Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 12, 2019	2019_771609_0008	010056-19, 012095-19	Complaint

Licensee/Titulaire de permis

Valley East Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Elizabeth Centre
2100 Main Street Val Caron ON P3N 1S7

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

CHAD CAMPS (609), STEVEN NACCARATO (744)

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): June 17-21, 23, 25-28, 2019.

The following intakes were inspected during this Complaint inspection:

-One intake related to a complaint the Director received regarding the frequent falls of a resident; and
-One Critical Incident System (CIS) intake related to the same issue (frequent falls of a resident).

A CIS inspection #2019_771609_0009 and a Follow-Up inspection #2019_771609_0007 were conducted concurrently with this inspection.

PLEASE NOTE: Non-compliance related to section (s). 6. (1) (c) and s. 6. (7) of the Long Term Care Homes Act (LTCHA), 2007, identified in concurrent inspection #2019_771609_0009 were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Directors of Care (Co-DOCs), Staff Educators, Restorative Care Coordinator (RCC), Staffing Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Supports Ontario (BSO) RPN, Personal Support Workers (PSWs), family members, and residents.

The Inspector(s) also conducted a daily tour of the home, reviewed relevant resident care records, home investigation notes, home policies, personnel files, as well as the delivery of resident care and services.

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

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

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

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

Specifically failed to comply with the following:

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #001 set out the planned care for the resident.

A complaint was submitted to the Director, related to resident #001's frequent falls within the home.

Further, a Critical Incident (CI) report was submitted by the home to the Director which outlined how on a particular day, resident #001 fell, was transferred to hospital, where they were diagnosed with injuries.

A review of resident #001's health care records found in their post falls assessments, that the resident had fallen a specific number of times within the review period.

a) Inspector #609 reviewed resident #001's health care records and found two post fall assessments which outlined how the resident had two falls out of their mobility aid within a short time frame of each other. The assessments indicated that the resident was exhibiting a specific behaviour and that Registered Practical Nurse (RPN) #101 had made a referral to restorative care to assess them for a specific intervention.

A further review of resident #001's health care records found in a progress note that the resident was provided with the specified intervention, one day after their last fall where they were transferred to the hospital with an injury.

During an interview with RPN #101, they outlined how resident #001 was exhibiting the

specified behaviour, which resulted in the resident falling. On a particular day, after one of the resident's falls, they noticed that the specified intervention was outside the resident's room. The specified intervention was not implemented as there was no mention of it in the day planner and no task for its use in Point of Care (POC).

During an interview with the Restorative Care Coordinator (RCC), a review of resident #001's health care records was conducted. They indicated that they provided resident #001 with the specified intervention on one of two particular days. The RCC could not identify who or if they told direct care staff about the resident's need for the specified intervention.

During interviews with RPN #101, RN #110 and RN #116, they all denied having any communication with the RCC related to resident #001's need for the specified intervention.

During the same interview with the RCC, they verified that they did not document anywhere in resident #001's health care records about the need for the specified intervention. The RCC further verified that as a result staff did not implement the specified intervention until after an additional fall in which the resident sustained injuries.

b) On two days, Inspector #609 observed resident #001 with the specified intervention.

During an interview with RPN #101, they indicated that resident #001's specified intervention was being used because the resident exhibited a specified behaviour.

During an interview with the RCC, they indicated that they had provided resident #001 with the specified intervention on one of two particular days.

A review of resident #001's plan of care found no mention that the resident required the specified intervention or any instruction to staff as to when or how the specified intervention was to be utilized for the resident.

A review of the home's policy titled "Resident Rights, Care and Services – Plan of Care – Plan of care" last revised March 13, 2018, required that the plan of care for each resident set out the planned care for the resident.

During an interview with Co-Director of Care (Co-DOC) #103, a review of resident #001's plan of care was conducted. They verified that the specified intervention and instructions

for staff on its use were not in the resident's plan of care. [s. 6. (1) (a)]

2. Inspector #609 reviewed resident #001's health care records and located in a progress note by RPN #101 on a particular day that the resident was exhibiting responsive behaviours and a specific intervention was implemented, but was not correctly implemented by the staff member responsible for the specified intervention.

A further review of resident #001's progress notes found that after the specified intervention was not properly implemented, resident #001 fell.

During an interview with RPN #101, a review of resident #001's progress notes was conducted. They described how the resident was exhibiting responsive behaviours. The RPN outlined how on the particular day, PSW #111 was supposed to provide the specified intervention in a specific manner.

During an interview with RN #110, they indicated that PSW #111 was told by them to provide the specified intervention for a specific time frame.

RN #110 could not recall if they provided any directions on the care of resident #001 to PSW #111. Nor could they recall if they were made aware that PSW #111 had not implemented the specified intervention properly. The RN verified they had not documented any of their actions related to resident #001 on the particular day.

During an interview with PSW #111, they denied being given direction on the correct implementation of the resident's intervention.

During an interview with the Co-DOC #103, a review of resident #001's health care records was conducted. They indicated that the specified intervention was implemented as an RN measure and should have been documented. They verified that RN #110 should have provided instructions to the PSW implementing the specified intervention. [s. 6. (1) (a)]

3. The licensee has failed to ensure that resident #003's plan of care set out clear directions to staff and others who provided direct care to the resident.

A CI report was submitted by the home to the Director which described an unwitnessed fall on a particular day, by resident #003 who was found with injuries. The resident was transferred to hospital. After returning from the hospital resident #003 was assessed with

a significant change in health status.

A review of resident #003's health care records found in the post fall assessment, that the resident did not have a specific intervention at the time of the fall.

A review of resident #003's plan of care found under one focus that the resident required the specified intervention, while under another focus, the plan of care indicated that the resident did not require the specified intervention.

A review of the home's policy titled "Resident Rights, Care and Services – Plan of Care" last revised March 13, 2018, required that the plan of care provided clear direction to staff and others providing care.

During an interview with PSW #129, they described how resident #003 used the specified intervention, but at times refused to use it.

During an interview with the RCC, a review of resident #003's plan of care was reviewed. When asked if the plan of care provided clear direction to staff in relation to the resident's specified intervention they stated "obviously not". [s. 6. (1) (c)]

4. The licensee has failed to ensure that the care set out in resident #001's and resident #004's plans of care were provided to the residents as specified in the plans.

A complaint was submitted to the Director, related to resident #001's frequent falls within the home.

Inspector #609 reviewed resident #001's health care records and found in their post fall assessments, that the resident fell a specific number of times during the review period. Please see Written Notification #1, finding #1 for further details.

A review of resident #001's multidisciplinary care conference notes indicated that the resident was at a specific risk for falls and required a specific intervention. Review of the resident's plan of care documented these requirements as well.

A review of resident #001's post fall assessments found that in 22 per cent of the falls in the review period, the resident's specified intervention was not operational when they fell. This was despite resident #001's POC tasks which found that the resident's specified intervention was documented by PSWs as operational hours after the falls.

The PSWs responsible for resident #001's care when the falls occurred were unavailable for an interview.

A review of the home's policy titled "Resident Rights, Care and Services – Plan of Care – Plan of care" last revised March 13, 2018, indicated that care should be provided to the resident as specified in the plan of care.

During an interview with the RCC, a review of resident #001's post fall assessments were conducted. The RCC verified that the resident's specified intervention should have been checked to ensure that it was operational when the resident fell. [s. 6. (7)]

5. A CI report was submitted to the Director regarding an altercation between resident #004 and resident #005.

Inspector #744 reviewed correspondence from the Director of Care (DOC) on a particular day, to the Administrator and Co-DOC #118, which identified that staff were to provide a specific intervention to resident #004 at all times.

A review of specific records indicated that resident #004 failed to receive their specific intervention at all times it was required.

In an interview with Co-DOC #118, they indicated that the decision to discontinue the specified intervention to resident #004 had been finalized during a meeting which included the DOC on a later particular day than when the specified intervention was stopped.

Inspector #744 interviewed the DOC, who indicated that in a report meeting held with RN #120, the DOC discussed the possibility of discontinuing the specified intervention to resident #004 during specific times. The DOC further indicated that there was no final decision made to discontinue the specified intervention to resident #004 at the time it was stopped.

In an Interview with RN #120, they indicated that the DOC had discussed discontinuing the specified intervention to resident #004 but misunderstood, discontinuing the specified intervention immediately after their conversation.

A review of the home's policy titled "Resident Rights, Care and Services- Plan of Care-

Plan of Care" effective September 16, 2013, stated that staff would ensure that care was provided to the resident as specified in the plan of care.

During the same interview with the DOC, they further stated that the decision to end the specified intervention to resident #004 was made on a later particular day and RN #120's decision to end the specified intervention days before, was not following the plan of care that was in place. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 002 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. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to minimize the restraining of residents was complied with.

A complaint was submitted to the Director, related to resident #001's frequent falls within the home. Please see Written Notification #1, finding #1 and #4 for further details.

On two particular days, Inspector #609 observed resident #001 with a specific intervention.

During an interview with RPN #101, they outlined to Inspector #609, that resident #001's specified intervention was implemented because the resident exhibiting specific behaviours. The RPN verified that the resident could not get out of the specific intervention when it was implemented in a specific manner.

A review of the home's policy titled "Resident Rights, Care and Services – Minimizing of Restraining – Documentation of Restraint Use" last revised May 22, 2018, required the RCC to conduct a multidisciplinary assessment of the restraint and ensure the assessment was documented. The RCC was also required to meet with the resident's Substitute decision-maker (SDM) to obtain informed consent. The policy required registered staff to obtain an order for the restraint from the physician or registered nurse in the extended class.

During an interview with the RCC, they indicated that they had provided resident #001 with the specified intervention on one of two particular days. The RCC verified that the resident could not get out of the specified intervention and said they were unaware that the specified intervention could be seen as a restraint. They further denied any involvement of resident #001's SDM in their decision to implement the specified intervention.

A review of resident #001's health care records found no documentation of a multidisciplinary assessment of the specified intervention nor any order for its use from a physician or registered nurse in the extended class. [s. 29. (1) (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 home's written policy to minimize the restraining of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident in the home that caused an injury to resident #001 for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition.

A CI report was submitted by the home to the Director on a particular day, which outlined how resident #001 fell weeks prior, that resulted in the resident being taken to hospital with injuries. Please see Written Notification #1, finding #1 and #4 for further details.

Inspector #609 reviewed resident #001's health care records and identified in a progress note that while the resident was in the hospital, RN #110 called the hospital and was informed that the resident had sustained injuries that required interventions.

A review of the home's policy titled "Resident Rights, Care and Services – Reporting and Complaints – Critical Incident Reporting" last revised March 15, 2019, indicated that the Director would be informed no later than one business day of an injury to a resident for which the resident was taken to the hospital and resulted in a significant change in the resident's condition.

During an interview with Co-DOC #103, they indicated that the CI report was reported late because when resident #001 returned, the report from the hospital was filed in the resident's chart, not reviewed by the Co-DOC and therefore not reported to the Director.

A review of the definition of a significant change in the resident's condition was conducted with Co-DOC #103, who verified that resident #001's injuries from the fall fit the definition of a significant change and should have been reported as a CI to the Director. [s. 107. (3) 4.]

Issued on this 15th day of July, 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

Ministère de la Santé et 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 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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHAD CAMPS (609), STEVEN NACCARATO (744)
Inspection No. / No de l'inspection :	2019_771609_0008
Log No. / No de registre :	010056-19, 012095-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 12, 2019
Licensee / Titulaire de permis :	Valley East Long Term Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	Elizabeth Centre 2100 Main Street, Val Caron, ON, P3N-1S7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chantal Carriere

To Valley East Long Term Care Centre 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with section (s.) 6. (7) of the Long-Term Care Homes Act, (LTCHA), 2007.

Specifically, the licensee must:

a) Ensure that a specific intervention required by a resident is properly applied at all times that the intervention is deemed necessary;

b) Develop and implement an on-going process to consistently monitor all residents' specific intervention to make certain they are properly applied at all times that the intervention is deemed necessary;

c) Develop and implement a process to ensure that all details of any discussion that results in the initiation or discontinuation of a specific intervention for a resident is in the resident's plan of care and/or health care records; and

d) Records are maintained of all actions undertaken to achieve compliance with section “b” and "c" of the order.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in resident #001’s and resident #004's plans of care were provided to the residents as specified in the plans.

A complaint was submitted to the Director, related to resident #001’s frequent falls within the home.

Inspector #609 reviewed resident #001's health care records and found in their post fall assessments, that the resident fell a specific number of times during the review period. Please see Written Notification #1, finding #1 for further details.

A review of resident #001's multidisciplinary care conference notes indicated that the resident was at a specific risk for falls and required a specific intervention. Review of the resident's plan of care documented these requirements as well.

A review of resident #001's post fall assessments found that in 22 per cent of the falls in the review period, the resident's specified intervention was not operational when they fell. This was despite resident #001's POC tasks which found that the resident's specified intervention was documented by PSWs as operational hours after the falls.

The PSWs responsible for resident #001's care when the falls occurred were unavailable for an interview.

A review of the home's policy titled "Resident Rights, Care and Services – Plan of Care – Plan of care" last revised March 13, 2018, indicated that care should be provided to the resident as specified in the plan of care.

During an interview with the RCC, a review of resident #001's post fall assessments were conducted. The RCC verified that the resident's specified intervention should have been checked to ensure that it was operational when the resident fell. (609)

2. A CI report was submitted to the Director regarding an altercation between resident #004 and resident #005.

Inspector #744 reviewed correspondence from the Director of Care (DOC) on a particular day, to the Administrator and Co-DOC #118, which identified that staff were to provide a specific intervention to resident #004 at all times.

A review of specific records indicated that resident #004 failed to receive their specific intervention at all times it was required.

In an interview with Co-DOC #118, they indicated that the decision to discontinue the specified intervention to resident #004 had been finalized during a meeting which included the DOC on a later particular day than when the specified intervention was stopped.

Inspector #744 interviewed the DOC, who indicated that in a report meeting held with RN #120, the DOC discussed the possibility of discontinuing the specified intervention to resident #004 during specific times. The DOC further indicated that there was no final decision made to discontinue the specified intervention to resident #004 at the time it was stopped.

In an Interview with RN #120, they indicated that the DOC had discussed discontinuing the specified intervention to resident #004 but misunderstood, discontinuing the specified intervention immediately after their conversation.

A review of the home's policy titled "Resident Rights, Care and Services- Plan of Care- Plan of Care" effective September 16, 2013, stated that staff would ensure that care was provided to the resident as specified in the plan of care.

During the same interview with the DOC, they further stated that the decision to end the specified intervention to resident #004 was made on a later particular day and RN #120's decision to end the specified intervention days before, was not following the plan of care that was in place.

The severity of this issue was determined to be a level three, as there was actual risk to resident #001 and all other residents of the home whose specific interventions were not applied properly or not receiving the intervention. The scope of the issue was a level two as there was a pattern of care provided not as specified among the residents who were reviewed. The home had a level three compliance history, as they had related non-compliance with this section of the LTCHA that included:

-a Voluntary Plan of Correction (VPC) issued September 8, 2017, (#2017_655679_0008);
-a VPC issued April 19, 2018, (#2018_740621_0010);
-a Written Notification (WN) issued January 29, 2019, (#2019_679638_0002); And

-a VPC issued April 8, 2019, (#2019_657681_0009).

Of the four previous non-compliances issued to the home related to this provision within the last 36 months three or 75 per cent were related to residents' specific intervention not applied properly. (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 2019

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

Order / Ordre :

The licensee must be compliant with section (s.) 6. (1) of the Long-Term Care Homes Act, (LTCHA), 2007.

Specifically, the licensee must ensure:

a) For resident #001 and all other residents with the use of a specific intervention, their plans of care clearly identifies the use of the specific intervention and instructions to staff;

b) Any actions taken from an RN or instructions they provide to staff related to the care of a resident are documented in the resident's plan of care and/or health care records and clearly communicated to staff;

c) That any actions taken by the RCC/designate or instructions they provide to staff related to the care of a resident are documented in the resident's plan of care and/or health care records and communicated to staff in a timely manner; and

d) A multidisciplinary review of all plans of care for residents in the home that use a mobility aid is conducted to make certain clear direction for their use are documented and that direct care staff are aware.

Grounds / Motifs :

1. The licensee has failed to ensure that the written plan of care for resident

#001 set out the planned care for the resident.

A complaint was submitted to the Director, related to resident #001's frequent falls within the home.

Further, a Critical Incident (CI) report was submitted by the home to the Director which outlined how on a particular day, resident #001 fell, was transferred to hospital, where they were diagnosed with injuries.

A review of resident #001's health care records found in their post falls assessments, that the resident had fallen a specific number of times within the review period.

a) Inspector #609 reviewed resident #001's health care records and found two post fall assessments which outlined how the resident had two falls out of their mobility aid within a short time frame of each other. The assessments indicated that the resident was exhibiting a specific behaviour and that Registered Practical Nurse (RPN) #101 had made a referral to restorative care to assess them for a specific intervention.

A further review of resident #001's health care records found in a progress note that the resident was provided with the specified intervention, one day after their last fall where they were transferred to the hospital with an injury.

During an interview with RPN #101, they outlined how resident #001 was exhibiting the specified behaviour, which resulted in the resident falling. On a particular day, after one of the resident's falls, they noticed that the specified intervention was outside the resident's room. The specified intervention was not implemented as there was no mention of it in the day planner and no task for its use in Point of Care (POC).

During an interview with the Restorative Care Coordinator (RCC), a review of resident #001's health care records was conducted. They indicated that they provided resident #001 with the specified intervention on one of two particular days. The RCC could not identify who or if they told direct care staff about the resident's need for the specified intervention.

During interviews with RPN #101, RN #110 and RN #116, they all denied having any communication with the RCC related to resident #001's need for the specified intervention.

During the same interview with the RCC, they verified that they did not document anywhere in resident #001's health care records about the need for the specified intervention. The RCC further verified that as a result staff did not implement the specified intervention until after an additional fall in which the resident sustained injuries.

b) On two days, Inspector #609 observed resident #001 with the specified intervention.

During an interview with RPN #101, they indicated that resident #001's specified intervention was being used because the resident exhibited a specified behaviour.

During an interview with the RCC, they indicated that they had provided resident #001 with the specified intervention on one of two particular days.

A review of resident #001's plan of care found no mention that the resident required the specified intervention or any instruction to staff as to when or how the specified intervention was to be utilized for the resident.

A review of the home's policy titled "Resident Rights, Care and Services – Plan of Care – Plan of care" last revised March 13, 2018, required that the plan of care for each resident set out the planned care for the resident.

During an interview with Co-Director of Care (Co-DOC) #103, a review of resident #001's plan of care was conducted. They verified that the specified intervention and instructions for staff on its use were not in the resident's plan of care. (609)

2. Inspector #609 reviewed resident #001's health care records and located in a progress note by RPN #101 on a particular day that the resident was exhibiting responsive behaviours and a specific intervention was implemented, but was not correctly implemented by the staff member responsible for the specified

intervention.

A further review of resident #001's progress notes found that after the specified intervention was not properly implemented, resident #001 fell.

During an interview with RPN #101, a review of resident #001's progress notes was conducted. They described how the resident was exhibiting responsive behaviours. The RPN outlined how on the particular day, PSW #111 was supposed to provide the specified intervention in a specific manner.

During an interview with RN #110, they indicated that PSW #111 was told by them to provide the specified intervention for a specific time frame.

RN #110 could not recall if they provided any directions on the care of resident #001 to PSW #111. Nor could they recall if they were made aware that PSW #111 had not implemented the specified intervention properly. The RN verified they had not documented any of their actions related to resident #001 on the particular day.

During an interview with PSW #111, they denied being given direction on the correct implementation of the resident's intervention.

During an interview with the Co-DOC #103, a review of resident #001's health care records was conducted. They indicated that the specified intervention was implemented as an RN measure and should have been documented. They verified that RN #110 should have provided instructions to the PSW implementing the specified intervention. (609)

3. The licensee has failed to ensure that resident #003's plan of care set out clear directions to staff and others who provided direct care to the resident.

A CI report was submitted by the home to the Director which described an unwitnessed fall on a particular day, by resident #003 who was found with injuries. The resident was transferred to hospital. After returning from the hospital resident #003 was assessed with a significant change in health status.

A review of resident #003's health care records found in the post fall

assessment, that the resident did not have a specific intervention at the time of the fall.

A review of resident #003's plan of care found under one focus that the resident required the specified intervention, while under another focus, the plan of care indicated that the resident did not require the specified intervention.

A review of the home's policy titled "Resident Rights, Care and Services – Plan of Care" last revised March 13, 2018, required that the plan of care provided clear direction to staff and others providing care.

During an interview with PSW #129, they described how resident #003 used the specified intervention, but at times refused to use it.

During an interview with the RCC, a review of resident #003's plan of care was reviewed. When asked if the plan of care provided clear direction to staff in relation to the resident's specified intervention they stated "obviously not".

The severity of this issue was determined to be a level three, as there was actual harm that occurred to resident #001 and #003. The scope of the issue was a level two, as it was identified to be a pattern among the residents who were reviewed. The home had a level two compliance history, as they had unrelated non-compliance with this section of the LTCHA. (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 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 12th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chad Camps

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