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 prévue 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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 10, 2019	2019_414110_0004	005463-19, 005652-19	Complaint

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Cedarvale Lodge Retirement and Care Community
121 Morton Avenue Keswick ON L4P 2M5

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

DIANE BROWN (110)

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): March 13, 14, 18 and 19, 2019.

During this inspection the following intakes were conducted:
Critical Incident Report related to a fall with injury.
Complaint related to improper care resulting in a change of condition.

During the course of the inspection, the inspector(s) spoke with Executive Director, Associate Director of Care, Registered Nursing staff, Physiotherapist, Personal Support Workers, Substitute Decision Makers, Environmental Services Supervisor and Coroner.

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.
- **1 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

The Ministry of Health and Long Term Care received a complaint on an identified date stating resident #001 had not received proper care which resulted in a significant change in the resident's health status.

The home submitted Critical Incident (CI) report on an identified date that resident #001 had an accident which resulted in a significant change in the resident's health status.

A record review of progress notes identified on an identified date and time how resident #001 sustained an injury while being provided care. The documentation revealed that a PSW was present and providing resident care.

The PSW was identified as PSW #101 in the CI report.

A record review of resident #001's plan of care under Support Actions, last updated approximately six months prior to the resident's injury revealed that resident #001 was required to have identified assistive devices, in an identified manner for mobility.

A review of resident #001's last identified Safety Assessment, dated approximately four months prior to the resident's injury, included the use of assistive devices. The assessment was completed by RN #107. An interview with RN #107 confirmed completing the assessment and that assistive devices were provided for an identified mobility and at time of the assessment the resident used the devices for repositioning.

A further record review revealed a 'Consent Form for Resident to Use PASD' dated and signed by the resident's SDM approximately 23 months prior to the resident's injury. The form provided consent for the use of assistive devices as a PASD in an identified manner.

An interview with PSW #101 confirmed they provided care to resident #001 at the time of the resident's injury. The PSW demonstrated and described to the Inspector how the resident sustained the injury. The PSW stated that the resident's assistive devices were not in place at the time of the incident and that approximately one month prior to they were removed. The PSW shared details on how they thought the assistive devices made the resident feel safe and stated that the resident used them.

An interview with PSW #102 revealed they had provided care a few months back when the resident's assistive devices were still in place. The PSW described the way in which the resident used the assistive devices and that PSWs were not involved in the assessment when the assistive devices were removed.

An interview with PSW #104 revealed that two days prior to the resident's injury they had spoken with the RN in charge expressing concern around providing care to resident #001's without assistive devices.

During an interview with PSW #105 they described resident #001 as having an identified movement, once in awhile, and how the resident used the assistive device.

An interview with PSW #106 revealed they had provided care to resident #001 the night prior to the resident's critical incident. The PSW stated and described why they felt uncomfortable providing care after the assistive devices were removed. The PSW described the manner in which the resident moved and revealed that on one occasion while they were providing care without the devices in place, the resident almost had an incident. Since that time, PSW #106 would always ensure another intervention was in place while providing care to the resident. PSW #106 revealed that resident #001 used the assistive device prior to their removal.

An interview with PSW #114 confirmed that PSW #106 would request an intervention was in place for resident #001 when providing care. The PSW revealed and described how resident #001 would use the assistive devices.

An interview with Physiotherapist (PT) #117 shared that the process in place was for nursing staff to collaborate with PT for an identified assistive device when considering and when discharging the device. The PT shared that nursing had not collaborated with PT in the removal of the resident #001's assistive device.

An interview with RN #107 shared that direction had come from Sienna's, the LTC home's corporate office, clinical consultant, that assistive devices used in an identified manner were to be removed. The RN shared that they along with RPN #109 and ESM #115 met and discussed which residents could have their devices removed. RN #107 stated they were unsure of when resident #001's assistive devices were removed and further stated they had informally asked PSWs about the resident and since the resident had had a declined in health and was no longer using the assistive device for mobility they removed the devices. The RN confirmed that there was no documentation to support that collaboration took place in the assessment to discharge resident #001's assistive device and that the resident's plan of care had not been updated to remove the assistive devices.

An interview with RPN #109 confirmed that three to four weeks prior to this inspection the resident's assistive device, used in an identified manner, had been removed but was unable to provide an exact date. The RPN shared that it was an informal discussion with RN #107 and ESM. The RPN shared that resident #001 was selected as they no longer moved in an identified manner and was not at high risk for falls.

An interview with the ADOC confirmed that staff should have completed an identified Safety Assessment prior to the removal of the assistive devices and that registered staff should have collaborated with PSWs and the PT prior to the removal of the assistive devices.

The licensee failed to to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other in the removal of resident #001's assistive devices. [s. 6. (4) (a)]

2. As a result of non-compliance being identified related to resident #001 the sample size was expanded by two additional residents including resident #002.

During an interview, RN #107 stated resident #002 had identified assisitive devices removed sometime over two identified months ago. The RN shared that after the devices were removed the resident had an incident and injury requiring medical attention to an identified area of the resident's body. After the incident the SDM requested to have the assistive devices implemented.

A record review and staff interview with RPN #109 revealed that an identified Safety Assessment was completed approximately one-two months prior to incident and although the corresponding progress note stated no assistive devices were required, the care plan under Support Actions stated resident #002's identified mobility required a PASD, one assistive device was required for repositioning. An interview with RPN #109 confirmed that the progress note on the identified date should have stated one assistive device was required. The RPN stated that sometime after this assessment direction was given by Sienna corporate office to start removing the identified assistive devices. The RPN shared that sometime one to two months prior to the incident resident #002's assistive devices were removed. The RPN further shared there was no assessment and it was just a case of anyone who was not moving in an identified way was to have their assistive devices removed.

A record review of progress notes following the identified Safety Assessment failed to identify any further assessment or documentation related to discharging the resident's assistive devices. The review of progress notes did however reveal that on an identified date resident #002 had an incident with injury. The resident received medical attention.

During an interview with the resident's SDM they shared that they were not aware the home had removed the residents assistive devices. The SDM stated it was after the resident's incident with injury that they had requested the assistive devices be again implemented.

An interview with PSW #105, the primary daytime care provider for the resident, revealed how the resident used the assistive devices when they providing care and stated when asked that registered staff had not collaborated with staff prior to the removal of the assistive device and that they would have shared how the resident used the device.

An interview with PT #117 shared that the process in place was for nursing staff to

collaborate with PT for an assessment when considering and when discharging assistive devices. The PT shared that nursing had not collaborated with PT in the removal of the resident #002's assistive device.

The licensee failed to collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other in the removal of resident #002's assistive devices. [s. 6. (4) (a)]

3. As a result of non-compliance being identified related to resident #001 the sample size was expanded by two additional residents including resident #003.

During an interview with RN #107 they stated resident #003 had their assistive devices removed sometime over one to two months ago.

A record review of progress notes failed to identify any assessment or documentation related to discharging the resident's assistive devices.

An interview with PT #117 confirmed they completed an identified assessment on an identified date as part of the resident's admission process. The resident had an assistive device and the purpose was to assist the resident with positioning. The PT shared that nursing staff had not collaborated with them in the removal of resident #003's assistive device.

An interview with PSW #118 shared that when the resident was admitted they had an assistive device and described how the resident would utilize them.

The licensee failed to collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other in the removal of resident #003's assistive device. [s. 6. (4) (a)]

4. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The Ministry of Health and Long Term Care received a complaint on an identified date stating resident #001 had not received proper care which resulted in a significant change in the resident's health status.

The home submitted Critical Incident (CI) report on an identified date that resident #001 had an accident which resulted in a significant change in the resident's health status.

A record review of progress notes identified on an identified date and time how resident #001 sustained an injury while being provided care. The documentation revealed that a PSW was present and providing resident care.

A further record review revealed a 'Consent Form for Resident to Use PASD' dated and signed by the resident's SDM approximately 23 months prior to the resident's injury. The form provided consent for the use of assistive devices as a PASD in an identified manner.

An interview with the resident's SDM shared concern that resident #001's identified assistive devices had been removed. The SDM confirmed that they had not been involved in the decision to remove the identified devices and would not have consented to their removal.

A record review failed to identify any communication with the SDM prior to the removal of the identified assistive devices. An interview with RN #107 and RPN #109 shared they had not communicated with resident #001's SDM to obtain consent to the removal of the identified assistive devices.

The licensee failed to ensure that resident #001's SDM been provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

5. As a result of non-compliance being identified related to resident #001 the sample size was expanded by two additional residents including resident #002.

During an interview, RN #107 stated resident #002 had identified assisitive devices removed sometime over two identified months ago. The RN shared that after the devices were removed the resident had an incident and injury requiring medical attention to an identified area of the resident's body. After the incident the SDM requested to have the assistive devices implemented. When the RN was asked if the SDM was involved in the decision to have the assistive devices removed the RN responded no they had not.

A record review and staff interview with RPN #109 revealed that an identified Safety Assessment was completed approximately one-two months prior to incident and although

the corresponding progress note stated no assistive devices were required, the care plan under Support Actions stated resident #002's identified mobility required a PASD, one assistive device was required for repositioning. An interview with RPN #109 confirmed that the progress note on the identified date should have stated one assistive device was required. The RPN stated that sometime after this assessment direction was given by Sienna corporate office to start removing the identified assistive devices. The RPN shared that sometime one to two months prior to the incident resident #002's assistive devices were removed. The RPN further shared there was no assessment and it was just a case of anyone who was not moving in an identified way was to have their assistive devices removed.

A record review of progress notes following the identified Safety Assessment failed to identify any further assessment or documentation related to discharging the resident's assistive devices. The review of progress notes did however reveal that on an identified date resident #002 had an incident with injury. The resident received medical attention.

During an interview with the resident's SDM they shared that they were not aware the home had removed the resident's assistive devices and had not been involved. The SDM stated it was after the resident's incident with injury that they had requested the assistive devices be again implemented.

The licensee failed to ensure resident #002's SDM was provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

6. As a result of non-compliance being identified related to resident #001 the sample size was expanded by two additional residents including resident #003.

During an interview with RN #107 they stated resident #003 had their assistive devices removed sometime over one to two months ago.

An interview with PT #117 confirmed they completed an identified assessment on an identified date as part of the resident's admission process. The resident had an assistive device and the purpose was to assist the resident with positioning. The PT shared that nursing staff had not collaborated with them in the removal of resident #003's assistive device.

An interview with PSW #118 shared that when the resident was admitted they had an assistive device and described how the resident would utilize them.

During a resident interview the inspector asked if they were involved in the decision to have the identified assistive device removed. The resident stated they had not been involved. [s. 6. (5)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 11th day of April, 2019

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

Ministère 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) :	DIANE BROWN (110)
Inspection No. / No de l'inspection :	2019_414110_0004
Log No. / No de registre :	005463-19, 005652-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 10, 2019
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Cedarvale Lodge Retirement and Care Community 121 Morton Avenue, Keswick, ON, L4P-2M5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Fiorinta Flammia

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

Ministère 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

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Ministère 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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 compliant with the LTCHA, 2007, s. 6. (4).

The licensee is ordered to:
1. Educate all registered and direct care staff on the risks associated with lack of collaboration in the assessment of the removal of assistive devices while sharing the investigation results leading up to the critical incident involving resident #001.
2. Educate all registered staff and PSWs on the use of assistive devices as either as PADS or restraints so that assessments are consistent and collaborative.
3. All residents who have had assistive devices removed, within the last 6 months, must have an assessment with evidence of collaboration with staff and others (PT).
4. All residents with assistive devices must have an assessment collaborating with staff and others involved in the different aspects of care prior to their removal.
5. The home's policy for discharging identified assistive devices must include collaboration among the disciplines and assessments and be shared with all registered staff and others involved.
6. A record shall be kept of steps #1 and #5.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

The Ministry of Health and Long Term Care received a complaint on an identified date stating resident #001 had not received proper care which resulted in a significant change in the resident's health status.

The home submitted Critical Incident (CI) report on an identified date that resident #001 had an accident which resulted in a significant change in the resident's health status.

A record review of progress notes identified on an identified date and time how resident #001 sustained an injury while being provided care. The documentation revealed that a PSW was present and providing resident care.

The PSW was identified as PSW #101 in the CI report.

A record review of resident #001's plan of care under Support Actions, last updated approximately six months prior to the resident's injury revealed that resident #001 was required to have identified assistive devices, in an identified manner for mobility.

A review of resident #001's last identified Safety Assessment, dated approximately four months prior to the resident's injury, included the use of assistive devices. The assessment was completed by RN #107. An interview with RN #107 confirmed completing the assessment and that assistive devices were provided for an identified mobility and at time of the assessment the resident used the devices for repositioning.

A further record review revealed a 'Consent Form for Resident to Use PASD' dated and signed by the resident's SDM approximately 23 months prior to the resident's injury. The form provided consent for the use of assistive devices as a PASD in an identified manner.

An interview with PSW #101 confirmed they provided care to resident #001 at

the time of the resident's injury. The PSW demonstrated and described to the Inspector how the resident sustained the injury. The PSW stated that the resident's assistive devices were not in place at the time of the incident and that approximately one month prior to they were removed. The PSW shared details on how they thought the assistive devices made the resident feel safe and stated that the resident used them.

An interview with PSW #102 revealed they had provided care a few months back when the resident's assistive devices were still in place. The PSW described the way in which the resident used the assistive devices and that PSWs were not involved in the assessment when the assistive devices were removed.

An interview with PSW #104 revealed that two days prior to the resident's injury they had spoken with the RN in charge expressing concern around providing care to resident #001's without assistive devices.

During an interview with PSW #105 they described resident #001 as having an identified movement, once in awhile, and how the resident used the assistive device.

An interview with PSW #106 revealed they had provided care to resident #001 the night prior to the resident's critical incident. The PSW stated and described why they felt uncomfortable providing care after the assistive devices were removed. The PSW described the manner in which the resident moved and revealed that on one occasion while they were providing care without the devices in place, the resident almost had an incident. Since that time, PSW #106 would always ensure another intervention was in place while providing care to the resident. PSW #106 revealed that resident #001 used the assistive device prior to their removal.

An interview with PSW #114 confirmed that PSW #106 would request an intervention was in place for resident #001 when providing care. The PSW revealed and described how resident #001 would use the assistive devices.

An interview with Physiotherapist (PT) #117 shared that the process in place was for nursing staff to collaborate with PT for an identified assistive device

when considering and when discharging the device. The PT shared that nursing had not collaborated with PT in the removal of the resident #001's assistive device.

An interview with RN #107 shared that direction had come from Sienna's, the LTC home's corporate office, clinical consultant, that assistive devices used in an identified manner were to be removed. The RN shared that they along with RPN #109 and ESM #115 met and discussed which residents could have their devices removed. RN #107 stated they were unsure of when resident #001's assistive devices were removed and further stated they had informally asked PSWs about the resident and since the resident had had a declined in health and was no longer using the assistive device for mobility they removed the devices. The RN confirmed that there was no documentation to support that collaboration took place in the assessment to discharge resident #001's assistive device and that the resident's plan of care had not been updated to remove the assistive devices.

An interview with RPN #109 confirmed that three to four weeks prior to this inspection the resident's assistive device, used in an identified manner, had been removed but was unable to provide an exact date. The RPN shared that it was an informal discussion with RN #107 and ESM. The RPN shared that resident #001 was selected as they no longer moved in an identified manner and was not at high risk for falls.

An interview with the ADOC confirmed that staff should have completed an identified Safety Assessment prior to the removal of the assistive devices and that registered staff should have collaborated with PSWs and the PT prior to the removal of the assistive devices.

The licensee failed to to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other in the removal of resident #001's assistive devices. [s. 6. (4) (a)]

(110)

2. 2. As a result of non-compliance being identified related to resident #001 the sample size was expanded by two additional residents including resident #002.

During an interview, RN #107 stated resident #002 had identified assisitive devices removed sometime over two identified months ago. The RN shared that after the devices were removed the resident had an incident and injury requiring medical attention to an identified area of the resident's body. After the incident the SDM requested to have the assistive devices implemented.

A record review and staff interview with RPN #109 revealed that an identified Safety Assessment was completed approximately one-two months prior to incident and although the corresponding progress note stated no assistive devices were required, the care plan under Support Actions stated resident #002's identified mobility required a PASD, one assistive device was required for repositioning. An interview with RPN #109 confirmed that the progress note on the identified date should have stated one assistive device was required. The RPN stated that sometime after this assessment direction was given by Sienna corporate office to start removing the identified assistive devices. The RPN shared that sometime one to two months prior to the incident resident #002's assistive devices were removed. The RPN further shared there was no assessment and it was just a case of anyone who was not moving in an identified way was to have their assistive devices removed.

A record review of progress notes following the identified Safety Assessment failed to identify any further assessment or documentation related to discharging the resident's assistive devices. The review of progress notes did however reveal that on an identified date resident #002 had an incident with injury. The resident received medical attention.

During an interview with the resident's SDM they shared that they were not aware the home had removed the residents assistive devices. The SDM stated it was after the resident's incident with injury that they had requested the

assistive devices be again implemented.

An interview with PSW #105, the primary daytime care provider for the resident, revealed how the resident used the assistive devices when they providing care and stated when asked that registered staff had not collaborated with staff prior to the removal of the assistive device and that they would have shared how the resident used the device.

An interview with PT #117 shared that the process in place was for nursing staff to collaborate with PT for an assessment when considering and when discharging assistive devices. The PT shared that nursing had not collaborated with PT in the removal of the resident #002's assistive device.

The licensee failed to collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other in the removal of resident #002's assistive devices. [s. 6. (4) (a)] (110)

3. 3. As a result of non-compliance being identified related to resident #001 the sample size was expanded by two additional residents including resident #003.

During an interview with RN #107 they stated resident #003 had their assistive devices removed sometime over one to two months ago.

A record review of progress notes failed to identify any assessment or documentation related to discharging the resident's assistive devices.

An interview with PT #117 confirmed they completed an identified assessment on an identified date as part of the resident's admission process. The resident had an assistive device and the purpose was to assist the resident with positioning. The PT shared that nursing staff had not collaborated with them in the removal of resident #003's assistive device.

An interview with PSW #118 shared that when the resident was admitted they had an assistive device and described how the resident would utilize them.

The licensee failed to collaborate with each other in the assessment of the

resident so that their assessments are integrated, consistent with and complement each other in the removal of resident #003's assistive device. [s. 6. (4) (a)]

The severity of this issue was determined to be a level 3 as there was actual harm to resident #001 and #002 related to a fall with injury. The scope of the issue was a level 3 widespread as it related to three out of three residents reviewed.

The home had a level 4 compliance history with ongoing non compliance in the same section with a Voluntary Plan of Correction (VPC) within the last 3 years that included:
-VPC issued April 27, 2016 in report # 2016_440210_0006.
-VPC issued November 22, 2017 in report # 2017_414110_0012.
(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

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

Ministère 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

Order # / Ordre no : 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Order / Ordre :

The licensee must be compliant with the LTCHA, 2007, s. 6. (5).

The licensee if ordered to:
1. Provide the resident, the SDM, if any, and the designate of the resident / SDM the opportunity to participate fully in the development and implementation of the plan of care as it relates to provision or discharge of identified assistive devices.
2. Contact all residents, the SDM, if any, and the designate of the resident / SDM of whom the identified assistive devices have been discharged to ensure participation in the care plan.
3. All future changes related to the discharging of an identified assistive device shall include evidence of the resident / SDM provided the opportunity to participate fully in the development and implementation of the plan of care.
4. A record shall be kept of all steps #1 -#3 for review by the Inspector.

Grounds / Motifs :

1. 4. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The Ministry of Health and Long Term Care received a complaint on an identified date stating resident #001 had not received proper care which resulted in a significant change in the resident's health status.

The home submitted Critical Incident (CI) report on an identified date that

resident #001 had an accident which resulted in a significant change in the resident's health status.

A record review of progress notes identified on an identified date and time how resident #001 sustained an injury while being provided care. The documentation revealed that a PSW was present and providing resident care.

A further record review revealed a 'Consent Form for Resident to Use PASD' dated and signed by the resident's SDM approximately 23 months prior to the resident's injury. The form provided consent for the use of assistive devices as a PASD in an identified manner.

An interview with the resident's SDM shared concern that resident #001's identified assistive devices had been removed. The SDM confirmed that they had not been involved in the decision to remove the identified devices and would not have consented to their removal.

A record review failed to identify any communication with the SDM prior to the removal of the identified assistive devices. An interview with RN #107 and RPN #109 shared they had not communicated with resident #001's SDM to obtain consent to the removal of the identified assistive devices.

The licensee failed to ensure that resident #001's SDM been provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]
(110)

2. 5. As a result of non-compliance being identified related to resident #001 the sample size was expanded by two additional residents including resident #002.

During an interview, RN #107 stated resident #002 had identified assisitive devices removed sometime over two identified months ago. The RN shared that after the devices were removed the resident had an incident and injury requiring medical attention to an identified area of the resident's body. After the incident the SDM requested to have the assistive devices implemented. When the RN was asked if the SDM was involved in the decision to have the assistive devices removed the RN responded no they had not.

A record review and staff interview with RPN #109 revealed that an identified Safety Assessment was completed approximately one-two months prior to incident and although the corresponding progress note stated no assistive devices were required, the care plan under Support Actions stated resident #002's identified mobility required a PASD, one assistive device was required for repositioning. An interview with RPN #109 confirmed that the progress note on the identified date should have stated one assistive device was required. The RPN stated that sometime after this assessment direction was given by Sienna corporate office to start removing the identified assistive devices. The RPN shared that sometime one to two months prior to the incident resident #002's assistive devices were removed. The RPN further shared there was no assessment and it was just a case of anyone who was not moving in an identified way was to have their assistive devices removed.

A record review of progress notes following the identified Safety Assessment failed to identify any further assessment or documentation related to discharging the resident's assistive devices. The review of progress notes did however reveal that on an identified date resident #002 had an incident with injury. The resident received medical attention.

During an interview with the resident's SDM they shared that they were not aware the home had removed the resident's assistive devices and had not been involved. The SDM stated it was after the resident's incident with injury that they had requested the assistive devices be again implemented.

The licensee failed to ensure resident #002's SDM was provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]
(110)

3. 6. As a result of non-compliance being identified related to resident #001 the sample size was expanded by two additional residents including resident #003.

During an interview with RN #107 they stated resident #003 had their assistive devices removed sometime over one to two months ago.

An interview with PT #117 confirmed they completed an identified assessment on an identified date as part of the resident's admission process. The resident had an assistive device and the purpose was to assist the resident with positioning. The PT shared that nursing staff had not collaborated with them in the removal of resident #003's assistive device.

An interview with PSW #118 shared that when the resident was admitted they had an assistive device and described how the resident would utilize them.

During a resident interview the inspector asked if they were involved in the decision to have the identified assistive device removed. The resident stated they had not been involved. [s. 6. (5)]

The severity of this issue was determined to be a level 3 as there was actual harm to resident #001 and #002 related to failing to provide the SDM the opportunity to participate fully in the development and implementation of the plan of care. The scope of the issue was a level 3 widespread as it related to three out of three residents reviewed.

The home had a level 4 compliance history with ongoing non- compliance in the same section with a Voluntary Plan of Correction (VPC) within the last 3 years that included:
-VPC issued April 27, 2016 in report # 2016_440210_0006.
-VPC issued September 28, 2018 in report #2018_748723_001.

(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

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 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, 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 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 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 de la Santé et 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 de la Santé et 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 10th day of April, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

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