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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 18, 2014	2014_207147_0021	H-000965-14	Resident Quality Inspection

Licensee/Titulaire de permis

488491 ONTARIO INC
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

AVALON RETIREMENT CENTRE
355 BROADWAY AVENUE, ORANGEVILLE, ON, L9W-3Y3

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

LALEH NEWELL (147), DARIA TRZOS (561), JESSICA PALADINO (586), ROSEANNE WESTERN (508)

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): July 30, 31, August 5, 6, 7 and 8, 2014

The following inspections were inspected in conjunction with the RQI Inspection:

Follow up to Orders - H-000059-14, H-000060-14, H-000061-14, H-000062-14, H-000063-14, H-000920-14 and H-000921-14
Complaint inspection - H-000852-14
CIS inspections - H-000888-14, H-000896-14, H-000747-14, H-000710-14, H-000854-14, H-000929-14 and H-000930-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Co-Director of Care, Unit Coordinator, Behavioural Support of Ontario Manager, Registered staff, Personal Support Workers (PSW), Housekeepers, Restorative Care Coordinator, Food Service Manager, Regional Nutrition Manager, Dietitian (RD), Volunteer Services Coordinator, Physiotherapist (PT), Family and Resident Council Presidents, families and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, and reviewed documents including but not limited to: clinical health records, policies and procedures, menus and meeting minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that residents, including resident #501, #507, and #508, had the right to be protected from abuse.

A) Resident #500 had been identified as having responsive behaviours. On an identified date in June 2014, resident #500 went into resident #501's room, resident #501 asked resident #500 to leave the room which upset resident #500. This altercation resulted in resident #500 becoming physically aggressive towards resident #501.

B) Resident #503 was admitted in May 2014 and had been identified as having responsive behaviours. On an identified date in June 2014, resident #503 was observed by a staff member to be touching a resident of the opposite sex in a sexually inappropriate manner, which was non-consensual.

C) Resident #504 was witnessed by staff to be touching resident #507 in a sexually inappropriate manner which was non-consensual. [s. 3. (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 ensure that residents have the right to be protected from abuse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

During family interview in Stage 1 of the Resident Quality Inspection it was noted that resident's wish was to have their face shaved and on numerous occasions when family visited resident's face was not shaved. Resident's plan of care was reviewed and did not address resident's preferences to be shaved. Interview with a PSW, a regular staff on the unit who provided direct care to resident #103 identified that she was aware of resident's preferences but did find resident unshaved a few times. Registered staff confirmed that the plan of care should have included resident's preferences to be shaved. The plan of care did not provide clear direction to staff that provided care to resident and assisted with personal hygiene. [s. 6. (1) (c)]

2. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #131 had two 3/4 rails used while in bed as a restraint. The care plan and kardex identified that the resident used two 3/4 rails up in bed and needed to be monitored every hour. The Point of Care (POC) documentation used by PSWs identified the use of one bed rail for resident #131 and directed staff to monitor resident every shift. The PSW on 2 North confirmed that the information on POC was wrong but staff knew that the resident had both rails applied and did monitor resident frequently. Restorative Coordinator confirmed that the POC did not provide clear direction to staff and needed to be changed with the correct interventions. [s. 6. (1) (c)]

3. The licensee did not ensure that the care set out in the plan of care was provided to resident #204 as specified in their plan of care.

Resident #204’s plan of care, including the document the home refers to as the care plan and the master diet list, stated that the resident is to receive double portions at meals to maintain weight and adequate nutrition, and to be served first, as soon as they enter the dining room as they do not like to sit too long due to discomfort, agitation, and noise level. During observation of lunch meal service on August 6, 2014, the resident did not receive double portions and was not served first. [s. 6. (7)]

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 ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident and the care set out in the plan of care was provided to all residents as specified in their plan of care, to be implemented voluntarily.

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 did not ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; the home's current policy and procedure is not in compliance with all applicable requirement under the Act.

Review of the home's Falls Prevention policy - Titled: Resident Rights, Care and Services - Required Programs - Falls Prevention and Management - Program, effective date: September 16, 2013 does not include that when a resident who has fallen the resident is assessed and that where the condition or circumstances of the resident require, the staff are to conduct a post fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls.

Interview with the Restorative Care Coordinator on August 7, 2014, confirmed that the home currently does not have an clinically appropriate assessment instrument for post fall assessment that is specifically designed for any residents who have fallen to be completed by the registered staff. [r.8(1)a]

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 ensure 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;, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee did not ensure that all residents were provided with food that was adequate in quantity.

A. During observation of lunch meal service on August 6, 2014, dietary staff was observed serving residents one half of a cheese dreams sandwich when they required a small portion intervention. The production sheet and therapeutic spreadsheet stated that a small portion intervention serving remains one whole sandwich. Interview with the Regional Nutrition Manager (NM) confirmed that residents should have received one whole sandwich and that they were not provided with the adequate protein during the lunch meal.

B. The staff who prepared the baked custard for lunch on August 6, 2014, stated that no diet version was prepared, and that residents just receive a half portion of the regular custard. The home's therapeutic spreadsheet confirmed that the residents are to receive the same serving size of the diet version. The residents were observed receiving half portions of custard, thus receiving half of the serving size they required for dessert. [s. 11. (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 ensure that all residents were provided with food and fluids that are safe, adequate in quantity, nutritious and varied, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee did not ensure alternatives to the use of a PASD (personal assistance services device) have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

Resident #103 and #112 were observed using one 3/4 bed rail while in bed. The review of residents’ health records indicated that there was no assessment done and the home did not ensure alternatives have been considered. The Restorative Coordinator confirmed that one bed rail was not considered as a PASD or restraint therefore no assessment was completed for the use of bed rails for both residents. [s. 33. (4) 1.]

2. The licensee did not ensure that the use of a PASD for residents #103 and #112 was approved by, any person provided for in the regulations.

Residents #103 and #112 had one 3/4 rails applied while in bed. Clinical records for both residents were reviewed and there were no documented approvals for the use of the bed rails as a PASD . The Restorative Coordinator confirmed that approvals were not obtained for the use of the bed rails as a PASD. [s. 33. (4) 3.]

3. The licensee did not ensure that the use of the PASD was consented to by the resident or, if the resident is incapable, a substitute decision-maker (SDM) of the resident with authority to give consent.

Residents #103 and #112 had one 3/4 bed rail applied while in bed. Clinical records were reviewed and identified that substitute decision maker (SDM) did not provide consent for the bed rails to be used as PASD . The Restorative Coordinator confirmed that bed rails were not consented by SDM to be used as a PASD. [s. 33. (4) 4.]

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 ensure alternatives to the use of a PASD (personal assistance services device) have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living and that the use of a PASD for residents are approved by, any person provided for in the regulations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (1) This section and sections 69 to 78 apply to,
(a) the organized program of nutrition care and dietary services required under clause 11 (1) (a) of the Act; and O. Reg. 79/10, s. 68 (1).
(b) the organized program of hydration required under clause 11 (1) (b) of the Act. O. Reg. 79/10, s. 68 (1).

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. There was not an organized program of nutrition care and dietary services.

The noon meal service start time was noted to be 1200 hours in both dining rooms, however meal service was observed to be very lengthy in the first floor dining room when observed on July 30 and August 6, 2014. On both occasions, the last table was not served their soup until 1230 hours and their entrées until 1255 hours. The home has two very large dining rooms consisting of 16 tables of four and one steam table for each dining room from which all of the entrees were plated by one staff member. Interview with residents and a family member during Stage 1 of the RQI confirmed it is a common occurrence in both dining rooms that residents are waiting for long periods of time for their food, one resident stating they often get “shaky” by the time their meal comes. Interview with the Resident's Council President and review of Food Committee Meeting minutes confirmed this issue has been brought forward to the home. [s. 68. (1)]

2. The licensee did not ensure that there was a system to monitor and evaluate the food and fluid intake of all residents with identified risks related to nutrition and hydration.

The home's “Hydration” Policy (revised October 7, 2013) stated that at the end of each meal and snack, the PSW is to document each resident's daily intake on Point of Care (POC). Interview with front line and management staff confirmed that PSWs are responsible for tracking each resident's food and fluid intake on POC. Review of resident #104's health records, who is at a high nutritional risk, demonstrated that not all food and fluid intake is being documented as many submissions have been left blank. Review of resident #104, #137, and #115's health records also demonstrate blank intake submissions. In a nutritional assessment, commenting on resident #104's fluid intake and hydration status, the RD stated they “question accuracy of documentation as many values are missing”. [s. 68. (2) (d)]

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 ensure that a system to monitor and evaluate the food and fluid intake of all residents with identified risks related to nutrition and hydration and that the organized program of nutrition care and dietary services required under clause 11(1)(a) of the Act, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the planned menu items were offered and available at each meal and snack.

A) On August 6, 2014, the therapeutic menu for a vegetarian diet indicated that vegetarian beef tacos were to be prepared as a second option however, interview with the cook confirmed this was not prepared or available, stating that only one vegetarian option is prepared per meal for the resident, and if they do not like that item then something else can be requested. As a result, resident #205 was not provided with two choices during the lunch meal.

B) The therapeutic spreadsheet indicated minestrone soup was to be prepared for the vegetarian diet. Interview with the cook and observation confirmed this was not prepared or available to resident #205.

C) On August 7, 2014, the therapeutic menu for a modified diabetic renal diet indicated that a toasted plain omelet was to be prepared as a second option, however interview with the cook and observation confirmed only one renal option was prepared for the resident. As a result, resident #117 was not provided with two choices during the lunch meal. [s. 71. (4)]

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 ensure that the planned menu items were offered and available at each meal and snack, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

**s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).**

**s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).**

**s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).**

Findings/Faits saillants :

1. The licensee did not ensure that food production system included standardized recipes for all menus.

A) The recipe for French onion soup indicated preparation of the items on site using fresh ingredients, however the FSM confirmed that this soup, along with some of the other soups, are outsourced and are not prepared in the home.

B) Observation of the kitchen's recipe book confirmed there was no recipe for pureed bread. This was confirmed by the cook.

C) The production sheets for several days in the home's week two and week three

menu cycles indicate “POS” (Point of Service) and zero total portions for all textures of white and whole wheat bread, which is served at every meal. Interview with the Regional NM confirmed that there is no direction for staff on how much bread to prepare at each meal, and that there should be standardized production values for these items. [s. 72. (2) (c)]

2. The licensee did not ensure that all food and fluids in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

Food quality was compromised as recipes were not always available or followed and production sheets were not updated appropriately to guide food production.

A) The recipe for the “lite” cheese dreams sandwich, to be served to residents on restricted energy diets and modified fat diets, stated that light cheese was to be used. Observation and interview with the cook on August 6, 2014, confirmed regular cheese was used for all sandwiches.

B) The recipe for the pureed cheese dreams sandwich called for buns, cheese, and hot 2% milk to be added to a food processor. The cook confirmed that they prepared the item by adding buns, cheese, ham, and hot vegetable broth to the food processor, and that no milk was used.

C) The recipe for the Asian slaw called for cabbage, carrots, homemade dressing and herbs to be used. Observation and interview with the cook confirmed an outsourced dressing was used and no herbs were added.

D) The recipe for diet baked custard (regular and pureed) called for the same measurements as the regular custard, however sugar substitute was to be used in replacement of sugar. The staff who prepared the custard stated that no diet version was prepared, and that residents just receive a half portion of the regular custard. The home’s therapeutic spreadsheet confirmed that the residents are to receive the same serving size of the diet version.

E) The production sheet for the “lite” cheese dream sandwiches (which is made with light cheese and no bacon, to be served to residents on reduced energy and modified fat diets) demonstrated zero portions were to be prepared, however observation and interview with the cook confirmed that approximately 20 portions were prepared

without bacon. As a result, nearing the end of lunch service on the first floor on August 6, 2014, observation and interview with staff confirmed they ran out of regular sandwiches with bacon, resulting in several residents receiving the sandwich without bacon. [s. 72. (3) (a)]

3. The licensee did not ensure that all food and fluids were served to prevention contamination.

During lunch meal service on August 6, 2014, a staff member serving the food was observed multiple times using their hands along with tongs to pick up the cheese dreams sandwiches that were stuck to the pan and placing them onto the residents’ plates. [s. 72. (3) (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 ensure that food production system included standardized recipes for all menus, that all food and fluids in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality and that all food and fluids were served to prevention contamination, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that foods and fluids were being served at safe and palatable temperatures.

The home's recipe sheets indicated that cold foods must be held at a maximum of 4°C. Temperatures were taken nearing the end of lunch service on August 6, 2014. The temperatures of the probed items were as follows: regular custard 15.8°C, pureed custard 14.3°C, and minced fruit 14.0°C on the second floor; and regular custard 16.8°C and pureed custard 15.3°C on the first floor. [s. 73. (1) 6.]

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 ensure that foods and fluids were being served at safe and palatable temperatures, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to a resident, including resident #500, under a program, including assessments, reassessments and interventions were documented.

A) On an identified date in June 2014, resident #500 had a physical altercation with resident #501.

A review of the clinical records indicated that the reassessments and the interventions had not been documented. Resident #500's behaviour care plan identified that the resident had responsive behaviours towards staff. It was not documented that resident #500 was physically aggressive towards co-residents. Interview with the registered staff and the BSO staff confirmed that the home had implemented strategies to minimize any further risk of altercations and had increased monitoring however, these interventions were not documented.

It was confirmed by the Director of Care that the reassessments and interventions had not been documented. [s. 30. (2)]

WN #11: 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 did not 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.

Review of resident #402's clinical records confirmed that the resident was admitted to the home in September 2013 and was assessed to be at high risk for falls and intervention and strategies were put in place to minimize falls. The resident fell on an identified date in June 2014 at which time the resident sustained multiple injuries and was sent to hospital for further assessment.
Further review of the resident's electronic and hard copy chart and interview with the Restorative Care Coordinator indicated that the home had not completed a post fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls for the fall the resident sustained. [s. 49. (2)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_214146_0011	147
LTCHA, 2007 S.O. 2007, c.8 s. 33. (4)	CO #005	2013_210169_0032	561
O.Reg 79/10 s. 44.	CO #001	2013_210169_0032	147
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #004	2013_210169_0032	147
O.Reg 79/10 s. 89. (1)	CO #002	2013_210169_0032	147
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Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs