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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 19, 2014	2014_347197_0030	O-001276-14	Resident Quality Inspection

Licensee/Titulaire de permis

2109577 ONTARIO LIMITED
195 Forum Drive Unit 617 MISSISSAUGA ON L4Z 3M5

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

2109577 ONTARIO LIMITED O/A ARBOUR HEIGHTS
564 Tanner Drive KINGSTON ON K7M 0C3

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

JESSICA PATTISON (197), AMBER MOASE (541), DARLENE MURPHY (103), KARYN WOOD (601), WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 8-12, 15, 16, 2014

Three Critical Incident inspections and two complaint inspections were completed within the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care, Dietary Manager, Physiotherapist, Environmental Manager, Resident Support Services Manager, Family and Community Coordinator, Clinical Nurse Manager, RAI Coordinator, Administrator Assistant, a Physiotherapy Aid, Registered Nurses, Registered Practical Nurses, Personal Care Providers, Maintenance staff and residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

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

7 WN(s)
2 VPC(s)
2 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	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.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 Resident #42 was reassessed when the resident's care needs changed as a result of a fall.

On an identified date, Resident #42 fell and sustained an injury that was not diagnosed until nine days later .

The resident's plan of care was reviewed for a period of time prior to the resident fall.

The care plan in effect just prior to the fall indicated under "Transferring":
-resident requires a walker to facilitate transfers
-resident transfers independently without supervision
-resident can weight bear

Under "Mobility":
-Bed mobility, ability to walk in room, ability to walk in corridor and locomotion on and off unit were all indicated as independent.
-Resident uses a walker except on days when legs are weak then uses a wheelchair

Under "Toileting":
-independent

Under "Dressing":
-limited assistance.

The physician's orders were reviewed and two months prior to the fall there was an order for an analgesic for pain control related to the resident's diagnosis.

The Narcotic and Controlled Substance Administration Records were reviewed and indicated Resident #42 received a total of two tablets of the analgesic over the two month period of time prior to the fall.

Prior to the fall, the resident was being seen by a physiotherapy assistant twice weekly for range of motion, strengthening exercises and sitting/standing balance and according to the documentation was compliant with the physiotherapy plan.

Following the fall, the resident exhibited a change in care needs including:
-a change in mobility
-a change in ability to perform activities of daily living
-a change in pain control and
-a change in ability to participate in physiotherapy.

Resident #42 was interviewed in regards to the mobility and level of pain post fall. The resident stated prior to the fall he/she was able to utilize a walker and could weight bear. The resident stated after the fall and the days that followed until such time he/she was sent to the hospital, the resident did not use the walker at all and could not weight bear. The resident recalled that two staff were required to help with all aspects of care and the staff began using a lift to assist him/her in and out of bed. Resident #42 stated he/she was having increased pain different than any previous pain prior to the fall.

Resident #42's Medication Administration record (MAR) was reviewed for the identified month the resident fell as well as the progress notes.

A total of seventeen tablets were taken over a nine day period of time. There were no physician orders for analgesics related to post fall pain management and there was no indication the physician was notified of the resident's need for analgesics or the ineffective response to the analgesics given.

Despite an increase in the resident's level of pain, a documented pain assessment was not completed. According to the home's "Pain Management" policy, RCSM-C-35, under “Procedure” the policy indicates to complete a pain assessment upon admission, significant change in resident status and quarterly as scheduled.

DOC S#107, was interviewed and stated she would expect to see a pain assessment completed to determine the need for the increase in analgesics. She confirmed a pain assessment was not completed during that time.

The physiotherapy sheets for the identified month were reviewed and the documentation indicated the resident “did not complete all of PT program as resident fell". S#125 was interviewed and stated Resident #42 was always motivated during physiotherapy sessions, but on this date had declined to complete the sitting and standing balance portion. S#125 did not believe this had been reported to the Physiotherapist.

The Physiotherapist, S#123 was interviewed and stated a physiotherapy referral is generally requested when a resident has fallen and sustained injuries that affect the resident’s ability to mobilize. This inspector advised S#123 that Resident #42 had previously been able to weight bear and ambulate independently with a walker, but post fall required the use of a sara lift. S#123 confirmed he was not asked to reassess Resident #42 and no referrals had been made post fall until after the resident had returned post operatively to the home. S#123 agreed a request for a physiotherapy referral should have been submitted to assess the resident’s change in mobility and ambulation.

The home's policy, "Falls Prevention and Management Program", RCSM-E115, states:observe and report changes in resident's mobility and complete physiotherapy referral if warranted.

The home failed to reassess Resident #42’s change in condition.

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. 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 has failed to comply with O. Regs 79/10 s. 49 (2) whereby a resident was not assessed at the time of a fall.

On an identified date, Resident #42 fell and sustained injuries that went undiagnosed for nine days. The resident progress notes and fall risk assessment documentation was reviewed and RPN S#122 indicated the resident's vital signs were stable, "resident is doing ok, complained of some discomfort in identified area, no bruise or abrasion noted at this time." There is no documented assessment to reflect a post fall assessment for injuries. S#122 was interviewed and could not recall working on the unit at the time of the resident fall.

Resident #42 was interviewed and confirmed being lifted into the wheelchair after the incident and was then returned to his/her room. The resident stated he/she remained in the wheelchair until it was time for bed.

RN S#113 was interviewed and stated she was one of the RN's working that day. S#113 stated she did not complete a post fall assessment of Resident #42 but recalled suggesting the resident should go to the hospital. S#113 was asked to review all of the documentation made at the time of the fall. S#113 agreed the documentation did not reflect a proper assessment of the resident and that she would expect a head to toe assessment including range of motion, any internal or external rotation of the lower limbs and the presence of any pain to have been included. S#113 was unable to find any additional documentation to reflect the completion of an assessment post fall.

DOC S#107 was interviewed and asked what she would expect to see in regards to the assessment of a resident to determine physical injuries. She stated she would expect the assessment to have included range or motion, internal/external rotation and an assessment of the resident's level of pain. The DOC agreed Resident #42 did not receive

a post fall assessment at the time of the fall.

The home's policy, "Fall Prevention and Management Program", RCSM-E-115 states under "Procedure"-Fall and Post Fall Assessment and Management states:
-when a resident has fallen, the person witnessing the fall or finding the resident after the fall will not move the resident if there is suspicion or evidence of an injury until a full head to toe assessment has been conducted,
-complete the head to toe assessment, including vital signs
-perform range of motion (ROM) movements with the resident and observe for pain or difficulty weight bearing if no injury is evident.

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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 2 whereby doors leading to non-residential areas must be kept closed and locked when they are not being supervised by staff.

On December 8, 2014 on or about 0945 hour during the initial tour of the home, Mudroom #149 on City Park was observed to be propped open with a wheeled blue bin and a sign that stated “do not close door-handle not working”. The room was noted to contain linens and one spray bottle of disinfectant. Additionally during the tour, the servery door on the Confederation home area was found unlocked. Both of these rooms are non-residential areas. At the time of the tour, there was no staff in the vicinity supervising either unlocked door.

On December 8, 2014 at 1545 hour, this inspector entered the main dining room doors on Confederation Park. Within the dining area, a separate door was observed that leads into the servery. The inspector entered through an unlocked door and observed fridges for food storage containing food, the steam table and coffee maker/hot water dispenser for hot drinks. The door leading into the servery was noted to have a lock. At the time of these observations, there was no staff observed in the area. DOC #S107 was notified and the servery doors were locked at that time.

The door for Mudroom #149 was later observed by the inspector to be locked. According to staff, this keypad had not been working and needed to be replaced. Staff were unsure how long the door lock had been non-functioning.

On December 11, 2014 at 1036 hour, this inspector found the servery door on the Confederation unit to be unlocked and there were no staff in the vicinity at that time. The inspector advised RPN #S102 that the door was unlocked and the staff member stated they would ensure it was locked. [s. 9. (1) 2.]

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 doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

On a specified date, Resident #41 submitted an email to the Director of Care #S107 alleging that staff member #S114 was verbally abusive. The email was acknowledged by the DOC #S107 the next day. DOC #S107 confirmed with Inspector #541 that the Director was not notified about this incident until five days after receiving the email when the critical incident report was submitted. [s. 24. (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 any person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (i) Abuse of a resident by anyone.

On a specified date, Resident #41 submitted an email to the Director of Care #S107 alleging that staff member #S114 was verbally abusive. The email was acknowledged by the DOC the next day via an email to the Registered Nurse in charge. During an interview with Inspector #541, DOC #S107 confirmed that the investigation into this allegation started four days after the email was received when staff member #S114 was first interviewed. [s. 23. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident’s hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 33(1) in that they did not ensure that a resident was bathed by the method of their choice.

On a specified date, Resident #20 indicated during an interview a preference for having a tub bath but that staff will only provide a shower. The resident further indicated feeling a tub bath might take longer and that's why the staff don't want to provide it.

Resident #20's current care plan states that the resident prefers tub baths, requires supervision and one person physical assist.

The bath sheet for the unit was reviewed for the current week and showed that the resident received showers.

Resident #20 was re-interviewed on one of her planned bath days and indicated not getting a bath but rather a shower. The resident stated that he/she had asked the staff about having a bath but staff member #S124 said no, it's a shower. Resident #20 further indicated never being offered a bath and anytime he/she asks the staff indicate it is unsafe.

Staff member #S124 was interviewed on two dates related to Resident #20 and bathing. The staff member indicated that residents who prefer a bath are able to have a bath, but that Resident #20 does not remember how to safely get into the tub. Staff member #S124 stated that specific measures may have to be taken to get the resident safely into the tub. [s. 33. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 229(4) in that a staff member did not participate in the implementation of the infection prevention and control program.

On a specified date, dining observation of the lunch meal was completed.

Staff member #S119 was observed to be feeding a resident. At approximately 1300 hours, staff member #S119 was observed to touch another resident's chin, rub his/her nose and then continue to feed the resident without stopping to hand wash. At approximately 1307 hours, staff member #S119 was then observed to rub his/her eyes profusely with both hands and then continue to feed the resident without hand washing. [s. 229. (4)]

Issued on this 19th day of December, 2014

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

Original report signed by the inspector.

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) :	JESSICA PATTISON (197), AMBER MOASE (541), DARLENE MURPHY (103), KARYN WOOD (601), WENDY BROWN (602)
Inspection No. / No de l'inspection :	2014_347197_0030
Log No. / Registre no:	O-001276-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 19, 2014
Licensee / Titulaire de permis :	2109577 ONTARIO LIMITED 195 Forum Drive, Unit 617, MISSISSAUGA, ON, L4Z-3M5
LTC Home / Foyer de SLD :	2109577 ONTARIO LIMITED O/A ARBOUR HEIGHTS 564 Tanner Drive, KINGSTON, ON, K7M-0C3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To 2109577 ONTARIO LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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 is hereby ordered to ensure a documented pain assessment is completed for all residents that exhibit a change in care needs such as an increased requirement for analgesics, a decrease in mobility, and a decrease in ability to ambulate.

Ensure a team approach is used including physiotherapy when residents experience changes in mobility and ambulation and the physician when pain control is inadequate.

Provide additional education to direct care staff as required to ensure changes in resident care needs are communicated to all team members in a timely manner.

Grounds / Motifs :

1. The licensee has failed to ensure Resident #42 was reassessed when the resident's care needs changed as a result of a fall.

On an identified date, Resident #42 fell and sustained an injury that was not diagnosed until nine days later.

The resident's plan of care was reviewed for a period of time prior to the resident fall.

The care plan in effect just prior to the fall indicated under “Transferring”:
-resident requires a walker to facilitate transfers
-resident transfers independently without supervision
-resident can weight bear

Under “Mobility”:
-Bed mobility, ability to walk in room, ability to walk in corridor and locomotion on and off unit were all indicated as independent.
-Resident uses a walker except on days when legs are weak then uses a wheelchair

Under "Toileting":
-independent

Under "Dressing":
-limited assistance.

The physician’s orders were reviewed and two months prior to the fall there was an order for an analgesic for pain control related to the resident's diagnosis.

The Narcotic and Controlled Substance Administration Records were reviewed and indicated Resident #42 received a total of two tablets of the analgesic over the two month period of time prior to the fall.

Prior to the fall, the resident was being seen by a physiotherapy assistant twice weekly for range of motion, strengthening exercises and sitting/standing balance and according to the documentation was compliant with the physiotherapy plan.

Following the fall, the resident exhibited a change in care needs including:
-a change in mobility
-a change in ability to perform activities of daily living
-a change in pain control and
-a change in ability to participate in physiotherapy.

Resident #42 was interviewed in regards to the mobility and level of pain post fall. The resident stated prior to the fall he/she was able to utilize a walker and could weight bear. The resident stated after the fall and the days that followed until such time he/she was sent to the hospital, the resident did not use the walker at all and could not weight bear. The resident recalled that two staff were

required to help with all aspects of care and the staff began using a lift to assist him/her in and out of bed. Resident #42 stated he/she was having increased pain different than any previous pain prior to the fall.

Resident #42's Medication Administration record (MAR) was reviewed for the identified month the resident fell as well as the progress notes.

A total of seventeen tablets were taken over a nine day period of time. There were no physician orders for analgesics related to post fall pain management and there was no indication the physician was notified of the resident's need for analgesics or the ineffective response to the analgesics given.

Despite an increase in the resident's level of pain, a documented pain assessment was not completed. According to the home's "Pain Management" policy, RCSM-C-35, under “Procedure” the policy indicates to complete a pain assessment upon admission, significant change in resident status and quarterly as scheduled.

DOC S#107, was interviewed and stated she would expect to see a pain assessment completed to determine the need for the increase in analgesics. She confirmed a pain assessment was not completed during that time.

The physiotherapy sheets for the identified month were reviewed and the documentation indicated the resident “did not complete all of PT program as resident fell". S#125 was interviewed and stated Resident #42 was always motivated during physiotherapy sessions, but on this date had declined to complete the sitting and standing balance portion. S#125 did not believe this had been reported to the Physiotherapist.

The Physiotherapist, S#123 was interviewed and stated a physiotherapy referral is generally requested when a resident has fallen and sustained injuries that affect the resident's ability to mobilize. This inspector advised S#123 that Resident #42 had previously been able to weight bear and ambulate independently with a walker, but post fall required the use of a sara lift. S#123 confirmed he was not asked to reassess Resident #42 and no referrals had been made post fall until after the resident had returned post operatively to the home. S#123 agreed a request for a physiotherapy referral should have been submitted to assess the resident's change in mobility and ambulation.

The home's policy, "Falls Prevention and Management Program", RCSM-E115, states: observe and report changes in resident's mobility and complete physiotherapy referral if warranted.

The home failed to reassess Resident #42's change in condition.
(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 30, 2015

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. 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).

Order / Ordre :

The licensee is hereby ordered to ensure all registered nursing staff comply with the home's policy, "Fall Prevention and Management Program", RCSM-E115, when assessing residents post fall.

Provide additional education to registered nursing staff as required to ensure comprehensive post fall assessments for injuries are being completed.

Grounds / Motifs :

1. The licensee has failed to comply with O. Regs 79/10 s. 49 (2) whereby a resident was not assessed at the time of a fall.

On an identified date, Resident #42 fell and sustained injuries that went undiagnosed for nine days. The resident progress notes and fall risk assessment documentation was reviewed and RPN S#122 indicated the resident's vital signs were stable, "resident is doing ok, complained of some discomfort in identified area, no bruise or abrasion noted at this time." There is no documented assessment to reflect a post fall assessment for injuries. S#122 was interviewed and could not recall working on the unit at the time of the resident fall.

Resident #42 was interviewed and confirmed being lifted into the wheelchair after the incident and was then returned to his/her room. The resident stated he/she remained in the wheelchair until it was time for bed.

RN S#113 was interviewed and stated she was one of the RN's working that day. S#113 stated she did not complete a post fall assessment of Resident #42

but recalled suggesting the resident should go to the hospital. S#113 was asked to review all of the documentation made at the time of the fall. S#113 agreed the documentation did not reflect a proper assessment of the resident and that she would expect a head to toe assessment including range of motion, any internal or external rotation of the lower limbs and the presence of any pain to have been included. S#113 was unable to find any additional documentation to reflect the completion of an assessment post fall.

DOC S#107 was interviewed and asked what she would expect to see in regards to the assessment of a resident to determine physical injuries. She stated she would expect the assessment to have included range or motion, internal/external rotation and an assessment of the resident's level of pain. The DOC agreed Resident #42 did not receive a post fall assessment at the time of the fall.

The home's policy, "Fall Prevention and Management Program", RCSM-E-115 states under "Procedure"-Fall and Post Fall Assessment and Management states:
-when a resident has fallen, the person witnessing the fall or finding the resident after the fall will not move the resident if there is suspicion or evidence of an injury until a full head to toe assessment has been conducted,
-complete the head to toe assessment, including vital signs
-perform range of motion (ROM) movements with the resident and observe for pain or difficulty weight bearing if no injury is evident.
(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 30, 2015

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 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
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.

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 19th day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jessica Pattison

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