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
Dec 13, 2021	2021_848748_0014	009592-21, 013317-21, 015660-21	Complaint

Licensee/Titulaire de permis

Waterdown Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street Midland ON L4R 2E1

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

Alexander Place
329 Parkside Drive P.O. Box 50 Waterdown ON L0R 2H0

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

EMMY HARTMANN (748), LISA BOS (683)

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): October 29, November 1, 2, 3, 4, 5, 8, 9, 10, 12, 15, 16, 17, 2021.

The following intakes were completed during this Complaint Inspection:

Log #009592-21, was related to falls prevention, medication, and responsive behaviours.
Log #013317-21, was related to an allegation of neglect, and falls prevention.
Log #015660-21, was related to change in condition and hospitalization.

This inspection was completed concurrently with Critical Incident Inspection (CIS) #2021_848748_0015. Non-compliance in section 6 (7) of the LTCHA was identified during the CIS inspection, and is issued in this report.

During the course of the inspection, the inspector(s) spoke with residents, the Acting Administrator, Director of care (DOC), Restorative Care Coordinator, RAI Coordinator, Staffing Clerk, Receptionist, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), and personal support assistants (PSA).

During the course of the inspection, the inspector also observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

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

- **5 WN(s)**
- **3 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	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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's Power of Attorney (POA) was provided the opportunity to participate fully in the resident's plan of care related to their falls.

The resident's progress notes identified that the resident was found on the floor on an identified date and time, and again about eight hours later.

The resident's POA was not informed of any of the fall incidents until prior to the time they were being sent to the hospital for further assessment.

The DOC verified that the POA was not notified of the fall incidents until the resident was about to be sent to hospital.

Sources: A resident's progress notes, the home's risk management, the home's investigation notes, the home's Falls Prevention and Management policy, last revised May 7, 2019; and interview with DOC #101.

2. The licensee failed to ensure that three residents' plans of care were followed as specified in the plan.

A. A resident was high risk for falls and had interventions that included frequent monitoring, and application of a device.

The resident was not checked frequently on an identified date, approximately five hours

prior to being found on the floor by a PSW.

The PSW identified that when they saw the resident at that time, their device was not applied.

There was a risk related to this non-compliance as the resident did not receive the interventions they needed related to falls prevention. The resident sustained injuries and was subsequently sent to hospital.

Sources: A resident's progress notes, care plan, the home's investigation notes; interview with PSW #128.

B. A resident was high risk for falls and had interventions that included the application of a device at all times.

During an observation of care on an identified date, the resident was observed without their device applied.

Two PSWs identified that they did not apply the device on the resident.

The resident was also observed to not have their device applied on another date, and an RPN verified with the inspector that the device was not applied on the resident.

The Restorative Care Coordinator confirmed that the resident still required the application of the device to manage their high falls risk.

There was a risk related to this non-compliance as the resident was at risk for injury if they fell and their device was not applied.

Sources: Observation of a resident's care on two identified dates; a resident's care plan; interviews with PSW #104, PSW #120, RPN #116, Restorative Care Coordinator #122.

C. A resident was high risk for falls and had interventions that included the application of a device while using their mobility aid.

During an observation of care on an identified date, the resident was observed without their device while the resident was using their mobility aid.

A PSW verified that the resident's device was not applied.

There was a risk related to this non-compliance as the resident may be at increased risk for falls with injury, while using their mobility aid.

Sources: Observation a resident's care on an identified date; a resident's care plan; interview with PSW #110.

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 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 :

The licensee failed to ensure that a resident was not neglected by staff.

Ontario Regulation 79/10 defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

The home's Falls Policy stated the following:

-a resident who had a fall or who was found on the floor was assessed by registered staff prior to being moved.
-a range of motion (ROM) assessment of extremities and neck was completed.
-a HIR was initiated.
-a point click care (PCC) risk management form for the fall was initiated.

-an immediate post fall huddle was completed, and would include participation of registered staff, PSW staff and any other individuals who witnessed the fall or could provide valuable input into the fall.

A resident was high risk for falls, and was found on the floor twice in 12 hours on identified dates. For the first incident, the nurse that responded to the fall did not complete a Head Injury Routine (HIR) on the resident, and did not document the incident via risk management or immediately document the incident in the progress notes. There was also no post- fall huddle completed by the team to look at strategies to prevent further falls.

The staff did not frequently monitor the resident, as outlined in their fall plan of care, and the resident was not seen for five hours, until the time they were found on the floor for the second time.

After the second fall, the PSW identified that the device that was supposed to be applied to the resident was not in place. They reported to the nurse that the resident had fallen but the nurse did not respond or complete an assessment of the resident. The PSW moved the resident prior to the resident being immediately assessed for any injury, including an assessment of their extremities and neck. The resident was later identified to have sustained injuries as a result of the fall, and only then was a HIR initiated on the resident, approximately two hours after they were found on the floor.

The DOC identified a lack of documentation by the nurse responding to the first fall incident. A PSW identified that there was no clear report at shift change to alert staff that the resident had fallen. These factors resulted in the resident's POA not being immediately notified of the incidents.

The resident was sent to the hospital, where they were diagnosed with a serious injury and passed away a few days later.

There was actual harm related to this non-compliance as the home had a pattern of inaction that jeopardized the resident's health, safety and well-being. The resident's plan of care was not followed, the resident was not properly assessed when they fell, and the resident's POA was not notified of the incidents so that they could participate in the resident's plan of care.

Sources: A resident's progress notes, care plan, assessments, the home's risk

management, the home's investigation notes; interviews with PSW #128, DOC #101.

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. 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 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 licensee was required to ensure that the policy was complied with.

Ontario Regulation 79/10 section 48 (1) (1) required that a falls prevention and management program was developed and implemented in the home to reduce the incidence of falls and risk of injury.

In accordance with Ontario Regulation 79/10 section 49 (1) and section 49 (2), the home was to ensure that the falls prevention program provided for strategies to reduce or mitigate falls, including the monitoring of residents; and that when a resident had fallen, they were assessed.

Specifically, the home did not comply with their Falls Policy, which directed staff to complete the following:

-a resident who had a fall or who was found on the floor was assessed by registered staff prior to being moved.
-a range of motion (ROM) assessment of extremities and neck was completed.
-a HIR was initiated.
-a point click care (PCC) risk management form for the fall was initiated.
-an immediate post fall huddle was completed, and would include participation of registered staff, PSW staff and any other individuals who witnessed the fall or could provide valuable input into the fall.

A resident was found on the floor on an identified date and time. There was no HIR completed on the resident, no PCC risk management form for the fall, and no immediate post-fall huddle completed.

The resident was found on the floor again about eight hours later, at which time, they were not assessed by the nurse prior to being moved, including a ROM assessment of their extremities and neck. A HIR was also not initiated until about two hours after the resident was found on the floor.

A PSW confirmed that the resident was not assessed by registered staff prior to being moved.

The DOC confirmed that the home's falls prevention policy was not followed when the resident was found on the floor on two identified dates.

There was actual harm related to this non-compliance as the resident did not receive the proper assessments they needed when they fell. The resident was sent to hospital, diagnosed with a serious injury; and passed away a few days later.

Sources: A resident's progress notes, post-fall assessments, the home's risk management, the home's investigation notes, the home's Falls Prevention and Management policy, last revised May 7, 2019; interview with PSW #128, and DOC #101. [s. 8. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A resident had an order for a medication to be used as needed, and included directions for staff to administer it up to twice daily. According to the resident's electronic medication administration record (eMAR), they were administered the medication three times on a specified date.

The DOC acknowledged that the medication was not given to the resident as prescribed.

Sources: A resident's eMAR; interview with DOC #101.

2. The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A review of a resident's records for a specified month identified that they did not receive six of their prescribed medications, in a span of two days.

A medication error incident form was completed and identified the issues as an omission error.

The DOC verified that there was a medication incident where the resident did not receive their medication as prescribed.

Sources: A resident's progress notes, eMAR; the home's Medication Incident Log Binder; Interview with DOC #101.

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 215. Police record check

Specifically failed to comply with the following:

s. 215. (8) When a licensee hires a staff member or accepts a volunteer during a pandemic, the following modifications to the requirements of subsection 75 (1) of the Act and of subsections (1) to (5) of this section apply:
1. Before a staff member is hired or a volunteer is accepted by a licensee, the licensee shall, subject to Column 4 of the Table to section 1 of the Schedule to the Police Record Checks Reform Act, 2015, require that the staff member or volunteer provide the licensee with a signed declaration disclosing the following matters with respect to the period since the date of their last police record check under subsection (2) was conducted, or if no such police record check has been conducted, of every occurrence of the following matters:
i. Every offence with which they have been charged under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada) and the outcome of the charge.
ii. Every order of a judge or justice of the peace made against them in respect of an offence under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada), including a peace bond, probation order, prohibition order or warrant to arrest.
iii. Every offence of which they have been convicted under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada). O. Reg. 72/20, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that when they hired a staff member during a pandemic, that the staff member provided the licensee with a signed declaration disclosing the following matters with respect to the period since the date of their last police record check:
i. Every offence with which they have been charged under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada) and the outcome of the charge.
ii. Every order of a judge or justice of the peace made against them in respect of an offence under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada), including a peace bond, probation order, prohibition order or warrant to arrest.
iii. Every offence of which they have been convicted under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada).

The home identified that an RPN and two PSWs were hired by the home through a nursing agency. The Administrator and the DOC, identified that in review of their records, they did not have a signed declaration for the three staff members, before they were hired.

There was a risk related to this non-compliance as the lack of knowledge of criminal offences of newly hired staff, could compromise the safety of residents.

Sources: Home's records for RPN #124, PSW #111, and PSW #113; interview with Administrator, and DOC #101. [s. 215. (8) 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 the staff member or volunteer provide the licensee with a signed declaration disclosing the following matters with respect to the period since the date of their last police record check under subsection (2) was conducted, or if no such police record check has been conducted, of every occurrence of the following matters:

i. Every offence with which they have been charged under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada) and the outcome of the charge.

ii. Every order of a judge or justice of the peace made against them in respect of an offence under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada), including a peace bond, probation order, prohibition order or warrant to arrest.

iii. Every offence of which they have been convicted under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada), to be implemented voluntarily.

Issued on this 14th day of December, 2021

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

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

Ordre(s) de l'inspecteur

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

Long-Term Care 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) :	EMMY HARTMANN (748), LISA BOS (683)
Inspection No. / No de l'inspection :	2021_848748_0014
Log No. / No de registre :	009592-21, 013317-21, 015660-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 13, 2021
Licensee / Titulaire de permis :	Waterdown Long Term Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, Midland, ON, L4R-2E1
LTC Home / Foyer de SLD :	Alexander Place 329 Parkside Drive, P.O. Box 50, Waterdown, ON, L0R-2H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mary Wariara

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Waterdown Long Term Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must comply with section 6 (7) of the Long Term Care Homes Act. Specifically, the licensee shall ensure that:
1. Resident #006, and resident #007's falls interventions are provided to the residents as specified in their plans of care.

Grounds / Motifs :

1. The licensee failed to ensure that three residents' plans of care were followed as specified in the plan.

A. A resident was high risk for falls and had interventions that included frequent monitoring, and application of a device.

The resident was not checked frequently on an identified date, approximately five hours prior to being found on the floor by a PSW.

The PSW identified that when they saw the resident at that time, their device was not applied.

There was a risk related to this non-compliance as the resident did not receive the interventions they needed related to falls prevention. The resident sustained injuries and was subsequently sent to hospital.

Sources: A resident's progress notes, care plan, the home's investigation notes; interview with PSW #128.

B. A resident was high risk for falls and had interventions that included the application of a device at all times.

During an observation of care on an identified date, the resident was observed without their device applied.

Two PSWs identified that they did not apply the device on the resident.

The resident was also observed to not have their device applied on another date, and an RPN verified with the inspector that the device was not applied on the resident.

The Restorative Care Coordinator confirmed that the resident still required the application of the device to manage their high falls risk.

There was a risk related to this non-compliance as the resident was at risk for injury if they fell and their device was not applied.

Sources: Observation of a resident's care on two identified dates; a resident's care plan; interviews with PSW #104, PSW #120, RPN #116, Restorative Care Coordinator #122.

C. A resident was high risk for falls and had interventions that included the application of a device while using their mobility aid.

During an observation of care on an identified date, the resident was observed without their device while the resident was using their mobility aid.

A PSW verified that the resident's device was not applied.

There was a risk related to this non-compliance as the resident may be at increased risk for falls with injury, while using their mobility aid.

Sources: Observation a resident's care on an identified date; a resident's care plan; interview with PSW #110.

An order was made by taking the following factors into account:

Severity: There was harm and risk to the residents as they did not receive the

interventions they required in fall prevention and management.

Scope: This was a widespread issue involving three residents' falls prevention plans of care not being followed.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 6 (7) and three Written Notifications (WNs), 2 Voluntary Plan of Corrections (VPCs), were issued to the home.
(748)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 11, 2022

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with section 19 (1) of the Long Term Care Homes Act.
Specifically, the licensee shall ensure that any resident that is high risk for falls is not neglected by staff, and that:
1. Their plan of care is followed related to falls interventions.
2. They are assessed when they fall, as per the home's falls prevention and management policy, including completion of a Head Injury Routine (HIR) as indicated, documentation of the fall, and completion of a post-fall huddle to look at strategies to prevent further falls.
3. Their Power of Attorney (POA) is notified of fall incidents to give them an opportunity to participate in their plan of care.

Grounds / Motifs :

1. The licensee failed to ensure that a resident was not neglected by staff.

Ontario Regulation 79/10 defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

The home's Falls Policy stated the following:

-a resident who had a fall or who was found on the floor was assessed by registered staff prior to being moved.
-a range of motion (ROM) assessment of extremities and neck was completed.
-a HIR was initiated.
-a point click care (PCC) risk management form for the fall was initiated.

-an immediate post fall huddle was completed, and would include participation of registered staff, PSW staff and any other individuals who witnessed the fall or could provide valuable input into the fall.

A resident was high risk for falls, and was found on the floor twice in 12 hours on identified dates. For the first incident, the nurse that responded to the fall did not complete a Head Injury Routine (HIR) on the resident, and did not document the incident via risk management or immediately document the incident in the progress notes. There was also no post- fall huddle completed by the team to look at strategies to prevent further falls.

The staff did not frequently monitor the resident, as outlined in their fall plan of care, and the resident was not seen for five hours, until the time they were found on the floor for the second time.

After the second fall, the PSW identified that the device that was supposed to be applied to the resident was not in place. They reported to the nurse that the resident had fallen but the nurse did not respond or complete an assessment of the resident. The PSW moved the resident prior to the resident being immediately assessed for any injury, including an assessment of their extremities and neck. The resident was later identified to have sustained injuries as a result of the fall, and only then was a HIR initiated on the resident, approximately two hours after they were found on the floor.

The DOC identified a lack of documentation by the nurse responding to the first fall incident. A PSW identified that there was no clear report at shift change to alert staff that the resident had fallen. These factors resulted in the resident's POA not being immediately notified of the incidents.

The resident was sent to the hospital, where they were diagnosed with a serious injury and passed away a few days later.

There was actual harm related to this non-compliance as the home had a pattern of inaction that jeopardized the resident's health, safety and well-being. The resident's plan of care was not followed, the resident was not properly assessed when they fell, and the resident's POA was not notified of the incidents so that they could participate in the resident's plan of care.

Sources: A resident's progress notes, care plan, assessments, the home's risk management, the home's investigation notes; interviews with PSW #128, DOC #101.

An order was made by taking the following factors into account:

Severity: There was actual harm to the resident, as their health status deteriorated following two found on floor incidents where they were not properly assessed and monitored. The resident was sent to hospital where they passed away a few days later.

Scope: This was an isolated issue involving one resident.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 6 (19) and two Written Notifications (WNs), 2 Voluntary Plan of Corrections (VPCs), were issued to the home.

(748)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 22, 2021

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 13th day of December, 2021

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Emmy Hartmann

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