pain medication, and there were changes in their mobility.

Prior to their fall, the resident was on routine pain medication. The home’s “Pain Management” policy indicated that residents who received routine pain medication would receive a weekly pain assessment. A review of the resident’s clinical record identified that they remained on routine pain medication of varying doses after their fall and they also received some pain medication as needed. There were no weekly pain assessments completed using a clinically appropriate assessment instrument until several weeks after their fall, despite administration of routine pain medication, a change in their mobility status, and continued reports of pain during PT assessment.

In interviews with PSW #110 and #112, they indicated that after their fall, resident #001 would demonstrate symptoms of pain, indicating that pain medications were only temporarily effective and that their reports of pain were significantly different than their reports of pain prior to their fall.

In an interview with RPN #114, they indicated that resident #001 always expressed pain and their pain medication was temporarily effective.

A review of the progress notes and interview with the NP suggested that they ordered diagnostic tests on two occasions, and no other progress notes suggested that they

assessed the resident.

In an interview with the resident's Physician, they indicated that they were not involved in the care of the resident after their fall and neither the NP nor the staff at the home notified them of the resident's pain until an identified date.

In an interview with DOC #101, they acknowledged after the resident’s fall, they experienced a significant change in condition. They indicated that they reviewed resident #001’s care plan and they did not note any revisions to the resident’s plan of care between identified dates, despite the resident being reassessed by the PT and their being no improvement in their condition, and there were no revisions to the resident’s plan of care between identified dates, despite documentation of pain, until requested by the an identified individual.

The cause of the resident’s pain was not diagnosed for an identified time period after their fall. In that time the resident continued to show a change in condition, worsening unrelieved pain and a change in their mobility. There was only documentation to suggest that the resident was assessed by the NP on two occasions, and the physician indicated that they were not informed of the resident’s condition by the registered staff or the NP until an identified date. The licensee’s pattern of inaction in relation to the reassessment, pain management, and revision of the plan of care for resident #001 after they had a change in condition jeopardized the health and well-being of the resident.

The home did not ensure that resident #001 was not neglected by the licensee or staff after their fall.

This finding will serve as further evidence to support CO #001 issued on November 22, 2019, during critical incident inspection #2019_661683_0020 to be complied February 28, 2020. [s. 19. (1)]

Issued on this 25th day of February, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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. 2007, chap. 8

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LISA BOS (683), STACEY GUTHRIE (750)
Inspection No. / No de l’inspection :	2020_661683_0002
Log No. / No de registre :	022710-19, 023337-19, 000311-20
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 21, 2020
Licensee / Titulaire de permis :	St. Joseph's Health System 50 Charlton Avenue East, Room M146, HAMILTON, ON, L8N-4A6
LTC Home / Foyer de SLD :	St. Joseph's Villa, Dundas 56 Governor's Road, DUNDAS, ON, L9H-5G7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Mieke Ewen

To St. Joseph's Health System, you are hereby required to comply with the following order(s) by the date(s) set out below:

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. 2007, chap. 8

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:

1. Ensure that residents who have fallen are reassessed and their plan of care reviewed and revised at least every six months and any other time when care set out in the plan is not effective, in relation to:
i) mobility and transfers
ii) pain management

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised at least every six months and any other time when care set out in the plan was not effective.

A critical incident (CI) report and a complaint were submitted to the Director related to a fall for resident #001 which resulted in a significant change in condition.

On an identified date, resident #001 had a fall and the initial post fall assessment indicated that they complained of pain in an identified area.

i) Initial assessment by Physiotherapist (PT) #116, noted that they were unable to assess a specific area due to pain on movement, and there was a change in their mobility. The resident's transfer status was changed, a diagnostic test was ordered and pain medication was given routinely and as needed for pain.

Two days after their fall the resident was reassessed by PT #116 and they indicated that they were unable to complete the assessment due to the same pain and there was no improvement in their mobility. PT #116 indicated that the resident would benefit from one to one PT intervention. Five days later, PT #116 reassessed the resident and there was no noted improvement in the resident's condition.

A review of the resident's written plan of care including review of the Physiotherapy Resident Log did not include documentation that the resident received the one to one PT intervention. There was no improvement in the resident's mobility after the fall and they continued to complain of pain in an identified area, receiving pain medication with temporary relief. The resident was not reassessed until 16 days later, at which time, the PT noted that they were still complaining of pain.

In an interview with DOC #101, they acknowledged that after the resident's fall they experienced a significant change in condition. They indicated that they reviewed resident #001's care plan and they did not note any revisions to the resident's plan of care between identified dates, despite the resident being reassessed by the PT and there being no improvement in their condition.

Resident #001 experienced a significant change in condition after their fall. The resident was reassessed by PT #116, and there was no improvement in their condition, worsened pain, and they did not receive physiotherapy interventions. The resident's mobility did not improve and there were no improvements in their transfer status. When the resident was reassessed by PT #116, their plan of care was not revised when the interventions in place were ineffective.

ii) A review of the progress notes indicated that resident #001's condition continued to deteriorate and they continued to complain of pain. On an identified date, the resident indicated that they had pain in an identified area. The NP assessed the resident and a diagnostic test was ordered, as well as

pain medication as needed for several days and then the resident was to be reassessed. The results of the diagnostic test were received by the home and the report recommended a repeat test if clinical concern persisted.

Resident #001's electronic medication administration record (eMAR) and progress notes were reviewed between identified dates and they indicated that the resident continued to complain of pain. Although they received as needed pain medication, it was only temporarily effective.

Despite the signs of pain, there were no repeat diagnostic tests taken, no reassessments documented and there were no changes made to the resident's medications until an identified individual expressed concerns about pain management.

Resident Care Manager (RCM) #117 documented in a progress note that they were alerted to the resident's increased pain, changes in their mobility and the status of their physiotherapy interventions. An interdisciplinary risk rounds progress note indicated that the resident expressed pain regardless if care was being provided or not. The resident's plan of care was not reviewed and revised when the home was aware that the resident was in pain, with only temporary relief from pain medication, and there were changes in their mobility.

A review of the progress notes and interview with the NP suggested that they ordered diagnostic tests on two occasions, and no other progress notes suggested that they assessed the resident.

In an interview with the resident's Physician, they indicated that they were not involved in the care of the resident after their fall and neither the NP nor the staff at the home notified them of the resident's pain until an identified date.

In an interview with DOC #101, they acknowledged that there were no revisions to the resident's plan of care and no reassessment of their condition between identified dates, despite documentation that the resident was in pain.

Resident #001 was not reassessed and their plan of care was not reviewed and revised when their condition continued to worsen and their pain management strategies were only temporarily effective.

The severity of this issue was a level 3 as there was actual harm to the resident. The scope was a level 1 as it related to one of three residents reviewed. The home had a level 3 compliance history as they had previous non-compliance to the same subsection that included:
• Voluntary Plan of Correction (VPC) issued April 4, 2017 (2017_57610a_0005);
• Written Notification (WN) issued October 26, 2017 (2017_542511_0011);
• VPC issued October 26, 2017 (2017_546585_0015);
• VPC issued July 13, 2018 (2018_689586_0014);
• VPC issued June 28, 2019 (2019_549107_0007);
• VPC issued November 22, 2019 (2019_661683_0020).
Additionally, the LTCH has a history of 27 compliance orders to other subsections in the last 36 months. (683)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 20, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 21st day of February, 2020

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Lisa Bos

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