Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 20, 2017	2017_547591_0008	008883-17, 009186-17	Complaint

Licensee/Titulaire de permis

DELCARE LTC INC.
4800 DUFFERIN STREET TORONTO ON M3H 5S9

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

CAWTHRA GARDENS LIMITED PARTNERSHIP
590 Lolita Gardens MISSISSAUGA ON L5A 4N8

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

NATASHA JONES (591)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 15, 16, and 17, 2017.

The following inspections were conducted concurrently with this inspection:

Complaint Inspection: 0091867-17 - related to injury and transfer to hospital post fall
Critical Incident Inspection: 008883-17 - related to injury and transfer to hospital post fall
Follow-Up Inspection: 002959-17 - related to provision of care as per plan of care in falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Instrument Assessment (RAI) Coordinator, Registered staff, personal support workers (PSWs), Residents, and Resident family members.
During the course of the inspection, the inspector reviewed resident health records, investigative notes, complaints logs and files, policies and procedures, and observed residents and care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 failed to ensure residents were not neglected by the licensee or staff.

A review of a critical incident system (CIS) report indicated a resident complained of pain in 2017, and was sent to the hospital where they were diagnosed with a specified injury. A complaint to the Director was received which indicated that the resident had a significant change in their condition and was subsequently transferred to the hospital and diagnosed with a specified injury.
The Resident could not be interviewed related to a medical condition.
In an interview, a personal support worker (PSW) stated that at the time of the incident, they responded to the resident's alarm with another PSW. When they arrived, the resident had a significant change in condition, which was unusual for the resident. A registered staff was notified and the three staff assisted the resident and the registered staff provided treatment to the resident. Hours later, the resident summoned for assistance again, and the two PSWs assisted them. The resident's condition remained the same. One of the PSWs stated the registered nurse (RN) in charge, was not notified of the change in the resident's condition.
In an interview, the registered staff stated at the time of the incident, they were notified by a PSW that the resident had a change in their condition. They assessed, assisted and then treated the resident. They further stated that they did not believe the resident sustained any injury.
In an interview, the RN in charge at the time of the incident stated they were not made aware of the resident's change in condition.
In an interview, a PSW stated they worked the next shift after the incident and in report, they were made aware by the staff of the resident's change in condition. The PSW stated they were unable to provide much care for the resident that shift, because of their change in condition. The PSW further stated a visitor later that shift requested for the resident to be transferred to the hospital.
The home's investigation notes were reviewed and indicated that at the time of the incident, the resident had a significant change in their condition. The staff confirmed they notified the registered staff immediately, who assisted them to provide care to the resident. The registered staff then assessed and treated the resident; however, the RN in charge was not notified. The following day, staff were made aware of the significant change in the resident's condition, but did not seek appropriate medical attention. A visitor expressed concern related to the resident's condition and requested for the resident to be transferred to the hospital. The resident was subsequently diagnosed with an injury.
A review of the home's policy #LTC-CA-WQ-100-0502, titled "Abuse Allegations and Follow-Up", indicated the home had "zero tolerance" for abuse of any type, and further defined abuse as "any action or inaction that the person knew or ought to have known that their actions may cause physical or emotion harm to the residents' health, safety, or

well-being".
The Long Term Care Homes (LTCH) act defines neglect 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".
In interviews, the Director of Care (DOC) and the Assistant Director of Care (ADOC) confirmed that registered staff failed to assess and respond appropriately to the resident's condition. The resident had sustained an injury, and the registered staff did not seek immediate medical attention.

The home did not ensure the resident was not neglected by the staff. [s. 19. (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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs changed or care set out in the plan was no longer necessary.
In an interview, it was noted that in 2017, a resident had a significant change in their condition for which they were subsequently transferred to the hospital and diagnosed with an injury. The resident was transferred back to the home the same day, with directions from the hospital on how to transfer the resident.
Observations of the resident during the course of the inspection revealed the resident was on bed rest. The inspector observed two PSW staff transfer the resident.
A review of the resident's clinical health records indicated the resident was assessed by an interdisciplinary team member from the home on their return from hospital, and they gave specified transfer directions for staff to follow. These directions were included on the resident's written plan of care.
A review of the resident's most recent written plan of care revealed did not include the directions mentioned above, nor did it reflect the resident's current condition and needs.
In interviews, two personal support workers (PSWs) and a registered staff confirmed the resident's written plan of care was not updated on their return from hospital and did not reflect the resident's current condition and needs.
In an interview, the Director of Care (DOC) and Resident Assessment Instrument (RAI) Coordinator confirmed it was the home's expectation that registered staff ensure resident written plans of care were updated with changes as necessary, to provide accurate direction to staff in the provision of safe resident care.

The resident's written plan of care was not updated when there was a significant change in their condition. [s. 6. (10) (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 to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident was dealt with as follows: 3. A response shall be made to the person who made the complaint, indicating what the licensee had done to resolve the complaint.

In an interview, the complainant stated a visitor noted that the resident had a significant change in their condition which was unusual, and requested for the resident to be transferred to the hospital. The home initiated an investigation into the cause of the resident's injury, however; according to the complainant, the home did not provide them with the results of their investigation.
A review of the home's policy #LTC-CA-WQ-100-05-08, titled "Complaints" indicated the

home must: contact the person who filed the complaint; arrange to meet with the complainant to discuss their concerns and the outcome of the investigation into the complaint; prepare a written response to the complainant within 10 business days and send it to the complainant.
A review of the home's investigation notes indicated there was no communication to the complainant of the results of their investigation into the cause of the resident's injury.
In an interview, the ADOC and the DOC confirmed a meeting had been scheduled to provide the investigation results; however, the meeting was cancelled and not rescheduled so the results of the investigation were not communicate to the complainant.
[s. 101. (1) 3.]

2. The licensee failed to ensure that a documented record was kept in the home that included,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

In an interview, the complainant stated a visitor noted that the resident had a significant change in their condition which was unusual, and requested for the resident to be transferred to the hospital. The home initiated an investigation into the cause of the resident's injury, however; according to the complainant, the home did not provide them with the results of their investigation.
A review of the home's policy #LTC-CA-WQ-100-05-08, titled "Complaints" indicated for verbal complaints not resolved in 24 hours after receipt, the home must: investigate the incident using the written "Investigation Report and Complaint Communication Log" and log it in the "Complaint Log Workbook"; log all communication with the person who made the complaint; document the results of the investigation on the "Investigation Report Form"; forward the form to the Administrator; prepare a written response to the complainant within 10 business days and send it to the complainant.
A review of the home's investigation notes into the injury sustained by the resident did not satisfy the legislated requirements for a documented record of investigations. The record did not include the nature of the verbal complaint, the date the complaint was received, the actions taken, the final resolution, nor the dates and descriptions of

responses to the complainant.

In an interview, the Assistant Director of Care (ADOC) confirmed a documented record of the verbal complaint related to an injury sustained by the resident was not kept. [s. 101. (2)]

Issued on this 12th day of August, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NATASHA JONES (591)
Inspection No. / No de l'inspection :	2017_547591_0008
Log No. / No de registre :	008883-17, 009186-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 20, 2017
Licensee / Titulaire de permis :	DELCARE LTC INC. 4800 DUFFERIN STREET, TORONTO, ON, M3H-5S9
LTC Home / Foyer de SLD :	CAWTHRA GARDENS LIMITED PARTNERSHIP 590 Lolita Gardens, MISSISSAUGA, ON, L5A-4N8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Elizabeth Bryce

To DELCARE LTC INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

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 shall prepare, submit and implement a corrective action plan to include the following:

1. Develop and implement training for all staff on recognition of a change in condition and actions to be taken when a change in condition occurs. Training should include when to notify professionals including the Registered Nurse, Registered Nurse in the Extended Class and the Physician or other appropriate professionals. Utilize a case study to demonstrate to all staff situations that relate to change in condition and the impact of their inaction on the resident, including how the situation would be expected to be managed.

2. The plan should include a method to review with each level of staff, actions to take when a resident identifies the presence of pain.

3. The plan should include training of registered staff related to when notification of the substitute decision maker (SDM) is required.

4. The plan should include a process for auditing the actions taken when there has been a change in a resident's condition, and identify who will be responsible for completing the audit and taking action related to concerns identified through the auditing process.

The plan is to be submitted to Long Term Care Homes Inspector, Natasha Jones, by email to: Natasha.g.jones@ontario.ca by August 15, 2017. The plan is to be complied with by December 31, 2017.

Grounds / Motifs :

1. Judgement Matrix:
-Severity: (3) Actual harm/risk of harm
-Scope: (1) Isolated
-Compliance History: (2) One or more unrelated non-compliance in the last three years

The licensee failed to ensure residents were not neglected by the licensee or staff.

A review of a critical incident system (CIS) report indicated a resident complained of pain in 2017, and was sent to the hospital where they were diagnosed with a specified injury. A complaint to the Director was received which indicated that the resident had a significant change in their condition and was subsequently transferred to the hospital and diagnosed with a specified injury. The Resident could not be interviewed related to a medical condition.
In an interview, a personal support worker (PSW) stated that at the time of the incident, they responded to the resident's alarm with another PSW. When they arrived, the resident had a significant change in condition, which was unusual for the resident. A registered staff was notified and the three staff assisted the resident and the registered staff provided treatment to the resident. Hours later, the resident summoned for assistance again, and the two PSWs assisted them. The resident's condition remained the same. One of the PSWs stated the registered nurse (RN) in charge, was not notified of the change in the resident's condition.
In an interview, the registered staff stated at the time of the incident, they were notified by a PSW that the resident had a change in their condition. They assessed, assisted and then treated the resident. They further stated that they did not believe the resident sustained any injury.
In an interview, the RN in charge at the time of the incident stated they were not made aware of the resident's change in condition.
In an interview, a PSW stated they worked the next shift after the incident and in report, they were made aware by the staff of the resident's change in condition. The PSW stated they were unable to provide much care for the resident that shift, because of their change in condition. The PSW further stated a visitor later that shift requested for the resident to be transferred to the hospital.
The home's investigation notes were reviewed and indicated that at the time of the incident, the resident had a significant change in their condition. The staff confirmed they notified the registered staff immediately, who assisted them to provide care to the resident. The registered staff then assessed and treated the

resident; however, the RN in charge was not notified. The following day, staff were made aware of the significant change in the resident's condition, but did not seek appropriate medical attention. A visitor expressed concern related to the resident's condition and requested for the resident to be transferred to the hospital. The resident was subsequently diagnosed with an injury.
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The Long Term Care Homes (LTCH) act defines neglect 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".
In interviews, the Director of Care (DOC) and the Assistant Director of Care (ADOC) confirmed that registered staff failed to assess and respond appropriately to the resident's condition. The resident had sustained an injury, and the registered staff did not seek immediate medical attention.

The home did not ensure the resident was not neglected by the staff.

(591)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20th day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Natasha Jones

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