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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 20, 2022	2021_673672_0040	011845-21, 018650-21, 020035-21	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue Woodstock ON N4S 3V9

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

Caressant Care Lindsay Nursing Home
240 Mary Street West Lindsay ON K9V 5K5

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

JENNIFER BATTEN (672)

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): December 13 to 17, 23 and 24, 2021

A Complaint inspection (Inspection #2021_673672_0039) was conducted concurrent to this inspection. Findings of non-compliance were also issued within that report.

The following intakes were completed during this Critical Incident System inspection:

One intake related to the an identified responsive behaviour of a resident in the home.

One intake related to an unexpected death of a resident.

One intake related to a resident fall with injury.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Resident Care Coordinator (RCC), Behavioural Support Ontario Lead (BSO RPN), Business Office Manager, Acting Food and Nutrition Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Physiotherapists (PT) and physio assistants (PTA), Dietary Aides (DAs), Housekeepers and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Falls Prevention, Prevention of Abuse and Neglect, Complaints, Pain Management and Responsive Behaviours. The Inspector(s) also observed staff to resident and resident to resident care and interactions and infection control practices in the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **4 WN(s)**
- **1 VPC(s)**
- **3 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. 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #006, #011 and #021, who required assistance with eating.

During observations conducted during the inspection, resident #021 was observed to receive assistance from PSW #114 with their food and fluid intake, while in an unsafe position. PSW #114 indicated that was the position the resident "always" ate in, due to specified concerns. Review of resident #021's health care record and current written plan of care indicated they had identified diagnoses and were at nutritional risk related to several concerns.

Resident #006 was observed to have their meal served and was attempting to eat independently while in bed, while the head of the bed was in a flat position. RPN #109 indicated resident #006 could put the head of the bed up into a raised position on their own, should they wish to do so and was capable of making their own decisions regarding positioning during food and fluid intake. Review of resident #006's health care record and current written plan of care indicated they had identified diagnoses, required a specified level of assistance from an identified number of staff for activities of daily living which indicated they could not raise the head of the bed independently nor make safe decisions related to their positioning during food/fluid intake and were at nutritional risk. On a later date, resident #006 was also observed to have their meal served in their bedroom while in an unsafe position.

Resident #011 was observed to have their meal served to their bedroom. The resident was attempting to eat independently while in bed, with the head of the bed in a flat position and the meal had been served to the cabinet bedside the bed, as there was no overbed table present in the room. Resident #011 was observed attempting to eat while lying in bed and propping themselves up on their arm. Review of resident #011's health care record and current written plan of care indicated they had identified diagnoses and required an identified level of assistance from an identified number of staff for activities of daily living.

During meal and snack observations, Inspectors also observed staff members assisting residents with their intake while standing above the residents instead of being seated beside them.

During separate interviews, RPN #104, the DOC and the Acting Nutrition Services Manager (ANSM) indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake in order to minimize the risk of

choking and/or aspirating. The DOC further indicated the expectation in the home was for all staff members to be properly seated beside the resident and not stand while assisting with food and/or fluid intake, to reduce the risk of resident discomfort due to improper positioning during intake and/or possibly contributing to the resident choking and/or aspirating.

By not ensuring residents were in safe positions during food and fluid intake, residents were placed at risk of possible episodes of choking and/or aspiration.

Sources: Observations conducted, interviews with PSWs, RPN #104, DOC and the ANSM. [s. 73. (1) 10.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the internal Head Injury Routine policy was complied with.

According to LTCHA, 2007. O. Reg. 79/10, r. 48 (1) the falls prevention and management program is a required organized program in the home.

O. Reg. 79/10, r. 49 (2) states that 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.

Review of the internal head Injury routine policy indicated that when a resident was placed on head injury routine assessment, staff were to use an identified form and follow the timeframes for assessment indicated for 72 hours.

A Critical Incident Report was submitted to the Director related to the unexpected death of resident #005. The CIR indicated that during a specified period of time, the resident sustained an identified number of falls. Following one fall, the resident developed identified symptoms. Later, the resident sustained a further number of unwitnessed falls, and was noted to have developed other identified symptoms. Several days later, the resident was transferred to hospital where they passed away a few hours later. Review of the head injury routine assessments indicated they had not been completed according to the internal policy, as there were times when staff did not assess the resident as they documented the resident was sleeping. There were also times when assessment sections were left completely blank.

A multifaceted complaint was received by the Director from resident #003's Substitute Decision Maker (SDM). One of the complaints were related to resident #003 frequently falling and the treatment received in the home afterwards. Resident #003 was noted to be at risk for falls and sustained an identified number of falls during a specified period of time. Resident #003's health care record indicated the resident was placed on head injury routine following one of the falls. Review of the head injury routine assessment indicated it had not been completed according to the internal policy, as there were times when staff documented the resident was sleeping, or there were sections of the assessment left blank.

Inspector expanded the scope of the inspection to include head injury routine assessments completed for resident #010.

Resident #010 was noted to be at risk for falls, and RPN #109 indicated they were frequently placed on head injury routine. Review of resident #010's health care record indicated the resident was placed on head injury routine multiple times during a specified period of time. Review of the head injury routine assessments indicated they had not been completed according to the internal policy, as there were times when staff did not complete the assessment as they documented the resident was sleeping, or there were

times when the assessment sections were left blank.

During separate interviews, RN #115, RPN #109 and the Executive Director indicated the expectation in the home was for head injury routine assessments to be completed in full according to the internal policy. RN #115, RPN #109 and the Executive Director further indicated it had been a well known, long standing concern throughout the home that head injury routine assessments were not being completed as required, therefore a new electronic documentation system was being implemented, specific to head injury routine assessments, which would assist in ensuring the assessments were completed on time and in full, as required. The Executive Director reviewed the head injury routines completed for residents #003, #005 and #010 and verified they had not been completed according to the internal policy. By not completing head injury routine assessments appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Critical Incident Report; Complaint received from resident #003's SDM; internal head injury routine policy; residents #003, #005 and #010's Post Fall and Head Injury Routine assessments; ; Resident #003's written plan of care; Resident #005's written plan of care; interviews with RN #115, RPN #109 and the Executive Director. [s. 8. (1)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005 was protected from neglect.

For the purposes of the Act and Regulation, "Neglect" is defined as:

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

A Critical Incident Report was submitted to the Director related to the unexpected death of resident #005. The CIR indicated that during a specified period of time, the resident sustained an identified number of falls. Following one fall, the resident developed identified symptoms. Later, the resident sustained a further number of unwitnessed falls, and was noted to have developed other identified symptoms. Several days later, the resident was transferred to hospital where they passed away a few hours later.

Review of the progress notes and MDS Assessment indicated that prior to the falls, the resident required an identified level assistance with activities of daily living, but following the falls required a different level of assistance due to a significant change in status.

Review of the post fall assessments and progress notes indicated that neither the physician nor nurse practitioner were directly notified following any of resident #005’s falls or about the symptoms exhibited until the resident was transferred to hospital.

During separate interviews, RN #115 and the Executive Director indicated it was a routine practice to document in a resident’s progress notes and/or in the post fall assessment whenever the physician or nurse practitioner were contacted. RN #115 verified the physician or nurse practitioner had not been notified following review of the post fall assessments, which indicated notations had been made in the physician’s communication book regarding the falls, instead of contacting the physician directly. The Executive Director indicated the expectation in the home was for the nurse to contact the physician or nurse practitioner directly to discuss a resident’s health condition, if changes were observed in the resident over a short period of time, especially following multiple falls which resulted in being placed on head injury routine. The Executive Director further indicated they were aware that further education and training was required for the Registered staff in the home related to neurological assessments, and they had been providing the same since resident #005’s unexpected death.

Sources: Critical Incident Report; resident #005's MDS Assessment, progress notes and post fall assessments; interviews with RN #115, the DOC and Executive Director. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

During observations conducted, Inspector observed an identified number of medicated treatment creams in resident #007's bedroom and bathroom. During separate interviews, RPN #109 and the DOC indicated the expectation in the home was for medicated treatment creams to be kept secured and locked at all times when not being utilized by staff.

By not ensuring that drugs were stored in an area or medication cart that was kept secured and locked, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of multiple medicated treatment creams and medications.

Sources: Observations conducted; interviews with PSWs, RPNs and the DOC. [s. 129. (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 to ensure that drugs are stored in an area or medication cart that is used exclusively for drugs and drug-related supplies and is kept secured and locked, to be implemented voluntarily.

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

Issued on this 21st day of January, 2022

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) :	JENNIFER BATTEN (672)
Inspection No. / No de l'inspection :	2021_673672_0040
Log No. / No de registre :	011845-21, 018650-21, 020035-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 20, 2022
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, Woodstock, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Lindsay Nursing Home 240 Mary Street West, Lindsay, ON, K9V-5K5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Green

To Caressant-Care Nursing and Retirement Homes Limited, 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. 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with section s. 73. (1) 10 of O. Reg. 79/10 of the LTCHA.

Specifically, the licensee must:

1. Conduct daily audits of meal services for a period of two weeks to ensure safe positioning of residents during meals is occurring. If unsafe positioning is noted, provide immediate redirection and re-education. Keep a documented record of the audits completed and make available for Inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #006, #011 and #021, who required assistance with eating.

During observations conducted during the inspection, resident #021 was observed to receive assistance from PSW #114 with their food and fluid intake, while in an unsafe position. PSW #114 indicated that was the position the resident "always" ate in, due to specified concerns. Review of resident #021's health care record and current written plan of care indicated they had identified diagnoses and were at nutritional risk related to several concerns.

Resident #006 was observed to have their meal served and was attempting to eat independently while in bed, while the head of the bed was in a flat position. RPN #109 indicated resident #006 could put the head of the bed up into a raised position on their own, should they wish to do so and was capable of making their own decisions regarding positioning during food and fluid intake. Review of resident #006's health care record and current written plan of care indicated they had identified diagnoses, required a specified level of assistance from an identified number of staff for activities of daily living which indicated they could not raise the head of the bed independently nor make safe decisions related to their positioning during food/fluid intake and were at nutritional risk. On a later date, resident #006 was also observed to have their meal served in their bedroom while in an unsafe position.

Resident #011 was observed to have their meal served to their bedroom. The resident was attempting to eat independently while in bed, with the head of the

bed in a flat position and the meal had been served to the cabinet bedside the bed, as there was no overbed table present in the room. Resident #011 was observed attempting to eat while lying in bed and propping themselves up on their arm. Review of resident #011's health care record and current written plan of care indicated they had identified diagnoses and required an identified level of assistance from an identified number of staff for activities of daily living.

During meal and snack observations, Inspectors also observed staff members assisting residents with their intake while standing above the residents instead of being seated beside them.

During separate interviews, RPN #104, the DOC and the Acting Nutrition Services Manager (ANSM) indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake in order to minimize the risk of choking and/or aspirating. The DOC further indicated the expectation in the home was for all staff members to be properly seated beside the resident and not stand while assisting with food and/or fluid intake, to reduce the risk of resident discomfort due to improper positioning during intake and/or possibly contributing to the resident choking and/or aspirating.

By not ensuring residents were in safe positions during food and fluid intake, residents were placed at risk of possible episodes of choking and/or aspiration.

Sources: Observations conducted, interviews with PSWs, RPN #104, DOC and the ANSM.

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

Severity: There was actual risk of harm to the residents from choking due to being assisted with food and/or fluid intake while not seated in a fully upright position and/or by staff standing above the resident while assisting with their intake.

Scope: The scope of this non-compliance was widespread, as three or more residents were observed attempting to eat while in an unsafe position.

Compliance History: Previous non-compliance was issued to the licensee under

different subsections of the legislation within the previous 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2022

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 :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with section s. 8 (1) of O. Reg. 79/10.

Specifically, the licensee must:

1. Educate the Registered staff on the internal policy entitled ³Post Fall Head Injury Routine"; Procedure Number: NP-S10-20.1; Revised/Reviewed: March 2021. Test the retention of this knowledge and a documented record must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure the internal Head Injury Routine policy was complied with.

According to LTCHA, 2007. O. Reg. 79/10, r. 48 (1) the falls prevention and management program is a required organized program in the home.

O. Reg. 79/10, r. 49 (2) states that 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.

Review of the internal head Injury routine policy indicated that when a resident

was placed on head injury routine assessment, staff were to use an identified form and follow the timeframes for assessment indicated for 72 hours.

A Critical Incident Report was submitted to the Director related to the unexpected death of resident #005. The CIR indicated that during a specified period of time, the resident sustained an identified number of falls. Following one fall, the resident developed identified symptoms. Later, the resident sustained a further number of unwitnessed falls, and was noted to have developed other identified symptoms. Several days later, the resident was transferred to hospital where they passed away a few hours later. Review of the head injury routine assessments indicated they had not been completed according to the internal policy, as there were times when staff did not assess the resident as they documented the resident was sleeping. There were also times when assessment sections were left completely blank.

A multifaceted complaint was received by the Director from resident #003's Substitute Decision Maker (SDM). One of the complaints were related to resident #003 frequently falling and the treatment received in the home afterwards. Resident #003 was noted to be at risk for falls and sustained an identified number of falls during a specified period of time. Resident #003's health care record indicated the resident was placed on head injury routine following one of the falls. Review of the head injury routine assessment indicated it had not been completed according to the internal policy, as there were times when staff documented the resident was sleeping, or there were sections of the assessment left blank.

Inspector expanded the scope of the inspection to include head injury routine assessments completed for resident #010.

Resident #010 was noted to be at risk for falls, and RPN #109 indicated they were frequently placed on head injury routine. Review of resident #010's health care record indicated the resident was placed on head injury routine multiple times during a specified period of time. Review of the head injury routine assessments indicated they had not been completed according to the internal policy, as there were times when staff did not complete the assessment as they documented the resident was sleeping, or there were times when the assessment sections were left blank.

During separate interviews, RN #115, RPN #109 and the Executive Director indicated the expectation in the home was for head injury routine assessments to be completed in full according to the internal policy. RN #115, RPN #109 and the Executive Director further indicated it had been a well known, long standing concern throughout the home that head injury routine assessments were not being completed as required, therefore a new electronic documentation system was being implemented, specific to head injury routine assessments, which would assist in ensuring the assessments were completed on time and in full, as required. The Executive Director reviewed the head injury routines completed for residents #003, #005 and #010 and verified they had not been completed according to the internal policy. By not completing head injury routine assessments appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Critical Incident Report; Complaint received from resident #003's SDM; internal head injury routine policy; residents #003, #005 and #010's Post Fall and Head Injury Routine assessments; ; Resident #003's written plan of care; Resident #005's written plan of care; interviews with RN #115, RPN #109 and the Executive Director.

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

Severity: There was actual risk of harm to the residents due to staff not completing head injury routine assessments appropriately, which could result in possible head injuries not being identified and/or treated appropriately.

Scope: The scope of this non-compliance was widespread, as three or more residents were observed to have been placed on head injury routine with incomplete neurological assessments.

Compliance History: Previous non-compliance was issued to the licensee under different subsections of the legislation within the previous 36 months. (672)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 28, 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 : 003

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 be compliant with section s.19 (1) of the LTCHA.

Specifically, the licensee must:

1. Create and submit a plan related to how the licensee will become compliant with s.19 (1) of the legislation, specific to resident neglect and how they will provide treatment, care, services and/or assistance required for resident health, safety or well-being when a resident's care needs change. The plan should also include how they will educate the Registered staff about normal and abnormal neurological assessment findings and when to communicate with the physician and/or nurse practitioner.
Submit the plan to Jennifer Batten at CentralEastSAO.MOH@ontario.ca.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #005 was protected from neglect.

For the purposes of the Act and Regulation, "Neglect" is defined as:

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

A Critical Incident Report was submitted to the Director related to the unexpected death of resident #005. The CIR indicated that during a specified period of time, the resident sustained an identified number of falls. Following one

fall, the resident developed identified symptoms. Later, the resident sustained a further number of unwitnessed falls, and was noted to have developed other identified symptoms. Several days later, the resident was transferred to hospital where they passed away a few hours later.

Review of the progress notes and MDS Assessment indicated that prior to the falls, the resident required an identified level assistance with activities of daily living, but following the falls required a different level of assistance due to a significant change in status.

Review of the post fall assessments and progress notes indicated that neither the physician nor nurse practitioner were directly notified following any of resident #005's falls or about the symptoms exhibited until the resident was transferred to hospital.

During separate interviews, RN #115 and the Executive Director indicated it was a routine practice to document in a resident's progress notes and/or in the post fall assessment whenever the physician or nurse practitioner were contacted. RN #115 verified the physician or nurse practitioner had not been notified following review of the post fall assessments, which indicated notations had been made in the physician's communication book regarding the falls, instead of contacting the physician directly. The Executive Director indicated the expectation in the home was for the nurse to contact the physician or nurse practitioner directly to discuss a resident's health condition, if changes were observed in the resident over a short period of time, especially following multiple falls which resulted in being placed on head injury routine. The Executive Director further indicated they were aware that further education and training was required for the Registered staff in the home related to neurological assessments, and they had been providing the same since resident #005's unexpected death.

Sources: Critical Incident Report; resident #005's MDS Assessment, progress notes and post fall assessments; interviews with RN #115, the DOC and Executive Director.

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

Severity: There was actual serious harm to the resident due to staff not properly assessing and collaborating with each other, which led to an untreated head injury.

Scope: The scope of this non-compliance was isolated, as only resident #005 was affected.

Compliance History: A Compliance Order was issued during Critical Incident System inspection #2020_643111_001, served to the licensee on November 16, 2020, with a compliance due date of February 12, 2021.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2022

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

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 20th day of January, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Batten

Service Area Office /
Bureau régional de services : Central East Service Area Office