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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 13, 2017	2017_600568_0009	006606-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

FOREST HEIGHTS
60 WESTHEIGHTS DRIVE KITCHENER ON N2N 2A8

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

DOROTHY GINTHER (568), JENNA BAYSAROWICH (667), NUZHAT UDDIN (532), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): May 18, 19, 23, 24, 25, 26, 29, 30, 31, 2017.

Critical Incidents #2707-000025-16 log #016482-16, #2707-000041-16 log #023621-16, #2707-000045-16 log #024040-16, #2707-000027-16 log #017066-16, #2707-000048-16 log #027902-16, #2707-000036-16 log #021306-16, #2707-000033-16 log #018981-16 related to responsive behaviours;
Critical Incidents #2707-000037-16 log #023297-16, #2707-000050-16 log #029678-16, #2707-000001-17 log #000049-17, #2707-000024-16 log #015812-16, #2707-000032-16 log #018672-16, #2707-000010-16 log #003083-16, #2707-000056-16 log #031004-16, #2707-000026-16 log #016652-16, #2707-000028-16 log #017150-16, #2707-000009-17 log #005342-17 related to abuse;
Critical Incidents #2707-000009-14 log #017931-16, #2707-000053-16 log #030305-16, #2707-000047-16 log #027145-16, #2707-000034-16 log #022746-16 related to falls;
Critical Incident #2707-000058-16 log #033296-16 related to improper care;
and complaint IL-44315-LO log #011920-16 related to missing property were completed in conjunction with the inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, two Associate Director of Cares, Recreation Manager, Admissions/ Resident Services Coordinator, two Resident Care Managers, a Registered Dietitian, Skin / Wound Care Lead, BSO Lead, six Registered Nurses, eight Registered Practical Nurses, nineteen Personal Support Workers, two Dietary Aides, one Housekeeping Aide, one Restorative Care Aide, Family Council Representative, Residents' Council Representative, families and residents.

The inspectors also toured the home, observed medication administration, medication storage; reviewed relevant clinical records, policies and procedures, meeting minutes, investigation notes, schedules, posting of required information; observed the provision of resident care, resident and staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **9 WN(s)**
- **6 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	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 has failed to ensure that the resident was protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Section 2.(1) of O.Reg 79/10, defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self worth, that is made by anyone other than a resident.

A Critical Incident System (CIS) report stated under the heading "incident description" that a staff member witnessed an incident of potential verbal abuse.

During an interview with the staff member that witnessed the incident, they said that they heard a staff speaking to a resident in a loud and reprimanding manner. The resident was upset by the way the staff spoke to them and felt blamed and angry. The DOC was informed and an investigation was initiated.

During an interview with the accused staff member they recalled having spoken to the resident in what they felt was a stern voice but acknowledged that it may have been perceived by others as yelling at the resident.

The Director of Care said that the staff member was provided with education related to dementia care and staff approach to prevent this type of incident from occurring again. [s. 19. (1)]

2. Section 2.(1) of Reg 79/10, 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.

Record review and a Critical Incident System (CIS) report stated that a resident reported to a registered staff that their caregiver left them unattended for a long period of time while they were performing an activity of daily living. The resident reported that when staff finally came to assist them they were rough. The registered staff assessed the resident and noted an injury as described by the resident.

Investigation notes confirmed that the identified resident had been left unattended for a period of time without access to the communication response system.

During an interview with the identified resident they said that the incident in question was upsetting and made even worse when the staff finally came to provide assistance and

they were rough.

In an interview with one of the staff members involved, they acknowledged that they left the resident unattended but said they had notified another staff member of the resident's situation before leaving the area. They acknowledged that the resident did not have access to the communication response system during the time they were unattended. The staff member denied having been rough.

The staff member that had been left to assist the resident stated that because they were so busy they did not have time to get to the resident. The resident was upset at having been left for so long but the staff member denied having been rough with them.

The Director of Care stated that after further investigation it was determined that the resident's physical injury was not likely caused by staff care. The DOC acknowledged that the resident was left unattended for an unacceptable amount of time and without access to the communication response system. The staff had failed to provide care for the resident and their inaction had the potential for harm to the resident. [s. 19. (1)]

3. A CIS report submitted to the Director, referred to an incident that was identified as abuse / neglect. The CI report identified that a staff member witnessed a resident exhibit inappropriate behaviours towards a co-resident. Staff intervened immediately and removed the resident. The co-resident did not not appear in distress and refused to be examined.

The identified resident's plan of care stated that the resident exhibited a number of responsive behaviours due to impaired cognition. The resident was followed by Behavioural Supports Ontario within the home and had a number of interventions in place to mitigate risk to residents and staff.

During an interview with the staff member that witnessed the incident they told the inspector that they recalled the situation where the identified resident exhibited inappropriate behaviours towards a co-resident. They intervened immediately and then notified the registered staff.

During interviews with two other staff they told the inspector that the identified resident had a number of responsive behaviours which were directed toward staff and residents.

The BSO Lead shared that the identified resident was being following by their team. A number of interventions had been put in place to mitigate the risk to staff and other residents related to the resident's behaviours. Following this incident they had introduced additional strategies in order to ensure other residents were protected.

The licensee failed to ensure that residents were protected from abuse by anyone. [s. 19. (1)]

4. A CIS report submitted to the Director described an incident where an identified resident was observed exhibiting inappropriate behaviours towards a co-resident. The co-resident was very upset by the behaviours.

During a review of the identified resident's clinical record, progress notes stated that a staff member had observed the identified resident exhibit inappropriate behaviours toward a co-resident. The co-resident was visibly upset by the incident. The identified resident tried to re-approach the co-resident but staff were able to intervene. Following the incident interventions were put in place for the identified resident and a referral was sent to BSO as the resident had not exhibited these types of behaviours in the past. Progress notes stated that the identified resident attempted to engage the co-resident the day after the first incident and the co-resident became extremely upset as they remembered the incident the day before.

The plan of care for the identified resident outlined that the resident exhibited some responsive behaviours for which interventions had been put in place, but the resident had not exhibited behaviours of this nature since being admitted to the home.

The severity was determined to be a level three as there was actual harm; and the scope of this issue was identified as isolated. The compliance history was a level three with one or more related noncompliance in the last three years. [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 O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A Critical Incident System (CIS) report was submitted to the Director in relation to an injury to an identified resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

During a review of the resident's clinical record it was noted that within a short period of time after the resident first exhibited signs of injury / disease they began to report associated pain. Over the next several days the resident's pain worsened, their mobility and participation in functional activities declined, and other signs and symptoms of injury / disease worsened. The resident was transferred to hospital for further assessment.

Review of assessments for the resident identified that there was a pain flow record initiated when the resident returned from hospital with respect to the resident's complaints of pain. There were no other pain assessments found for the resident prior to their transfer to hospital.

During an interview with a Personal Support Worker, they told the inspector that they recalled providing care for the identified resident just before the resident went to hospital. When asked if the resident had any signs of injury before going to hospital, they said that the resident had exhibited some signs / symptoms of injury including pain.

A registered staff told the inspector that it was the home's expectation that any new area of pain would be assessed using their assessment on Point Click Care. They would also complete a 72 Hour Pain Flow Record. When asked if the staff member recalled the period of time before the identified resident went to hospital for further evaluation of their pain, the registered staff said that they remembered this time period. When asked if the

resident had reported any pain, the registered staff said that they complained of pain a few days prior to going to hospital and there were other signs / symptoms of injury.

The home's policy titled "Pain Assessment and Symptom Management Program", Index CARE8-P10 effective August 31, 2016, stated that all residents are assessed using a standardized, evidence-informed clinical tool that is appropriate for the Resident's cognitive level. Procedure "Pain Assessment and Management, Index CARE*-010.01 effective August 31, 2016 stated that a resident would be screened for pain with any new or worsened pain or a change in condition i.e. confirmed fracture. If a resident answers yes, or shows signs of observed pain, then the Nurse would assess for pain using the Pain Assessment Tool and initiate a 72-Hour Pain Monitoring Tool.

During an interview with Associate Director of Care (ADOC) and Pain Lead, they said that the identified resident should have had a pain assessment conducted when they first complained of pain. In addition, there should have been a 72 hour pain flow record initiated at the same time to evaluate the progression of pain and effectiveness of interventions being used. The ADOC acknowledged that there were no pain assessments conducted for the identified resident when pain was not relieved by initial interventions, using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

2. A CIS report was submitted to the Director related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIS report and clinical record review identified that on a specified date a resident told a staff member that they had hurt themselves. The resident was assessed by registered staff and there were no visible signs of injury. A short time later the resident complained of limited movement and pain. The resident was re-assessed and there were signs and symptoms of injury. The resident was sent to hospital for further assessment of the injury.

During a review of the progress notes for the identified resident it was noted that the resident reported pain and was given medication. The resident continued to complain of pain the following day and was given medication before being sent to hospital. The resident returned from hospital after being diagnosed with an injury. The resident continued to complain of pain related to their injury and received medication for the pain.

During a review of the identified resident's clinical record there was no evidence that the resident's pain was assessed prior to going to hospital as well as after the resident

returned from hospital with a diagnoses. There were no 72 Hour Pain Flow records found in the residents chart from the time the resident first reported pain until at least ten days after the resident returned from hospital. A physician order / prescription from the hospital prescribed pain medication to be given for the next fourteen days as needed.

The home's policy titled "Pain Assessment and Symptom Management Program", Index CARE8-P10 effective August 31, 2016, stated that all residents are to be assessed using a standardized, evidence-informed clinical tool that is appropriate for the Resident's cognitive level. Procedure "Pain Assessment and Management, Index CARE8-010.01 effective August 31, 2016 stated that a resident would be screened for pain with any new or worsened pain or a change in condition i.e. confirmed fracture. If a resident answers yes, or shows signs of observed pain, then the Nurse would assess for pain using the Pain Assessment Tool and initiate a72-Hour Pain Monitoring Tool".

During an interview with the Associate Director of Care (ADOC) and pain program lead they told the inspector that it was the home's expectation that a pain assessment be completed for any new onset of pain. They had an assessment tool on Point Click Care (PCC) but they would also accept a detailed progress note that included the location, onset, description, aggravating and easing factors, interventions and their effect. The ADOC said that a 72 Hour Pain Flow Record should also be completed for any new area of pain if the resident was receiving medication. Upon review of the identified resident's clinical record the ADOC agreed that the resident should have had a pain assessment when they returned from hospital given their diagnoses, and a 72 Hour Pain Flow Record should have been initiated before and after the resident went to hospital.

The severity was determined to be a level three as there was actual harm; and the scope of this issue was identified as being a pattern. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and Regulations. [s. 52. (2)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

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 has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care for a resident was reviewed and it stated that when assisting the resident with an activity of daily living, the resident's privacy was to be maintained but staff were to stay in the area due to risk for falls. Staff were to ensure that the call bell was accessible.

Record review and CIS report stated that on a specified date, staff assisted an identified resident with an activity of daily living. Instead of remaining with the resident, staff left them unattended for a period of time.

During an interview with the identified resident they said that staff left them unattended for a long period of time without access to the communication response system.

During an interview with one of the staff providing care for the resident on the specified date, they acknowledged that they had assisted the resident with an activity of daily living and left them unattended without access to the call bell. The staff member stated that they had notified another staff member of the situation before leaving the area.

The Director of Nursing stated that the resident should not have been left unattended and without access to the call bell as it was against the homes' policy and the resident's plan of care. The Executive Director acknowledged that staff failed to provide care as set out in the plan of care. [s. 6. (7)]

2. The licensee has 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 the resident's care needs change or care set out in the plan was no longer necessary.

During a staff interview in stage one of the Resident Quality Inspection it was identified that a resident had a device for an unspecified reason.

During an observation the identified resident was seen sitting in their chair with the device visible. The resident told the inspector they had the device for a short time.

Review of the resident's plan of care did not provide documentation related to the device.

Interview with a Personal Support Worker revealed that the resident just recently got the device because of a change in condition.

During an interview with registered staff, they said that the resident had the device for several weeks following a change in condition. Upon review of the plan of care for the resident the registered staff said that there was no order for the device and nothing documented in the treatment administration record with respect to instructions relating to the device.

The Resident Care Manager (RCM) acknowledged that the identified resident's plan of care had not been revised when the resident's care needs changed.

The severity was determined to be a level two with minimal harm / potential for actual harm; and the scope of this issue was identified as being isolated. The compliance history was a level three with one or more related noncompliance in the last three years. [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 care set out in the plan of care was provided to the resident as specified in the plan and that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm
2. Abuse of a resident by anyone or neglect of a resident that resulted in harm or a risk of harm.

A Critical Incident System (CIS) report was submitted on a specified date related to an incident that took place the day before. The CI category was identified as abuse / neglect.

The Director of Care told the inspector that once they were made aware, they conducted a full investigation of the alleged incident of abuse as described in the CIS report. The DOC acknowledged that the Critical Incident was not reported to the Director immediately. [s. 24. (1)]

2. Review of a Critical Incident System (CIS) report identified that a resident reported to the registered staff an incident of staff to resident abuse. The CIS report stated that a resident had been physically responsive with staff. The same day another staff reported that the resident had a possible injury.

The CIS report identified that the Mandatory Report Category was Abuse/ Neglect. The incident was not reported to the Director until six days after the alleged incident occurred.

During an interview with the DOC, they acknowledged that the registered staff didn't understand that they were to immediately report any alleged or suspected incident to the managers. The DOC shared that the managers were becoming aware of the incidents through a documentation review and once they became aware then they were reporting the information to the Director. The DOC said that there had been education provided to the registered staff related to mandatory reporting. [s. 24. (1)]

3. Review of a CIS report identified an incident of alleged verbal abuse. The home's investigation substantiated the claim of verbal abuse.

The Critical Incident was not reported to the Director for more than twenty four hours after the incident. The DOC acknowledged that the Critical Incident should have been reported to the Director immediately. [s. 24. (1)]

4. A CIS report submitted on a specified date related to an incident that took place twenty-four hours earlier. The CI category was identified as abuse / neglect.

The incident was reported to the manager on call and an investigation was initiated, however the incident was not reported to the Director until the following day. The DOC acknowledged that the incident of alleged abuse was not reported to the Director

immediately. [s. 24. (1)]

5. A CIS report submitted on a specified date related to an incident that took place the previous day. The CI category was identified as abuse / neglect.

The Director of Care shared that the home had conducted a full investigation of the alleged incident of abuse, but they had not reported the incident to the Director until the following day. [s. 24. (1)]

6. Record review and CIS report stated that a resident reported to a registered staff that care staff had left them unattended for a period of time without access to the communication response system. The resident also reported an incident of abuse.

The registered staff acknowledged that they documented the incident, assessed the resident and notified the charge nurse but did not inform the manager on call.

The Director of Care (DOC) said that it was the responsibility of the registered staff when they became aware of the alleged incident of abuse / neglect, to report the information upon which it was based to the manager immediately. The DOC acknowledged that the registered staff had not reported the incident to the manager, nor had the home immediately reported the alleged incident of abuse / neglect to the Director.

The severity was determined to be a level one with minimal risk of harm; and the scope of this issue was identified as a pattern. The compliance history was a level three with one or more related noncompliance in the last three years. [s. 24. (1)]

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 ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs.

Review of an identified resident's clinical record showed that on a specified date the resident was sent to hospital for further assessment of pain and other signs/ symptoms of injury. The resident returned from hospital within a few days with a specified diagnoses.

During a review of the resident's clinical record it was noted that within a period of time after first exhibiting signs of injury / disease the resident began to report associated pain. The resident's pain worsened, their mobility and participation in functional activities declined, and other signs and symptoms of injury / disease were noted. The resident was transferred to hospital for further assessment.

There was no evidence that the plan of care related to pain was based on an interdisciplinary assessment with respect to the resident's health conditions, including pain.

During an interview with Associate Director of Care (ADOC) and pain program lead they said that the identified resident should have been assessed with respect to their complaints of pain. Based on this assessment a plan of care would then have been developed to reflect the strategies and interventions being put in place to manage this pain. The ADOC acknowledged that the plan of care related to pain was not based on an interdisciplinary assessment with respect to the identified resident's health conditions including pain. [s. 26. (3) 10.]

2. A CIS report stated that a resident had a witnessed fall on a specified date. The

resident was transferred to hospital for further assessment.

Review of the clinical record identified a Falls Risk Assessment that was completed before the resident had fallen. There were no other assessments related to the resident's risk for falls and there was nothing documented in the resident's plan of care to address the resident's risk for falls and strategies / interventions that had been put in place to mitigate the resident's risk.

During an interview with the Director of Care they told the inspector that the plan of care related to falls should be based on an assessment of the resident's fall risk. Prevention strategies / interventions to reduce the risk of falls would be identified in the plan of care specific to the resident's individual needs. The DOC acknowledged that there was no documentation in the identified resident's plan of care related to fall prevention strategies that had been developed to mitigate risk for future falls. [s. 26. (3) 10.]

3. A CIS report was submitted to the Director related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. According to the CIS report, a resident reported pain to a staff member. The resident was assessed by the registered staff and there were no signs of injury. A short time later the resident reported movement limitations. The resident was assessed and there were signs and symptoms of an injury. The resident was sent to hospital where a specified injury was identified.

During a review of the progress notes for the identified resident it was noted that on a specified date the resident reported pain and was given pain medication. The resident was assessed the following day when symptoms persisted at which point further signs of injury were identified. The resident went to hospital and returned with a diagnoses of a specific injury. The resident continued to report pain upon return from hospital and received medication for pain relief.

During a review of the identified resident's clinical record there was no evidence that the resident had been assessed with respect to their pain either before or after they returned from hospital with a specified diagnoses. A physician order / prescription stated that the resident was to be given an analgesic medication of a specified dose on an as needed basis for a specific time period.

During an interview with the Associate Director of Care (ADOC) and pain program lead they told this inspector that it was the home's expectation that a plan of care related to

pain be established based on an interdisciplinary assessment of the resident's pain. The pain assessments would include the full Pain Assessment on PCC and the 72 hour Pain Flow Record. Upon review of the identified resident's clinical record the ADOC acknowledged that the resident's plan of care related to pain had not been based on an interdisciplinary assessment of the resident's pain when they returned from hospital with a specified injury.

The severity was determined to be a level two with minimal harm / potential for actual harm; and the scope of this issue was identified as being isolated. The compliance history was a level three with one or more related noncompliance in the last three years. [s. 26. (3) 10.]

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 plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including, allergies, pain, risk of falls, and other special needs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Record review and CIS report stated that on a specified date, two staff assisted a resident with an activity of daily living. The resident was left unattended for a period of time without access to the communication response system. When staff did return, the resident reported that they had been rough with them while providing care resulting in injury.

During an interview with the identified resident they said that staff left them unattended for a period of time without access to the call bell. When staff returned some time later they were rough while providing care.

Clinical record review showed that there was no head to toe assessment completed for the resident.

Skin and Wound Care policy Care12-010.01 dated August 31, 2016, reviewed July 31, 2016, stated that all residents are to have a head to toe assessment whenever there was a change in health status that affects skin integrity. The resident non-abuse toolkit for conducting an alleged abuse investigation dated November 2010 stated under the twelve steps of an internal investigation "step one: assess the resident. A nursing assessment including a full body check of the resident is conducted to determine any signs of injury. This should be completed by the registered staff on duty at the time of the incident but may be completed by a member of the clinical management team".

A progress note on the date of the incident stated that the identified resident was assessed and an area of altered skin integrity was noted.

During an interview with the staff member that conducted the assessment they acknowledged that while they had documented a progress note they had not completed the full head to toe assessment.

In an interview with the Wound Care Nurse they shared that they received a referral for the resident related to the identified incident. The staff member said that they would have documented any areas of altered skin integrity in the Treatment Administration Record (TAR) for the registered staff to monitor. The TAR for that time period was reviewed and there was no documentation related to the altered skin integrity. The staff member acknowledged that they must have missed adding it to the TAR, but that would be the expectation. The Wound Care Nurse confirmed that there was no skin assessment and no head to toe assessment completed after the identified incident and the reported altered skin integrity.

The DOC said that the expectation was that registered staff would complete an assessment and document their assessment, reassessments, interventions and the resident's responses to interventions whenever there was a change in a resident's condition. The DOC agreed that the identified resident should have had a head to toe assessment and ongoing monitoring with respect to injuries sustained as a result of the incident.

The severity was determined to be a level two with minimal harm / potential for actual harm; and the scope of this issue was identified as being isolated. The compliance history was a level three with one or more related noncompliance in the last three years. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and, if required, a post-fall assessment conducted using a clinically appropriate

assessment instrument that was specifically designed for falls.

A CIS report submitted to the Director described an incident where a resident had a witnessed fall.

During a review of the resident's clinical record, including the electronic documentation system and the resident's paper chart, there was no documentation of a post fall assessment for the identified fall.

The Director of Care (DOC) told this inspector that it was the home's expectation that a post fall assessment be completed for every fall. The DOC acknowledged that there was no documented post fall assessment for the resident's identified fall.

The licensee failed to ensure that when the identified resident had fallen, they were assessed using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

2. A CIS report submitted to the Director related to an incident where a resident reported to a staff that they had fallen and injured themselves. The resident was assessed by the registered staff and there were no signs of injury. A short time later the resident was reassessed and there were signs and symptoms of injury.

During a review of the progress notes for the identified resident it was noted that the resident told a staff member that they had a fall and they were experiencing pain. The resident was given medication for the pain. When the resident was assessed there were signs and symptoms of injury.

During a review of the identified resident's clinical record there was no evidence that a post fall assessment had been conducted for the incident outlined in the CI report and clinical records.

The Post-Fall Management Procedure, Index CARE5-010-02 effective August 31, 2016 stated that all falls are entered into the Risk Management Module or Resident Incident Internal Report.

During an interview with the Resident Care Manager (RCM) they told the inspector that it was the home's expectation that a post fall assessment be conducted for all falls in their Risk Management System and this information would push into Point Click Care as a

post falls assessment. The RCM acknowledged that a post fall assessment had not been conducted for the identified resident's fall.

The severity was determined to be a level two with minimal harm / potential for actual harm; and the scope of this issue was identified as being a pattern. The compliance history was a level two with one or more unrelated noncompliance in the last three years. [s. 49. (2)]

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 when a resident has fallen, the resident was assessed and, if required, a post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

During a review of the resident's clinical record it was noted that within a short period of time after the resident first exhibited signs of injury / disease they began to report associated pain. Over the next several days the resident's pain worsened, their mobility and participation in functional activities declined, and other signs and symptoms of injury / disease worsened. The resident was transferred to hospital when pain levels reached a point that it was difficult to provide care for the resident.

During an interview with a registered staff they told the inspector that they had not conducted an assessment of the entire area when the resident first exhibited signs of potential injury as they were focused on the specific sign. The registered staff could not recall being advised of an area of altered skin integrity. If they had been advised of altered skin integrity they would have sent a referral to the wound nurse and conducted a thorough assessment of the area. The wound nurse would then put it on the Treatment Administration Record (TAR) to ensure that it was monitored.

The Director of Care acknowledged that there had been documentation prior to a specified date that identified altered skin integrity. The DOC said that staff should have completed a head to toe assessment and a skin assessment in relation to the altered skin integrity.

The licensee has failed to ensure that the identified resident received a skin assessment, using a clinically appropriate assessment instrument, when altered skin integrity was identified. [s. 50. (2) (b) (i)]

2. During a review of the identified resident's clinical record it was noted that the resident returned from hospital and staff conducted a head to toe assessment. The assessment identified areas of altered skin integrity. There were no skin assessments found for these areas of altered skin integrity in the resident's electronic clinical record or the paper chart.

During an interview with the Skin and Wound Lead / RN they told inspectors that it was

the home's expectation that all areas of altered skin integrity were assessed by registered staff. The assessment would be found in the progress notes. Staff should send a referral to one of the skin and wound leads and they would ensure that the area of altered skin integrity was entered on the Treatment Administrator Record (TAR) to ensure that the area was monitored and reassessed.

The Resident Care Manager (RCM) told inspectors they had reviewed the identified resident's clinical record and they could not find any skin assessments related to the areas of altered skin integrity found during the head to toe assessment.

The licensee failed to ensure that the identified resident's altered skin integrity was assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian who is a member of the staff of the home.

During a review of the identified resident's clinical record it was noted that a resident returned from hospital and staff conducted a head to toe assessment. The assessment identified areas of altered skin integrity.

Review of the resident's clinical record did not identify any referrals to the Registered Dietitian (RD) related to the areas of altered skin integrity noted in the head to toe assessment. In addition, there were no RD assessments or interventions in the plan of care related to the identified areas of altered skin integrity.

During an interview with the RD they shared that it was the expectation of the home that a referral be sent to the RD for any areas of altered skin integrity. The RD told the inspector that they had not received a nutrition care referral for the identified resident related to altered skin integrity. They said they had not assessed the resident related to these areas of altered skin integrity. [s. 50. (2) (b) (iii)]

4. The licensee has failed to ensure that a resident at risk of altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The Associate Director of Care (ADOC) submitted a CIS report to the Ministry of Health and Long-Term Care (MOHLTC) to inform the Director of an alleged incident of abuse of a resident. The CIS stated that the identified resident sustained an area of altered skin integrity as a result of the incident.

During a review of the identified resident's plan of care in Point Click Care (PCC) and the resident's paper chart there was no documentation that the altered skin integrity was monitored and reassessed by a member of the registered nursing staff.

The policy titled "Skin and Wound Care" that was last reviewed July 31, 2016, stated that the steps for altered skin integrity included "eTAR/TAR: enter order to assess and document in Interdisciplinary Progress Note Q7 days minimum or more frequently as indicated".

In interviews with the Registered Nurse/Wound Care Lead and ADOC they said that the identified resident's altered skin integrity should have been monitored daily and assessed at a minimum weekly by the registered staff and this should be documented in the progress notes and Treatment Administration Record. The ADOC acknowledged that this had not been done for the identified resident's skin concern.

The licensee has failed to ensure that the identified resident, who had altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated. [s. 50. (2) (b) (iv)]

5. Review of the identified resident's clinical record showed that when the resident returned from hospital a head to toe assessment was completed. The assessment identified that the resident had several areas of altered skin integrity.

There were no skin assessments or documentation in the Treatment Administration Record (TAR) related to these areas of altered skin integrity in the resident's electronic clinical record or the paper chart.

During an interview with the Skin and Wound Lead/RN they told inspectors that it was the home's expectation that all areas of altered skin integrity were monitored and assessed by registered staff at a minimum weekly until the areas had resolved. This would be documented in the progress notes. Once an area of altered skin integrity was identified the registered staff would send a referral to one of the skin and wound leads and they would ensure that the Treatment Administration Record (TAR) was updated to ensure

that the areas were monitored and reassessed.

The RCM told inspectors they had reviewed the identified resident's clinical record and acknowledged that there were no weekly skin assessments completed with respect to the resident's altered skin integrity. The TAR had no record of these areas of altered skin integrity.

The licensee failed to ensure that the the resident's identified areas of altered skin integrity were monitored and reassessed at least weekly by a member of the registered nursing staff.

The severity was determined to be a level two with minimal harm / potential for actual harm; and the scope of this issue was identified as being widespread. The compliance history was a level three with one or more related noncompliance in the last three years. [s. 50. (2) (b) (iv)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment; that the resident was assessed by the registered dietitian; and that the areas of altered skin integrity were reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

The previous ADOC submitted a CIS report to the Ministry of Health and Long-Term Care (MOHLTC) to inform the Director of an alleged incident of resident abuse. The CIS stated that the long-term action would be developed based on the outcome of the investigation.

The Centralized Intake Assessment Triage Team (CIATT) requested an amendment of the identified CIS report that included the outcome of the investigation and the interventions that were put in place to prevent re-occurrence.

In an interview with the Executive Director it was stated that the long-term actions to prevent recurrence and the results of the investigation related to the alleged abuse of the resident should have been reported to the MOHLTC and were not.

The licensee has failed to report to the Director the results of the investigation related to the alleged abuse of the identified resident and the long-term actions taken to prevent re-occurrence.

The severity was determined to be a level one with minimal risk of harm; and the scope of this issue was identified as being isolated. The compliance history was a level three with one or more related noncompliance in the last three years. [s. 23. (2)]

Issued on this 1st day of November, 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) :	DOROTHY GINTHER (568), JENNA BAYSAROWICH (667), NUZHAT UDDIN (532), SHERRI COOK (633)
Inspection No. / No de l'inspection :	2017_600568_0009
Log No. / No de registre :	006606-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 13, 2017
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000
LTC Home / Foyer de SLD :	FOREST HEIGHTS 60 WESTHEIGHTS DRIVE, KITCHENER, ON, N2N-2A8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kim Brennan

To REVERA LONG TERM CARE 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. 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 ensure that all residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A CIS report submitted to the Director described an incident where an identified resident was observed exhibiting inappropriate behaviours towards a co-resident. The co-resident was very upset by the behaviours.

During a review of the identified resident's clinical record, progress notes stated that a staff member had observed the identified resident exhibit inappropriate behaviours toward a co-resident. The co-resident was visibly upset by the incident. The identified resident tried to re-approach the co-resident but staff were able to intervene. Following the incident interventions were put in place for the identified resident and a referral was sent to BSO as the resident had not exhibited these types of behaviours in the past.

Progress notes stated that the identified resident attempted to engage the co-resident the day after the first incident and the co-resident became extremely upset as they remembered the incident the day before.

The plan of care for the identified resident outlined that the resident exhibited some responsive behaviours for which interventions had been put in place, but the resident had not exhibited behaviours of this nature since being admitted to the home. (568)

2. A CIS report submitted to the Director, referred to an incident that was identified as abuse / neglect. The CI report identified that a staff member witnessed a resident exhibit inappropriate behaviours towards a co-resident. Staff intervened immediately and removed the resident. The co-resident did not appear in distress and refused to be examined.

The identified resident's plan of care stated that the resident exhibited a number of responsive behaviours due to impaired cognition. The resident was followed by Behavioural Supports Ontario within the home and had a number of interventions in place to mitigate risk to residents and staff.

During an interview with the staff member that witnessed the incident, they told the inspector that they recalled the situation where the identified resident exhibited inappropriate behaviours towards a co-resident. They intervened immediately and then notified the registered staff.

During interviews with two other staff they told the inspector that the identified resident had a number of responsive behaviours which were directed toward staff and residents. The BSO Lead shared that the identified resident was being following by their team. A number of interventions had been put in place to mitigate the risk to staff and other residents related to the resident's behaviours. Following this incident they had introduced additional strategies in order to ensure other residents were protected. (568)

3. Section 2.(1) of Reg 79/10, 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.

Record review and a Critical Incident System (CIS) report stated that a resident reported to a registered staff that their caregiver left them unattended for a long period of time while they were performing an activity of daily living. The resident reported that when staff finally came to assist them they were rough. The registered staff assessed the resident and noted an injury as described by the resident.

Investigation notes confirmed that the identified resident had been left unattended for a period of time without access to the communication response

system.

During an interview with the identified resident they said that the incident in question was upsetting and made even worse when the staff finally came to provide assistance and they were rough.

In an interview with one of the staff members involved, they acknowledged that they left the resident unattended but said they had notified another staff member of the resident's situation before leaving the area. They acknowledged that the resident did not have access to the communication response system during the time they were unattended. The staff member denied having been rough. The staff member that had been left to assist the resident stated that because they were so busy they did not have time to get to the resident. The resident was upset at having been left for so long but the staff member denied having been rough with them.

The Director of Care stated that after further investigation it was determined that the resident's physical injury was not likely caused by staff care. The DOC acknowledged that the resident was left unattended for an unacceptable amount of time and without access to the communication response system. The staff had failed to provide care for the resident and their inaction had the potential for harm to the resident.

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(532)

4. Section 2.(1) of O.Reg 79/10, defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A Critical Incident System (CIS) report stated under the heading "incident description" that a staff member witnessed an incident of potential verbal abuse. During an interview with the staff member that witnessed the incident, they said that they heard a staff speaking to a resident in a loud and reprimanding manner. The resident was upset by the way the staff spoke to them and felt blamed and angry. The DOC was informed and an investigation was initiated.

During an interview with the accused staff member they recalled having spoken

to the resident in what they felt was a stern voice but acknowledged that it may have been perceived by others as yelling at the resident.

The Director of Care said that the staff member was provided with education related to dementia care and staff approach to prevent this type of incident from occurring again.

The severity was determined to be a level three as there was actual harm; and the scope of this issue was identified as isolated. The compliance history was a level three with one or more related noncompliance in the last three years. A VPC was issued during an RQI inspection #2016_271532_0009 on March 21, 2016.
(532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 13, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee shall ensure that when a resident's pain is not relieved by initial interventions:
i) the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose;
ii) strategies/interventions are developed and implemented to address the identified pain;
iii) the pain is reassessed to determine the effectiveness of strategies and the need for new interventions.

Grounds / Motifs :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A CIS report was submitted to the Director related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

The CIS report and clinical record review identified that on a specified date a resident told a staff member that they had hurt themselves. The resident was assessed by registered staff and there were no visible signs of injury. A short time later the resident complained of limited movement and pain. The resident was re-assessed and there were signs and symptoms of injury. The resident was sent to hospital for further assessment of the injury.

During a review of the progress notes for the identified resident it was noted that

the resident reported pain and was given medication. The resident continued to complain of pain the following day and was given medication before being sent to hospital. The resident returned from hospital after being diagnosed with an injury. The resident continued to complain of pain related to their injury and received medication for the pain.

During a review of the identified resident's clinical record there was no evidence that the resident's pain was assessed prior to going to hospital as well as after the resident returned from hospital with a diagnoses. There were no 72 Hour Pain Flow records found in the residents chart from the time the resident first reported pain until at least ten days after the resident returned from hospital. A physician order / prescription from the hospital prescribed pain medication to be given for the next fourteen days as needed.

The home's policy titled "Pain Assessment and Symptom Management Program", Index CARE8-P10 effective August 31, 2016, stated that all residents are to be assessed using a standardized, evidence-informed clinical tool that is appropriate for the Resident's cognitive level. Procedure "Pain Assessment and Management, Index CARE8-010.01 effective August 31, 2016 stated that a resident would be screened for pain with any new or worsened pain or a change in condition i.e. confirmed fracture. If a resident answers yes, or shows signs of observed pain, then the Nurse would assess for pain using the Pain Assessment Tool and initiate a 72-Hour Pain Monitoring Tool".

During an interview with the Associate Director of Care (ADOC) and pain program lead they told the inspector that it was the home's expectation that a pain assessment be completed for any new onset of pain. They had an assessment tool on Point Click Care (PCC) but they would also accept a detailed progress note that included the location, onset, description, aggravating and easing factors, interventions and their effect. The ADOC said that a 72 Hour Pain Flow Record should also be completed for any new area of pain if the resident was receiving medication. Upon review of the identified resident's clinical record the ADOC agreed that the resident should have had a pain assessment when they returned from hospital given their diagnoses, and a 72 Hour Pain Flow Record should have been initiated before and after the resident went to hospital.
(568)

2. A Critical Incident System (CIS) report was submitted to the Director in

relation to an injury to an identified resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

During a review of the resident's clinical record it was noted that within a short period of time after the resident first exhibited signs of injury / disease they began to report associated pain. Over the next several days the resident's pain worsened, their mobility and participation in functional activities declined, and other signs and symptoms of injury / disease worsened. The resident was transferred to hospital for further assessment.
Review of assessments for the resident identified that there was a pain flow record initiated when the resident returned from hospital with respect to the resident's complaints of pain. There were no other pain assessments found for the resident prior to their transfer to hospital.

During an interview with a Personal Support Worker, they told the inspector that they recalled providing care for the identified resident just before the resident went to hospital. When asked if the resident had any signs of injury before going to hospital, they said that the resident had exhibited some signs / symptoms of injury including pain.

A registered staff told the inspector that it was the home's expectation that any new area of pain would be assessed using their assessment on Point Click Care. They would also complete a 72 Hour Pain Flow Record. When asked if the staff member recalled the period of time before the identified resident went to hospital for further evaluation of their pain, the registered staff said that they remembered this time period. When asked if the resident had reported any pain, the registered staff said that they complained of pain a few days prior to going to hospital and there were other signs / symptoms of injury.

The home's policy titled "Pain Assessment and Symptom Management Program", Index CARE8-P10 effective August 31, 2016, stated that all residents are assessed using a standardized, evidence-informed clinical tool that is appropriate for the Resident's cognitive level. Procedure "Pain Assessment and Management, Index CARE*-010.01 effective August 31, 2016 stated that a resident would be screened for pain with any new or worsened pain or a change in condition i.e. confirmed fracture. If a resident answers yes, or shows signs of observed pain, then the Nurse would assess for pain using the Pain Assessment Tool and initiate a 72-Hour Pain Monitoring Tool.

During an interview with Associate Director of Care (ADOC) and pain program lead, they said that the identified resident should have had a pain assessment conducted when they first complained of pain. In addition, there should have been a 72 hour pain flow record initiated at the same time to evaluate the progression of pain and effectiveness of interventions being used. The ADOC acknowledged that there were no pain assessments conducted for the identified resident when pain was not relieved by initial interventions, using a clinically appropriate assessment instrument specifically designed for this purpose.

The severity was determined to be a level three as there was actual harm; and the scope of this issue was identified as being a pattern. The home does not have a history of noncompliance in this subsection of the Long-Term Care Homes Act and Regulations. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 13, 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, 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
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 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 13th day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Dorothy Ginther

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