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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 11, 2020	2020_633577_0004	022591-19, 023150-19, 024255-19	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street THUNDER BAY ON P7B 5G7

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

Bethammi Nursing Home
63 Carrie Street THUNDER BAY ON P7A 4J2

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

DEBBIE WARPULA (577)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 14-17, and 20-23, 2020.

The following intakes were inspected during this Critical Incident System (CIS) Inspection:
- Two intakes related to a fall and fracture; improper/incompetent treatment; and
- One intake related to a fall and fracture.

Complaint (CO) Inspection #2020_633577_0003 was conducted concurrently with this CIS Inspection.

Findings of non-compliance pursuant to the Long-Term Care Homes Act (LTCHA), 2007, s. 19. and Ontario Regulation (O. Reg.) 79/10, s. 36. identified during this inspection have been issued in the Complaint report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Clinical Manager, Registered Nurses (RNs), Best Practice Registered Nurse (Best Practice RN), Resident Assessment Instrument (RAI) Coordinator, Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviwed employee files and training records, reviewed relevant health care records, and various policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

3 WN(s)
1 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 O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home.

a) A Critical Incident System (CIS) report was received by the Director on an identified date, related to resident #006 who had a specified incident and suffered an injury. The report indicated that during the evening of an identified date, resident #006 had been found on their bedroom floor, and an identified number of hours later, they were sent to the hospital.

A review of the home’s policy, “Fall Prevention and Management Program, RC-15-01-01", revised August 2019, indicated that if a resident experienced an unwitnessed fall, staff were to have completed a “Clinical Monitoring Record” which entailed an assessment of vital signs, neuro vital signs, pain assessment and changes in behaviour, every hour for four hours, then every eight hours for 72hrs; the neuro vital signs were to have included the resident’s level of consciousness, ability to move/handgrips, and pupil response. A fall with serious injury as assessed by the nurse would have resulted in the resident's transfer to a hospital. At each shift for 72hrs, staff were required to assess vital signs, pain, bruising, change in functional status, cognitive status and changes in range

in motion (ROM).

During a record review, Inspector #577 found that a particular assessment record had been implemented to monitor specified assessments, but they were not completed every hour for four hours. A particular assessment had not been completed at two specified hours; and their assessment was documented as ‘refused’; another particular assessment had not been completed at a specified hour; and another particular assessment wasn’t assessed or documented.

During an interview with RPN #111, they reported to Inspector #577 that staff were required to initiate a particular assessment record after an unwitnessed specified incident; which included three particular assessments, every hour for four hours and every eight hours for 72 hours.

During an interview with the Director of Care (DOC), they confirmed that staff were not following and implementing the home’s Falls Program, as staff had not completed the required particular assessments.

During an interview with the Administrator, they confirmed with Inspector #577 that the staff had not implemented the Falls program; two particular assessments were not completed every hour for four hours; and another particular assessment was not completed as required.

b) Critical Incident System (CIS) reports were received by the Director on two identified dates, related to resident #007 who had a specified incident and suffered an injury. The report indicated that the resident was found on the floor in a particular position at an identified time, and was transferred back to bed without the assistance of specific equipment. The report further indicated that during the transfer, the resident could not engage in a certain activity; and was later transferred to the hospital for an assessment. The second report indicated improper/incompetent care of the resident, as it pertained to the specific incident.

A review of the home’s policy, “Fall Prevention and Management Program, RC-15-01-01", revised August 2019, indicated that if a resident experienced an unwitnessed fall, staff were to have completed a “Clinical Monitoring Record” which entailed an assessment of vital signs, neuro vital signs, pain assessment and changes in behaviour, every hour for four hours, then every eight hours for 72hrs; the 'Post Fall Clinical Pathway', indicated that staff were to move the resident using a mechanical lift after a

fall, following assessment by the nurse and approval for transfer.

During a record review, Inspector #577 found that a particular assessment record had been implemented, but the particular assessment was not completed every hour; three particular assessments were documented initially after the specified incident, and not repeated hourly.

A review of the physician order on an identified date, at a specific time, directed staff to send the resident to the hospital for an assessment.

A progress note related to the specified incident, indicated that the resident was transferred to the hospital at an identified time.

A review of the home's internal "Incident Review" related to resident #007's specified incident on an identified date, indicated that at the time of the specified incident, the resident was assisted to lift themselves off the floor, expressed pain and the inability to perform a particular activity; the resident suffered an injury and further, that when a resident experienced a specific incident and could not get up on their own, specific equipment was to be used.

During an interview with RPN #112, they reported to Inspector #577 that at the time of resident #007's specified incident, they and PSW #113 were directed by RN #103 to transfer the resident off the floor, without the assistance of specific equipment. They further reported that they transferred the resident back to bed by assisting them to a particular position from the floor.

During an interview with RN #103, they reported to Inspector #577 that after resident #007's specified incident, PSW #113 and RPN #112 transferred the resident back to bed as a two person transfer without using specific equipment.

During an interview with the Assistant Clinical Manager, they reported to Inspector #577 that staff were required to initiate a particular assessment record after an unwitnessed specified incident; which included three particular assessments, every hour for four hours and every eight hours for 72 hours.

The DOC, together with Inspector #577, reviewed resident #007's particular assessment record and the DOC confirmed that staff had not completed the specified assessments, as required. They confirmed that within the home's Falls program, there was a pathway

that directed staff to move a resident using specific equipment after a specified incident, following the assessment by the nurse and approval for transfer. They further reported that staff should have used specific equipment when they transferred resident #007 off the floor, and staff had not implemented the Falls program. [s. 48. (1) 1.]

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other.

A Critical Incident System (CIS) report was received by the Director on an identified date, related to resident #006 who had a specified incident and suffered an injury. The report indicated that during the evening of an identified date, resident #006 had been found on their bedroom floor, and an identified number of hours later, they were sent to the hospital.

A record review of resident #006's progress notes on an identified date, documented by RN #114, indicated an assessment of the resident after their specified incident. They had noted that an identified area of the resident's body appeared to be in a particular position and the resident had difficulty performing a particular activity independently; a progress note at an identified time, indicated that the resident had been complaining of pain to an

identified area at two specific hours; at an identified time, the resident was unable to perform a particular activity and had been complaining of pain to a specific area of their body; at an identified time, the physician was notified and the resident was transferred to the hospital at an identified time.

Inspector #577 conducted a review of the home's "Incident Review" report related to resident #006's specified incident with injury from an identified date. The report indicated that the resident had an unwitnessed specified incident on an identified date and time, where the RPN assessed the resident and they transferred them into bed with specific equipment. At an identified time, the RN assessed the resident and noted that an identified area of the resident's body appeared to be in a particular position and the resident had difficulty performing a particular activity. At two identified hours, the resident complained of specific pain to two identified areas of their body, and at an identified time, the resident complained of pain to another area of their body with attempted movement and was sent to the hospital at an identified time. The report indicated that the resident was showing signs indicative of a specified injury immediately after the specified incident; had nursing appreciated those signs at the time, their transfer to the hospital would have been sooner and may have experienced less pain; the document further indicated that when residents had displayed signs of a suspected specified injury, the resident should have been left in the position which they had been found and been sent to the hospital promptly via ambulance for an assessment.

During an interview with RN #115, they reported that if they had assessed a resident's body to have been in a particular position after a specified incident, they were to have notified the physician and transfer the resident to the hospital for an assessment.

During an interview with RN #114, they reported to Inspector #577 that on their initial assessment of resident #006 they noted that an identified area of the resident's body was in a particular position, the resident was unable to perform a particular activity and they had suspected an injury; they called the physician hours later because the resident complained of pain to an identified area of their body and they were unable to perform a particular activity.

During an interview with the Assistant Clinical Manager, they reported that at the time when RN #114 had assessed resident #006, an identified area of their body appeared to have been in a particular position, and they should have sent the resident to the hospital for an assessment.

During an interview with the Administrator, they reported to Inspector #577 that RN #114 had failed to collaborate with the physician when they had noted a specified injury, and they should have notified the physician promptly. [s. 6. (4) (a)]

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. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

Critical Incident System (CIS) reports were received by the Director on two identified dates, related to resident #007 who had a specified incident and suffered an injury. The report indicated that the resident was found on the floor in a particular position at an identified time, and was transferred back to bed without the assistance of specific equipment. The report further indicated that during the transfer, the resident could not engage in a certain activity; and was later transferred to the hospital for an assessment. The second report indicated improper/incompetent care of the resident, as it pertained to the specific incident.

Inspector #577 reviewed the home's policy, "Care planning - RC-05-01-01", revised April 2017, which indicated that the care plan was a guide that directed care that was to be provided to the resident; individual resident care plans reflected specific information about a resident which included interventions required to produce expected outcomes.

A review of the home's policy, "Care and Comfort Rounds - RC-12-01-06", revised February 2017, indicated that the home would schedule regular care and comfort rounds at set intervals to proactively anticipate resident needs related pain, positioning, prompted toileting, proximity to personal items and other comfort and safety issues. Appendix 1 of the policy indicated that comfort rounds were scheduled every two hours.

A review of resident #007's care plan interventions related to a particular focus, indicated that the resident required assistance with continence care at identified times.

A review of the home's investigation notes related to an identified date, indicated the following:
-video footage indicated that the resident had been checked and received continence care at an identified time; they were not checked over a specified time period; an emergency bell had been activated by the housekeeper at a specified time.

During an interview with RN #103, they reported to Inspector #577 that on an identified date, they assisted resident #007 with continence care at an identified time, and resident #007 had not received assistance with continence changes at identified times.

During an interview with the DOC, they reported to Inspector #577 that care rounds were required every hour and resident #007's care plan indicated required continence care at identified times; they confirmed that the resident received assistance with continence at one particular time only, and video confirmed that the resident had not been checked over a specified time period. [s. 51. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

Issued on this 27th day of February, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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) :	DEBBIE WARPULA (577)
Inspection No. / No de l’inspection :	2020_633577_0004
Log No. / No de registre :	022591-19, 023150-19, 024255-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 11, 2020
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	Bethammi Nursing Home 63 Carrie Street, THUNDER BAY, ON, P7A-4J2
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Janine Black

To St. Joseph's Care Group, 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 :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

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

The licensee must be in compliance with Ontario Regulation (O. Reg.) 79/10, r. 48.
Specifically the licensee must:

a) Retrain registered and non registered staff member's on the home's policy, "Fall Prevention and Management Program, RC-15-01-01"; ensuring that the "Post Fall Clinical Pathway" and "Clinical Monitoring Record" is included.

b) The home will maintain a record of the retraining, what the training entailed, who completed the training and when the training was completed.

c) Conduct a knowledge audit of their staff's understanding of falls management best practices and policy/program.

d) Establish a falls management review committee to evaluate falls incidents with the goal of doing the following:
-identifying positive actions on behalf of incident respondents
-identifying any deficiency in the management of falls incidents, and
-make recommendations for actions where deficiencies are identified.
-Maintain a record of who participated in the committee, and what actions were taken.

Grounds / Motifs :

1. The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home.

a) A Critical Incident System (CIS) report was received by the Director on an identified date, related to resident #006 who had a specified incident and suffered an injury. The report indicated that during the evening of an identified date, resident #006 had been found on their bedroom floor, and an identified number of hours later, they were sent to the hospital.

A review of the home's policy, "Fall Prevention and Management Program, RC-15-01-01", revised August 2019, indicated that if a resident experienced an unwitnessed fall, staff were to have completed a "Clinical Monitoring Record" which entailed an assessment of vital signs, neuro vital signs, pain assessment

and changes in behaviour, every hour for four hours, then every eight hours for 72hrs; the neuro vital signs were to have included the resident's level of consciousness, ability to move/handgrips, and pupil response. A fall with serious injury as assessed by the nurse would have resulted in the resident's transfer to a hospital. At each shift for 72hrs, staff were required to assess vital signs, pain, bruising, change in functional status, cognitive status and changes in range in motion (ROM).

During a record review, Inspector #577 found that a particular assessment record had been implemented to monitor specified assessments, but they were not completed every hour for four hours. A particular assessment had not been completed at two specified hours; and their assessment was documented as 'refused'; another particular assessment had not been completed at a specified hour; and another particular assessment wasn't assessed or documented.

During an interview with RPN #111, they reported to Inspector #577 that staff were required to initiate a particular assessment record after an unwitnessed specified incident; which included three particular assessments, every hour for four hours and every eight hours for 72 hours.

During an interview with the Director of Care (DOC), they confirmed that staff were not following and implementing the home's Falls Program, as staff had not completed the required particular assessments.

During an interview with the Administrator, they confirmed with Inspector #577 that the staff had not implemented the Falls program; two particular assessments were not completed every hour for four hours; and another particular assessment was not completed as required.

b) Critical Incident System (CIS) reports were received by the Director on two identified dates, related to resident #007 who had a specified incident and suffered an injury. The report indicated that the resident was found on the floor in a particular position at an identified time, and was transferred back to bed without the assistance of specific equipment. The report further indicated that during the transfer, the resident could not engage in a certain activity; and was later transferred to the hospital for an assessment. The second report indicated improper/incompetent care of the resident, as it pertained to the specific

incident.

A review of the home's policy, "Fall Prevention and Management Program, RC-15-01-01", revised August 2019, indicated that if a resident experienced an unwitnessed fall, staff were to have completed a "Clinical Monitoring Record" which entailed an assessment of vital signs, neuro vital signs, pain assessment and changes in behaviour, every hour for four hours, then every eight hours for 72hrs; the 'Post Fall Clinical Pathway', indicated that staff were to move the resident using a mechanical lift after a fall, following assessment by the nurse and approval for transfer.

During a record review, Inspector #577 found that a particular assessment record had been implemented, but the particular assessment was not completed every hour; three particular assessments were documented initially after the specified incident, and not repeated hourly.

A review of the physician order on an identified date, at a specific time, directed staff to send the resident to the hospital for an assessment.

A progress note related to the specified incident, indicated that the resident was transferred to the hospital at an identified time.

A review of the home's internal "Incident Review" related to resident #007's specified incident on an identified date, indicated that at the time of the specified incident, the resident was assisted to lift themselves off the floor, expressed pain and the inability to perform a particular activity; the resident suffered an injury and further, that when a resident experienced a specific incident and could not get up on their own, specific equipment was to be used.

During an interview with RPN #112, they reported to Inspector #577 that at the time of resident #007's specified incident, they and PSW #113 were directed by RN #103 to transfer the resident off the floor, without the assistance of specific equipment. They further reported that they transferred the resident back to bed by assisting them to a particular position from the floor.

During an interview with RN #103, they reported to Inspector #577 that after resident #007's specified incident, PSW #113 and RPN #112 transferred the

resident back to bed as a two person transfer without using specific equipment.

During an interview with the Assistant Clinical Manager, they reported to Inspector #577 that staff were required to initiate a particular assessment record after an unwitnessed specified incident; which included three particular assessments, every hour for four hours and every eight hours for 72 hours.

The DOC, together with Inspector #577, reviewed resident #007's particular assessment record and the DOC confirmed that staff had not completed the specified assessments, as required. They confirmed that within the home's Falls program, there was a pathway that directed staff to move a resident using specific equipment after a specified incident, following the assessment by the nurse and approval for transfer. They further reported that staff should have used specific equipment when they transferred resident #007 off the floor, and staff had not implemented the Falls program. [s. 48. (1) 1.]

The decision to issue a Compliance Order (CO) was based on the severity which indicated actual harm, and the scope, which indicated that there was a pattern of non compliance. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation, as follows:
- a Voluntary Plan of Correction (VPC) was issued from a Resident Quality Inspection (RQI)
#2019_768693_0005, on April 15, 2019. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2020

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 : 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. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee must be in compliance with LTCHA, 2007 S. O. 2007, s. 6. Specifically the licensee must:

a) Retrain registered staff member's on hip assessments post fall; to include signs of a suspected hip fracture, proper management, documentation, notifying physician and transfer to the hospital.

b) The home will maintain a record of the retraining, what the training entailed, who completed the training and when the training was completed.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other.

A Critical Incident System (CIS) report was received by the Director on an identified date, related to resident #006 who had a specified incident and suffered an injury. The report indicated that during the evening of an identified date, resident #006 had been found on their bedroom floor, and an identified number of hours later, they were sent to the hospital.

A record review of resident #006's progress notes on an identified date, documented by RN #114, indicated an assessment of the resident after their

specified incident. They had noted that an identified area of the resident's body appeared to be in a particular position and the resident had difficulty performing a particular activity independently; a progress note at an identified time, indicated that the resident had been complaining of pain to an identified area at two specific hours; at an identified time, the resident was unable to perform a particular activity and had been complaining of pain to a specific area of their body; at an identified time, the physician was notified and the resident was transferred to the hospital at an identified time.

Inspector #577 conducted a review of the home's "Incident Review" report related to resident #006's specified incident with injury from an identified date. The report indicated that the resident had an unwitnessed specified incident on an identified date and time, where the RPN assessed the resident and they transferred them into bed with specific equipment. At an identified time, the RN assessed the resident and noted that an identified area of the resident's body appeared to be in a particular position and the resident had difficulty performing a particular activity. At two identified hours, the resident complained of specific pain to two identified areas of their body, and at an identified time, the resident complained of pain to another area of their body with attempted movement and was sent to the hospital at an identified time. The report indicated that the resident was showing signs indicative of a specified injury immediately after the specified incident; had nursing appreciated those signs at the time, their transfer to the hospital would have been sooner and may have experienced less pain; the document further indicated that when residents had displayed signs of a suspected specified injury, the resident should have been left in the position which they had been found and been sent to the hospital promptly via ambulance for an assessment.

During an interview with RN #115, they reported that if they had assessed a resident's body to have been in a particular position after a specified incident, they were to have notified the physician and transfer the resident to the hospital for an assessment.

During an interview with RN #114, they reported to Inspector #577 that on their initial assessment of resident #006 they noted that an identified area of the resident's body was in a particular position, the resident was unable to perform a particular activity and they had suspected an injury; they called the physician

hours later because the resident complained of pain to an identified area of their body and they were unable to perform a particular activity.

During an interview with the Assistant Clinical Manager, they reported that at the time when RN #114 had assessed resident #006, an identified area of their body appeared to have been in a particular position, and they should have sent the resident to the hospital for an assessment.

During an interview with the Administrator, they reported to Inspector #577 that RN #114 had failed to collaborate with the physician when they had noted a specified injury, and they should have notified the physician promptly. [s. 6. (4) (a)]

The decision to issue a Compliance Order (CO) was based on the severity which indicated actual harm, the scope was isolated. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation, as follows:
- a Voluntary Plan of Correction (VPC) was issued from Follow Up Inspection #2019_740621_0023 on August 20, 2019;
-a Voluntary Plan of Correction (VPC) was issued from Resident Quality Inspection (RQI) #2019_768693_0005 on April 15, 2019;
-a Voluntary Plan of Correction (VPC) was issued from Critical Incident System (CIS) Inspection #2019_703625_0003 on February 8, 2019; and
-a Voluntary Plan of Correction (VPC) was issued from RQI #2017_463616_0007 on August 2, 2017.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 11th day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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