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 8, 2019	2019_624196_0018	024712-18, 024715-18, 025652-18, 032183-18	Critical Incident System

Licensee/Titulaire de permis

Geraldton District Hospital
500 Hogarth Avenue West GERALDTON ON P0T 1M0

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

Geraldton District Hospital
500 Hogarth Avenue West GERALDTON ON P0T 1M0

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

LAUREN TENHUNEN (196), KATHERINE BARCA (625)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 17 - 21, 2019.

The following intakes were inspected during this Critical Incident System (CIS) inspection:

- One intake related to staff to resident emotional abuse;

- One intake related to a medication incident; and

- Two intakes related to residents' falls that resulted in a significant change to their health condition.

During the course of the inspection, the inspector(s) spoke with the Chief Nursing Executive (CNE), Long-Term Care Nurse Managers (LTC Nurse Managers), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapist (PT), Physiotherapy Assistant (PTA), Kinesiologist, Staff Educator, Behavioural Supports Ontario (BSO) Therapeutic Recreationist, Long-Term Care Coordinator, Personal Support Workers (PSWs), Ward Clerk, Resident Assessment Instrument (RAI) Coordinator and residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident, and resident to resident interactions, reviewed relevant health care records, home's investigation records, employee files, staff education records, staff schedules, Critical Incident System (CIS) reports, and applicable licensee policies, procedures and programs.

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

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

9 WN(s)
5 VPC(s)
0 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).

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 there was a written plan of care for resident #003 that set out clear directions to staff and others who provided direct care to the resident regarding their transferring ability, mobility and use of mobility aids.

A Critical Incident System (CIS) report was submitted to the Director for a fall that occurred on an identified date, for which the resident was taken to hospital and which resulted in a significant change to their health condition.

(a) The Transferring section of resident #003's current care plan identified their particular transferring ability; the physical assistance required; and specific staff support as needed.

During an interview with PSW #105, they stated that resident #003 required staff to provide specific assistance when transferring as they no longer transferred in a particular

way.

During an interview with RPN #107, they stated that they had responded to resident #003's fall on the identified date, and that the resident had attempted to transfer themselves in a particular way when they fell. The RPN identified that the resident no longer transferred in a particular way but required specific assistance with transfers. The RPN stated the current care plan was not clear when it identified the resident was independent with transfers, as well as required specific assistance to transfer.

During an interview with LTC Coordinator #108, they stated that resident #003's current care plan was not clear as to their transfer status and new staff would not know what the correct transfer status of the resident was.

During an interview with the current LTC Nurse Manager #109, they reviewed the Transferring section of resident #003's current care plan and indicated that it was not clear as it listed different transferring abilities for the resident.

(b) The Falls/Balance section of resident #003's current care plan identified that the resident should be encouraged to use different ambulation devices at specific times.

During observations of resident #003 throughout the inspection, the Inspector did not observe the resident with a specific ambulation device. The Inspector had observed the resident with a different ambulation device in their bedroom, in the TV lounge and in the dining room.

During an interview with PSW #105, they stated that the resident no longer used a specific ambulation device, but now walked with a different ambulation device.

During an interview with RPN #107, they stated that resident #003 had not used a specific ambulation device for a while and currently walked with different ambulation device.

During an interview with the current LTC Manager #109, they stated that resident #003's Falls/Balance section of their current care plan was not clear as to whether the resident used a specific ambulation device at all times or a different ambulation device for locomotion. They stated that it was not clear at all as to what the resident was to use.

(c) Resident #003's current care plan identified:

- in the Locomotion on Unit section, that the resident would be able to mobilize on the unit with the help of their specific ambulation device with staff assistance; was to use their different specific ambulation device at all times when ambulating; staff were to supervise if they experienced a change in health status; the resident now used a specific ambulation device for locomotion; staff were to encourage the resident to perform an action as much as possible; and
- in the Walk in Room section, the resident would maintain their ability to walk in their room independently; staff were to ensure they assisted the resident at all times with ambulation; staff were to assist the resident with ambulating within their room at all times; that the resident was independent with ambulation in their room; that the resident required a specific type of assistance to walk in their room.

During an interview with PSW #105, they stated, with respect to the Locomotion on Unit section of resident #003's current care plan, that the resident no longer used a specific ambulation device and did not need to be encouraged by staff to perform an action with a specific ambulation device as they now walked with a different ambulation device. They also stated, with respect to the Walk in Room section of the current care plan, that the resident was not independent with ambulation in their room but needed a specific type of assistance. The PSW identified that the care plan had conflicting information.

During an interview with the current LTC Nurse Manager #109, they stated that resident #003's current care plan was not clear with respect to their mobility as listed in the Locomotion on Unit and Walk in Room sections. [s. 6. (1) (c)]

2. The licensee has failed to ensure that there was a written plan of care for resident #003 that set out clear directions to staff and others who provided direct care to the resident regarding the level of assistance they required for mobility.

A CIS report was submitted to the Director for a fall that occurred on an identified date, for which the resident was taken to hospital and which resulted in a significant change to their health condition. The report identified that, effective after the fall, the resident would require a specific type of assistance when ambulating with their specific ambulation device.

Resident #003's care plan in place post-fall identified the following interventions:
- in the Walk in Room section, the resident was independent with ambulation in their room;
- in the Walk in Corridor section, the resident was to ask for assistance when they

experienced a change in health status;
- in the Locomotion On Unit section, staff were to supervise the resident if they experienced a change in health status; staff were to provide a specific type of assistance; and
- in the Locomotion Off Unit section, the resident may require a specific type of assistance from staff as necessary to use an ambulatory aid for safety; staff were to provide a specific type of assistance only.

Each of the identified sections contained handwritten entries dated on a specific date, located in each section's expected outcomes area, indicating the resident required specific staff assistance when using their specific ambulation device.

During an interview with PSW #105, they reviewed resident #003's care plan in place after their fall. The PSW identified the sections Walk in Room, Walk in Corridor, Locomotion On Unit and Locomotion Off Unit, contained the details noted by Inspector #625. The PSW stated that the resident required a specific type of assistance at all times and the other mobility interventions were no longer current.

During an interview with the Resident Assessment Instrument (RAI) Coordinator #110, they reviewed the sections Walk in Room, Walk in Corridor, Locomotion On Unit and Locomotion Off Unit of resident #003's care plan in place after their fall. The RAI Coordinator stated that, in addition to listing the current intervention of a specific type of assistance provided by staff, the care plan continued to list items that were not current as staff would change the care plan by hand but would not cross off items that were not current. They stated staff would have to follow whichever intervention reflected the most recent date.

During an interview, the current LTC Nurse Manager #109 reviewed the sections Walk in Room, Locomotion on Unit and Locomotion off Unit, from resident #003's care plan in place after their fall. They identified that the older interventions and expected outcomes were not removed when the updated ones were included and indicated that it was not clear to staff the type of assistance the resident required. [s. 6. (1) (c)]

3. The licensee has failed to ensure that there was a written plan of care for resident #002 that set out clear directions to staff and others who provided direct care to the resident #002.

(a) A CIS report was submitted for a fall that occurred on an identified date, where

resident #002 lost their footing while being assisted by staff during an activity of daily living. The report identified the resident sustained an injury which resulted in a significant change to their health status. The CIS report identified that, after resident #002's fall, they transferred with a specific type of staff assistance using an assistive device.

Inspector #625 reviewed resident #002's care plan in place after their fall, which identified an expected outcome that the resident would transfer safely with a specific type of staff assistance; contained interventions which indicated the resident transferred with a particular level of assistance of a specified number of staff for all transfers; and transferred from bed to a type of chair on particular days using a specific type of assistive device and requiring the presence of the Occupational Therapist (OT) or PT until staff were instructed on how to transfer the resident.

During an interview with PSW #105, they reviewed resident #002's care plan in place post fall and identified the resident had required a specific number of staff to transfer using a specific type of assistive device, and identified the transferring section of the resident's care plan in place after their fall also listed that the resident required the assistance of a specific number of staff.

During an interview with the current LTC Nurse Manager #109, they indicated that resident #002's care plan in place post fall did not provide clear direction to staff with respect to transfers.

(b) Inspector #625 reviewed resident #002's current care plan with a focus on falls prevention and management and mobility:
- the Locomotion on Unit section identified the resident required a specific type of staff assistance to use a specific type of ambulation device; required staff to provide a particular type of assistance on the unit as they used a specific assistive device; and the resident used a different assistive device as their primary mode of locomotion;
- the Transferring section identified a goal as the resident would be able to transfer safely with a specific type of staff assistance; as well as required an assistive device;
- the Aids to Daily Living section identified the resident used a specific type of assistive device; staff were to ensure a safety device was applied; the resident was not using a safety device while in the specific type of ambulation device;
- the Safety Devices/Restraints section identified the resident was to be transferred by a specific number of staff until reassessed by OT; used a type of safety device when using their specific type of ambulation device;
- the Bowel function section, staff were to encourage the resident to do a particular

activity by themselves on the unit for exercise and to promote elimination; and
- in the Potential/High Risk for Falls section, the resident was to use a specific safety device in their specific type of ambulation device; and staff were to ensure certain aids were in place when in their specific types of positioning and ambulation devices.

During an interview with PSW #105, they reviewed resident #002's current care plan and stated that the Locomotion on Unit section listed the resident used both a specific type of ambulation device and a different type of ambulation device, but the resident only used a specific type of ambulation device; in the Potential/High Risk for Falls section listed the resident used certain safety devices when in their ambulation or positioning devices stated they were not sure what a particular devices were, the resident did not use those things but did use a different safety device; and the Bowel function section identified staff were to encourage the resident to perform an activity which was contradictory to the Locomotion on Unit which identified the resident required a level of assistance of a number of staff with the use of their ambulation device.

During an interview with the RAI Coordinator #110, they stated that resident #002's care plan Locomotion on Unit section listed the resident used both a specific type of ambulation device and a different type of ambulation device, when the resident used only the one specific type of ambulation device; the care plan listed the resident required two different types of assistance using the ambulation device; and listed the resident transferred with the assistance of a number of staff as well as transferred using a specific type of transfer device. The RAI Coordinator identified that staff were referred from one section to another in the 58 page care plan for details and, for some interventions, staff would then need to check the dates to see which section contained the most recent date to determine what to follow.

During an interview with the current LTC Nurse Manager #109, they identified that resident #002's current care plan did not provide clear direction to staff regarding the resident's use of ambulation devices, or personal assistive service devices. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the care set out in the plan of care related to an activity of daily living, and positioning was provided to resident #002 as specified in the plan.

(a) A CIS report was submitted to the Director for a fall that occurred on an identified date for which resident #002 was taken to hospital and which resulted in a significant change to their health status. The report identified that RPN #103 was assisting resident #002

with an activity of daily living, resident #002 lost their footing during an action, RPN #103 assisted the resident to the floor, and resident #002 was transferred back to bed with the assistance of two staff. The report identified that that RPN #103 was present during the incident, and also identified that resident #002 required a specific number of staff to transfer at all times. The report did not list a second person present during the incident.

A progress note of the fall that occurred on the identified date, entered by RPN #103, was consistent with the details of the fall in the CIS report, and identified that resident #002 was assisted to the floor by RPN #103. The note did not identify the presence of a second staff member during the fall.

Resident #002's care plan in place at the time of the fall, identified the resident required the physical assistance of a specific number of staff with an activity of daily living. The care plan identified the resident may require a specific type of assistance.

During an interview with RPN #103, they stated that they were the only staff member present when resident #002 fell while being assisted with an activity of daily living. The RPN stated that they believed the resident required the assistance of one staff member with an activity of daily living, at that time, but that sometimes two staff would assist with this activity of daily living, as they wouldn't want to stand up anymore.

During an interview with previous LTC Nurse Manager #101, they reviewed resident #002's care plan in place at the time of the fall and indicated that resident #002's care plan had not been followed if only one staff member was present when the resident was assisted with an activity of daily living, and fell.

(b) During multiple observations of resident #002 during the inspection, Inspector #625 noted the resident positioned in an ambulation device with their legs positioned in a specific manner.

On a specific date during the inspection, Inspector #625 observed resident #002 seated in their ambulation device, positioned in a certain way.

A review of resident #002's current care plan identified that staff were to ensure proper positioning of the resident while in their ambulation device for a particular reason; and that the resident was to use a positioning aid to be positioned in a certain way as per an assessment by the Physiotherapist (PT).

During an interview with Behavioural Supports Ontario (BSO) Therapeutic Recreationist #111, they stated that resident #002 required the use of a positioning aid when in their ambulation device, and that this intervention had been added to the resident's care plan about two weeks prior.

During an interview with Kinesiologist #112, they stated that resident #002 should have had a positioning aid on their ambulation device, and that they were included in their care plan.

During an interview with PT #113, they stated resident #002 required a positioning aid when in their ambulation device and that they had put the use of the positioning aid in place two weeks prior.

The Inspector then observed Kinesiologist #112 and PT #113 reposition/elevate the resident in their ambulation device and apply the positioning aid, positioned in a certain way. [s. 6. (7)]

5. The licensee has failed to ensure that resident #003 was reassessed and their plan of care was reviewed and revised when their care needs changed, or care in the plan was no longer necessary, with respect to their mobility and ambulation aid use.

A CIS report was submitted to the Director for a fall that occurred on an identified date, for which resident #003 was taken to hospital and which resulted in a significant change to their health status.

(a) A review of resident #003's current care plan identified, under the Aids to Daily Living section, that the resident used an ambulation device with staff assistance for certain distances. The Locomotion Off Unit focus, identified the resident would be assisted to the dining room for meals with a certain type of staff assistance.

During observations of resident #003 throughout the inspection, Inspector #625 had observed the resident with their ambulation aid in the TV lounge and dining room.

During an interview with PSW #105, they stated that resident #003 used their ambulation aid when ambulating with staff not just for short distances, but also for longer distances, like to the dining room and no longer required staff to assist them there. The PSW stated the care plan had not been updated and had old information.

During an interview with RPN #107, they stated that resident #003 was able to walk to the TV room and dining room with staff present. The RPN stated the resident's current care plan was not correct when it identified the resident walked short distances like to the bathroom and used an ambulation aid to get to the dining room. The RPN stated that the care plan needed to be updated.

During an interview with the current LTC Nurse Manager #109, they identified that, if the Locomotion Off Unit section of resident #003's current care plan identified that the resident was to be provided with a certain type of staff assistance to the dining room for meals by staff, but that staff were assisting the resident to walk to the dining room with their ambulation aid, the care plan had not been reviewed and revised. They also indicated that, if the Aids to Daily Living section of the current care plan identified the resident used an ambulation aid when ambulating with staff for short distances only, such as from their bed to their bathroom, but the resident now walked from their room to the dining room, the care plan had not been reviewed and revised.

(b) The Falls/Balance focus of resident #003's current care plan identified the resident had an order for a safety device while in their ambulation device dated on a particular date and that a safety device monitoring sheet was in place.

During observations of resident #003, Inspector #625 had not observed the resident to use an ambulation device or a safety device.

During an interview with PSW #105, they stated that resident #003 no longer used an ambulation device, that their family had removed their personal ambulation device as the resident did not use it. The PSW identified that, if the resident was going out, they would use the unit's spare ambulation device which did not have a safety device attached to it. The PSW stated they no longer signed safety device monitoring sheets as the resident did not use an ambulation device with a safety device.

During an interview with RPN #107, they stated that resident #003 had previously used an ambulation device with a safety device, but no longer used these devices.

During an interview with current LTC Nurse Manager #109, they stated that resident #003's Falls/Balance focus of their current care plan had not been reviewed and revised to reflect the resident's current status as they no longer used the safety device and now ambulated on the unit. [s. 6. (10) (b)]

6. The licensee has failed to ensure that resident #002 was reassessed and their plan of care was reviewed and revised when their care needs changed, or care in the plan was no longer necessary, with respect to their use of a health device, the application of a type of positioning aid, support required for an extremity during transfers, and their use of a safety device when in bed.

A CIS report was submitted to the Director for a fall that occurred on an identified date, for which resident #002 was taken to hospital and which resulted in a significant change in their health condition.

(a) The CIS report identified resident #002 was offered a specific health device but was not able to comprehend instructions for use.

A review of resident #002's current care plan identified an intervention which, if the resident was experiencing a particular condition, that staff were to use a specific health device with the resident as a nursing measure.

During an interview with PSW #105, they stated that the current care plan was not accurate when it identified resident #002 used a specific health device.

During an interview with the current LTC Nurse Manager #109, they stated that the resident's current plan included an intervention for use of a specific health device as a nursing measure. The LTC Nurse Manager stated that the residents' health status had changed and staff no longer used this specific health device with the resident.

(b) The CIS report identified resident #002 required a specific type of positioning aid applied to a body part for a period of time, and during certain activities. Staff were to support the resident's extremity during certain activities using an assistive aid.

A review of resident #002's current care plan identified the resident was to wear a specific type of positioning aid at certain times and during certain activities.

During an interview with PSW #105, they stated resident #002 no longer used the specific type of positioning aid but transferred in a certain way with the assistance of a number of staff.

During an interview with RPN #107, they stated that resident #002's care plan needed to be updated as the resident had been assessed by the PT and was able to perform an

activity, able to transfer in a specific way, and no longer required staff to support their extremity during transfers.

During an interview with the LTC Nurse Manager #109, they indicated that resident #002's current care plan had not been reviewed and revised to indicate the resident no longer used a specific type of positioning aid and didn't transfer in a specific way.

(c) The CIS report identified the resident required an ambulation device and a safety device for falls prevention.

A review of resident #002's current care plan identified specific interventions related to the use of the safety device for falls prevention.

Inspector #625 observed a specific type of safety device for falls prevention in place on resident #002's bed.

During an interview with PSW #105, they stated that staff did not transfer resident #002's safety device for falls prevention from their ambulation device to their bed as they no longer had to because the resident had a different type of safety device for falls prevention on their bed.

During an interview with the RAI Coordinator #110, they stated the resident's current care plan did not list the use of specific type of safety device for falls prevention but listed that the resident used a different type of safety device for falls prevention.

During an interview with the current LTC Nurse Manager #109, they indicated that resident #002's current care plan had not been reviewed and revised to reflect their use of a specific type of safety device for falls prevention. [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 that ensures; there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident; that the care set out in the plan of care is provided to the resident as specified in the plan; and that the resident is 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 is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A CIS report was submitted to the Director on an identified date, for an incident which had occurred four days previous, in which RPN #100 was alleged to emotionally abuse resident #001. The report indicated that resident #001's Substitute Decision Maker (SDM) had provided information to a day staff RPN about an incident in which the resident was provided medications in a forceful manner the evening before. The report further indicated that the resident didn't take HS (bedtime) medication.

Ontario Regulation 79/10, s. 2. (1), defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are

performed by anyone other than a resident.

The homes' policy titled, "Zero Tolerance of Abuse and Neglect Long Term Care" indicated that, "All staff, volunteers, contractors, affiliated personnel and management/administration are required:
- To immediately report to the registered staff, charge nurse, LTC Nurse Manager or designate on duty, and /or administration on-call for the Home, after hours, at the time of the witnessed or alleged incident of abuse or neglect.
- To fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the MOHLTC by telephone notification to the Centralized Intake Assessment Triage Team (CIATT)..."

The Geraldton District Hospital policy read:
- "If the abuse occurs on the LTC Home, staff must immediately notify the MOHLTC by phone".

The "Chain of response" that was posted on the board by the nursing desk with the MOHLTC decision trees, included actions which indicated that:
- RPN notifies Charge RN of incident or Code White is called;
- Charge RN and RPN discuss details of incident and determine plan of action, following the MOHLTC decision trees;
- RPN contacts CIATT to report critical incident;
- RN contacts administration on-call to inform them of the incident and plan of action;
- RPN and RN collaborate and give report to team; and
- Administration on-call or nursing manager completed the Critical Incident form, as required.

Inspector #196 reviewed the home's investigation file that was provided by the previous LTC Nurse Manager #101. The home's internal incident report completed by RPN #103, outlined a medication incident with the description of the what had been reported by the SDM of resident #001.

The hand written notes recorded by LTC Nurse Manager #101, identified that they had received a phone message from RPN #102 and RPN #103 on an identified date, that the SDM of resident #001 had reported that their family member was given the wrong medication.

Further typed notes outlined a meeting between the SDM and LTC Nurse Manager #101

on an identified date and indicated the resident's SDM was upset as their family member had said they were forced into doing something they didn't want to do or take; and felt they had effects that next day a result of the medication that was given and was not supposed to be administered. Notes from an interview with resident #001 identified that they felt a specific way and had made a statement at the time to refuse the medication but it was still given.

During an interview, resident #001, with the assistance of RPN #104, reported to Inspector #196 that they liked to look at their pills to make sure they were theirs. They went on to say that the nurse came in, told them to open their mouth, and put the pills (which were mixed up on a spoon) into their mouth. They further added that they knew they weren't their pills as they didn't take pills at night, and they felt upset.

During an interview with RPN #102, they reported to the Inspector that the SDM had come to them in the afternoon on an identified date and said that their family member was given medication even though the resident had said "no" to taking it. They added this incident was not reported at the time it was brought up by the SDM; management was not informed, the charge RN was not informed; but that a message was left on the LTC Nurse Manager #101's phone.

During an interview with RPN #103, they reported to the Inspector that the SDM was very upset that the nurse had forced pills down into their family member's mouth. RPN #103 reported they knew at that time that this was not right, further elaborating that, everything wasn't right about it; the resident had the right to refuse any treatment and any care, and the word "forced" didn't sit right.

During an interview with the Chief Nursing Executive (CNE), they reported that the RPNs that became aware of the incident on an identified date and should have notified the Charge RN, then contacted the MOHLTC (Ministry of Health and Long-Term Care), and on the weekend, notify the Administration on call. They confirmed to the Inspector this was not done according to the home's policy. [s. 20. (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 that ensures the licensee's written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, was immediately investigated: abuse of a resident by anyone.

Please see WN #2, Finding #1 for further details.

The health care record for resident #001 were reviewed by Inspector #196. The progress notes on a date, as documented by RPN #102, identified the SDM's concern regarding the nurse having given resident #001 medication the previous evening, even though the resident didn't want it.

The investigation notes, as provided by the previous LTC Nurse Manager #101, were reviewed. The internal incident report completed by RPN #103 on an identified date, outlined a medication incident with the description of what had been reported by the SDM of resident #001. The investigation records outlined a meeting between the SDM and LTC Nurse Manager #101 on an identified date and indicated the resident's SDM was upset as their family member had said they were forced into doing something they didn't want to do or take; and felt they had effects that next day a result of the medication that was given and was not supposed to be administered. Notes from an interview with resident #001 identified that they felt a specific way and had made a statement at the time to refuse the medication but it was still given.

According to an interview with RPN #102, they reported that an internal incident report was completed, and a telephone message was left for LTC Nurse Manager #101 on the day the SDM reported the incident to them.

During an interview with the previous LTC Nurse Manager #101, they stated they first became aware of the incident on their first day in the role, two days after the incident was reported by the SDM. On this date, they met with resident #001 and their SDM and conducted an investigation into the incident.

During an interview with the CNE, they reported to the Inspector that they first became aware of this incident involving resident #001, most likely, two days after the incident was reported by the SDM, when a copy of the internal incident report was received by email. They further confirmed that the Administration on call was the Financial Manager and they had not been informed of the abuse incident over that weekend. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: abuse of a resident by anyone, to be implemented voluntarily.

WN #4: 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 resident #003 fell, the resident was assessed and that where the condition of circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CIS report was submitted to the Director for a fall that occurred on an identified date, for which the resident was taken to hospital and which resulted in a significant change to their health condition.

During a review of resident #003's health care record, Inspector #625 was not able to locate a post-fall assessment completed for the fall.

During an interview with the RAI Coordinator, they identified that the home completed Falls Assessments and Post Falls Huddle Checklists after residents fell. The RAI Coordinator indicated that the Falls Assessment was an assessment of the resident's risk

of falling. The RAI Coordinator was not able to provide the Inspector with a post-fall assessment instrument that was specifically designed for falls that was in use in the home.

During an interview with RPN #107, they stated that they had responded to resident #003's fall on the identified date, and that they were not aware of a post-fall assessment instrument used by the home. They indicated that the home completed a Falls Assessment of the resident's fall risk, a Post Fall Huddle Checklist, and a Neurological Flow Sheet but could not recall a post-fall assessment that was in place for the clinical aspects of a fall.

During an interview with former LTC Nurse Manager #114, they stated that the home completed Post Falls Huddle Checklists to determine the causes of the fall and a Falls Assessment to determine the fall risk. The former LTC Nurse Manager stated the home did not have a clinical instrument to assess residents post-fall as the legislation required.

During an interview with the current LTC Nurse Manager #109, they stated that the home did not have a tool in use which met the legislative requirements for a post-fall assessment. [s. 49. (2)]

2. The licensee has failed to ensure that, when resident #002 fell, the resident was assessed and that where the condition of circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CIS report was submitted to the Director for a fall that occurred on an identified date, for which resident #002 was taken to hospital and which resulted in significant change in their health condition.

During a review of resident #002's health care record, Inspector #625 was not able to locate a post-fall assessment completed for the fall.

During an interview with RPN #107, they stated that they could not recall a post-fall assessment that was in place for the clinical aspects of resident falls.

During an interview with RAI Coordinator #110, they were not able to provide Inspector #625 with a post-fall assessment instrument that was specifically designed for falls that was in use in the home.

During an interview with former LTC Nurse Manager #114, they stated that the home did not have a clinical instrument to assess residents post-fall as the legislation required.

During an interview with the current LTC Nurse Manager #109, they stated that the home did not have a tool in use which met the legislative requirements for a post fall assessment. [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 that ensures 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A CIS report was submitted to the Director on an identified date, for a medication incident in which resident #001 was administered medications which had not been prescribed. The report indicated that resident #001's Substitute Decision Maker (SDM) had provided information to a day staff RPN about an incident in which the resident was provided medications in a forceful manner the evening before. The report further indicated that the resident didn't take HS (bedtime) medication.

O. Reg. 79/10, s. 1, defines “medication incident” as a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes,
(a) an act of omission or commission, whether or not it results in harm, injury or death to a resident, or
(b) a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted;"

A review of the home’s policy titled “Medication Administration (General) - PH-M13", revised June 2017, read, "Medications are administered only upon a physician's order and must be verified prior to their administration by use of the Medication Administration Record (MAR) and /or original physician order.”

The health care record for resident #001 was reviewed. The physician’s orders did not identify pills were to be administered to this resident at HS.

During an interview, resident #001, with the assistance of RPN #104, reported to Inspector #196 that they liked to look at their pills to make sure they were theirs. They went on to say that the nurse came in, told them to open their mouth, and put the pills (which were mixed up on a spoon) into their mouth. They further added that they knew they weren't their pills as they didn't take pills at night, and they felt a certain way.

Inspector #196 reviewed the home’s investigation notes as documented by the previous LTC Manager #101. Notes from the meeting which was held with resident #001’s SDM, identified that RPN #100 was alleged to have given unknown medications at bedtime on an identified date, that were not supposed to be given.

During an interview with the CNE, they reported that resident #001 had stated they had been given medications at HS that were not ordered. They further added that the licensee's medication policy was not followed, specifically the identification of the resident was not checked and there was no physician order for those medications the resident said were given to them. [s. 131. (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 that ensures that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 1, and in reference to O. Reg. 79/10, s. 49 (1), the licensee was required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, including strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the licensee's policy titled, "Long-Term Care Falls Prevention and Management Program", undated, which identified that registered nursing staff were required to initiate a neurological assessment for all unwitnessed falls and for witnessed falls that had resulted in a possible head injury. The staff were to complete the assessment according to orders received from a physician.

A CIS report was submitted to the Director for a fall that occurred on an identified date, for which resident #003 was taken to hospital and which resulted in a significant change in their health condition. The report identified the resident had symptoms and evidence of injury.

A review of the home's internal incident report submitted for the fall identified that, the resident sustained an injury to a specific area and as a result was observed and monitored according to the policy.

Inspector #625 reviewed resident #003's health care record and was not able to locate an order from the physician for completion of a neurological assessment at any frequency, for their fall on the identified date.

Inspector #625 located a Neurological Flow Sheet with two entries on an identified date, at two different times, three hours apart. The flow sheet identified that vital signs and neurological checks were to be completed every 15 minutes for one hour; every 30 minutes for one hour; every hour for four hours; then every four hours for 24 hours. The sheet included assessment of level of consciousness, movement, hand grasps, pupil size, pupil reaction, speech and vital signs.

A review of a progress note entered by RPN #107 on the identified date, approximately two hours after the fall, included a set of vital signs, and that the resident was alert and orientated to three specific areas.

During an interview with RPN #107, they stated that they had completed a neurological assessment [documented in the progress note] and asked the resident if they were okay when they responded to the resident. The RPN stated they had been new to nursing at the time of the fall and may not have known to complete a Neurological Flow Sheet, but that they now knew to do the whole thing, to fill it all out.

During an interview with the current LTC Nurse Manager #109 they reviewed resident #003's Neurological Flow Sheet with two entries that had been completed on the identified date, and indicated that neurological monitoring of the resident had not been completed at the frequency specific on the flow sheet, that the policy identified that a neurological assessment was to be completed for a fall with a head injury, and that the flow sheet should have been completed.

During an interview with the CNE, the reviewed the following documents with the Inspector and acknowledged the documents contained the following details
- an internal incident report for resident #003's fall on the incident date, identified a specific type of injury was sustained and the resident was observed and monitored according to policy;
- the Long-Term Care Falls Prevention and Management Program which directed staff to complete a neurological assessment if a falls was unwitnessed or possible head injury had occurred. Staff were to complete the assessment according to orders received from the physician;
- an Order Sheet and Progress Notes which contained no physician's order for a neurological assessment for the fall on the identified date; and
- a Neurological Flow Sheet which contained two entries on an identified date.

The CNE stated that, in the absence of a physician's order for specific neurological assessment monitoring frequency, the staff were required to complete a Neurological Flow Sheet in it's entirety, which had not been done. They stated that the neurological monitoring of resident #003 had not been completed in accordance with the home's policy. [s. 8. (1) (b)]

WN #7: 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, a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: 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.

O. Reg 79/10, s. 2. (1) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A CIS report was submitted to the Director on an identified date, for an incident which had occurred four days previous, in which RPN #100 was alleged to emotionally abuse resident #001. According to the report, RPN staff had been informed of the incident by the resident's SDM, the day after the occurrence. The report indicated the after-hours pager was not contacted and that the resident and the SDM requested the incident be reported.

The homes' policy titled, "Zero Tolerance of Abuse and Neglect Long Term Care" indicated that, "All staff, volunteers, contractors, affiliated personnel and management/administration are required:
- To immediately report to the registered staff, charge nurse, LTC Nurse Manager or designate on duty, and /or administration on-call for the Home, after hours, at the time of the witnessed or alleged incident of abuse or neglect.
- To fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the MOHLTC by telephone notification to the Centralized Intake Assessment Triage Team (CIATT)..."

The Geraldton District Hospital policy read:
- "If the abuse occurs on the LTC Home, staff must immediately notify the MOHLTC by phone".

The "Chain of response" that was posted on the board by the nursing desk with the MOHLTC decision trees, included the following actions, specific to reporting to the Director:
- RPN notifies Charge RN of incident or Code White is called;

- Charge RN and RPN discuss details of incident and determine plan of action, following the MOHLTC decision trees;
- RPN contacts CIATT to report critical incident;
- RN contacts administration on-call to inform them of the incident and plan of action; and
- Administration on-call or nursing manager completed the Critical Incident form, as required.

During an interview with RPN #102, they reported to the Inspector that the SDM had come to them in the afternoon on an identified date and said that their family member was given medication even though the resident had said "no" to taking it. The RPN said they left a phone message for the LTC Nurse Manager regarding this incident and told the SDM to meet with the manager about the medication that was given when the resident didn't want it. They further added, they knew this was abusive to the resident and should have reported it to the Ministry.

During an interview with RPN #103, they reported to the Inspector that the SDM was very upset that the nurse had forced pills down into their family member's mouth. RPN #103 said they knew the resident had the right to refuse any treatment and care and the word "forced" didn't sit right. They further reported that they completed an internal incident form and a phone message was left for the LTC Nurse Manager.

During an interview with the previous LTC Nurse Manager #101, they reported that they first became aware of the incident, through a message on their voice mail in the morning on the identified date, on the first day they started in this role. The CIS report was submitted to the Director on the following day for the incident which had been reported to RPN staff three days earlier. [s. 24. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, in making a report to the Director under subsection 23 (2) of the Act, the licensee included the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone that led to the report: a description of the individuals involved in the incident, including, names of all residents involved in the incident, and names of any staff members or other persons who were present at or discovered the incident.

Please see WN #2, Finding #1 for further details.

The Inspector reviewed the CIS report and did not identify the resident by name and instead provided a number as identification. In addition, the staff member alleged to have emotionally abused the resident was not named in the report.

During an interview with the previous LTC Nurse Manager #101, they reported that resident #001 was the resident identified by a number on the submitted CIS report, and identified RPN #100 as the staff member that had emotionally abused the resident.

During an interview with the CNE, they reported to the Inspector that they had been told not to put resident's names on the CIS reports. [s. 104. (1) 2.]

WN #9: 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.

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident,

or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the fall resident #002 experienced on an identified date, which resulted in a significant change to their health condition, no later than one business day after the occurrence of the incident, followed by a report required under subsection (4).

A CIS report was submitted to the Director for a fall that occurred on an identified date for which the resident was taken to hospital and which resulted in a significant change to their health condition. The CIS report was submitted to the Director four business days after the occurrence of the fall.

Inspector #625 was not able to locate a record that the Director was notified of the critical incident prior to the submission of the CIS report on the identified date.

During an interview with the previous LTC Nurse Manger #101, they indicated that the home knew that resident #002's fall had resulted in an injury which was a significant change to their health condition on an identified date. They acknowledged that the home had not notified the Director of the critical incident until the CIS report was submitted four business days after the fall. [s. 107. (3) 4.]

2. The licensee has failed to ensure that, when required to inform the Director of an incident under subsection (3.1), including resident #003's fall on an identified date, that, within 10 days of becoming aware of the incident, or sooner if required by the Director, a report was made in writing to the Director setting a description of the incident, including the type of incident, the time of the incident and the events leading up to the incident.

A CIS report was submitted to the Director for a fall that occurred on an identified date for which resident #003 was taken to hospital and which resulted in a significant change to their heath condition. The report identified that the resident was in an area of the home

and gave the specifics of the fall. The report identified that RPN #107 was present when the resident fell and listed the CIS date and time as well as, in the narrative of the report, identified another date four days previous with no time identified. The report was submitted to the Director on yet another date.

A review of the home's internal incident report identified resident #003's fall had not been witnessed and had occurred on a specific date and at a specific time. The report contained follow-up actions entered by the CNE approximately three days later and that the CNE had signed off on the report approximately 13 days after that.

During an interview with RPN #107, they stated they had not witnessed resident #003 fall as they were in the medication room at the time and believed they were notified of the fall by a PSW who had discovered the resident but could not recall who the PSW was. The RPN identified that they responded to the fall and found resident #003 in a particular position. RPN also elaborated that the resident used an assistive device and may not have had the device in proper use when rising, or may have pushed to get up from the chair on their assistive device and not on their chair as the RPN had previously reminded the resident to do. The RPN stated they believed the resident's assistive device went fast and the resident slipped, and that the resident's foot may have caught the heel of their non-slip socks [on the floor] as the resident refused a particular item. When the RPN asked the resident about the fall, the resident stated they were fine and "I just fell".

During an interview with the CNE who submitted the CIS report to the Director, they acknowledged that they had identified in the report that resident #003's fall had been witnessed, and had occurred at a specific time. The CNE stated that they must have thought the responding RPN had witnessed the fall and that they had not recorded the time of the fall as a different time. [s. 107. (4) 1.]

3. The licensee has failed to ensure that, when required to inform the Director of an incident under subsection (3.1), including resident #003's fall on an identified date, that, within 10 days of becoming aware of the incident, or sooner if required by the Director, a report was made in writing to the Director setting out the outcome or current status of resident #003 with respect to their fall.

A CIS report was submitted to the Director for a fall that occurred on an identified date, for which resident #003 was taken to hospital and which resulted in a significant change in health status. The report was submitted on a date and identified, in narrative of the description of the incident section, that the resident had symptoms of injury. The narrative

of the outcome/current status of the resident section, identified that the resident most likely had a specific type of injury, which the resident's physician assessed and had made a statement regarding further treatment. The report did not include the outcome of resident #003 with respect to the injuries they sustained from the fall, or changes to the level of assistance the resident required as a result of the fall.

On a specific date, the Centralized Intake and Triage Team (CIATT) Inspector requested an amendment via the CIS from the home including three different areas of resident #003's activities of daily living. The home responded on another date and listed changes to the level of assistance the resident required related to two areas of activities of daily living.

During an interview with the CNE who had submitted the CIS report, they stated they did not update CIS reports within 10 days and had never updated CIS reports within 10 days, or at all, unless it was in response to questions posed [from triaging Inspectors]. The CNE stated that they had replied to the questions asked on the specific date and had not updated the report with the outcome or status of resident #003 within 10 days. [s. 107. (4) 3. v.]

4. The licensee has failed to ensure that, when required to inform the Director of an incident under subsection (3.1), including resident #002's fall on an identified date, that, within 10 days of becoming aware of the incident, or sooner if required by the Director, a report was made in writing to the Director setting out the outcome or current status of resident #002 with respect to their fall.

A CIS report was submitted to the Director for a fall that occurred on an identified date, for which resident #002 was taken to hospital and which resulted in a significant change in health condition. The report was submitted on a date, and identified in the narrative of the description of the incident section, the injury and an assessment of the resident and transfer to an acute care facility for further treatment. The narrative in the outcome/current status of the resident section, identified that the resident was admitted to an acute care facility for treatment on a date and the outcome at the time of the report, was that the resident had a specific level of mobility until further assessed by OT/PT at the acute care facility.

On a date, approximately three months after the CIS report was submitted, a CIATT Inspector requested an amendment from the home as to the status of resident #002 upon return to the home.

On the date of request, the home provided an update on resident #002's status which identified the resident had returned to the home approximately a week after the incident, and included, but was not limited to, changes to the resident's activities of daily living and comfort.

During an interview with LTC Nurse Manger #101, they stated that resident #002 had returned to the long-term care unit on a date approximately a week after the incident but that the LTC Nurse Manager had not known that they could go back into the CIS report and amend it. The LTC Nurse Manager indicated that they had not amended the report within 10 days to include the outcome or status of resident #002 upon return to the home. [s. 107. (4) 3. v.]

5. The licensee has failed to ensure that, when required to inform the Director of an incident under subsection (3.1), including resident #003's fall on an identified date that, within 10 days of becoming aware of the incident, or sooner if required by the Director, a report was made in writing to the Director setting out immediate actions that had been taken to prevent recurrence.

A CIS report was submitted to the Director for a fall that occurred on an identified date, for which resident #003 was taken to hospital and which resulted in a significant change in their health status. The report was submitted on a date and identified, in the narrative of the immediate actions taken to prevent recurrence section, that the resident used an assistive device when ambulating, wore non-slip foot wear and had been situated close to the nursing station.

On a date approximately six weeks after the incident, a CIATT Inspector requested an amendment from the home including falls prevention interventions in place post fall. The home responded and listed post fall interventions implemented including, but not limited to, ambulation status and staff assistance with an ambulation device.

During an interview with the CNE who had submitted the CIS report, they stated they did not update CIS reports within 10 days and had never updated CIS reports within 10 days, or at all, unless it was in response to questions posed by an Inspector via the online reporting system. The CNE stated that, on a date, they had replied to the questions asked two days prior. The CNE indicated they had not updated the report within 10 days with the immediate actions that had been taken to prevent recurrence, with respect to resident #003's fall. [s. 107. (4) 4. i.]

6. The licensee has failed to ensure that, when required to inform the Director of an incident under subsection (3.1), including resident #002's fall on an identified date, that, within 10 days of becoming aware of the incident, or sooner if required by the Director, a report was made in writing to the Director setting out immediate actions that had been taken to prevent recurrence.

A CIS report was submitted to the Director for a fall that occurred on an identified date for which resident #002 was taken to hospital and which resulted in a significant change in their health status. The report was submitted on a date, and identified that the resident fell when transferring during an activity of daily living. In the narrative of the immediate actions taken to prevent recurrence section, generic actions taken by the home were listed such as "[Resident #002] is on the Falls Prevention and Management program which reflects [their] careplan". The resident had not returned to the home, and had not been assessed by the staff in the home with respect to their activities of daily living at the time the report was submitted to the Director.

On a date, approximately three months later, a CIATT Inspector requested an amendment from the home to include the status of the resident upon return to the home. The home responded and listed immediate action taken to prevent recurrence including, but not limited to, changes to the resident's activities of daily living.

During an interview with the previous LTC Nurse Manger #101, they stated that resident #002 had returned to long-term care approximately two weeks after the fall but that the LTC Nurse Manager had not known that they could go back into the CIS report and amend it. The LTC Nurse Manager indicated that they had not amended the report within 10 days to include the immediate actions taken to prevent recurrence. [s. 107. (4) 4. i.]

7. The licensee has failed to ensure that, when required to inform the Director of an incident under subsection (3.1), including resident #003's fall on an identified date that, within 10 days of becoming aware of the incident, or sooner if required by the Director, a report was made in writing to the Director setting out the long-term actions planned to correct the situation and prevention recurrence.

A CIS report was submitted to the Director for a fall that occurred on an identified date, for which resident #003 was taken to hospital and which resulted in a significant change in their health condition. The report was submitted three days after the incident and identified, in the narrative of the long-term actions planned to correct the situation and

prevent recurrence section, that the staff would continue to monitor the resident more closely, and shadow the resident until the injury healed to ensure they did not fall again due to their existing injury.

On a date approximately six weeks after the incident, a CIATT Inspector requested an amendment from the home including falls prevention interventions in place post fall. The home responded and listed post fall interventions implemented including, but not limited to, changes to resident #003's restorative program and activities of daily living.

During an interview with the CNE who had submitted the CIS report, they stated they did not update CIS reports within 10 days and had never updated CIS reports within 10 days, or at all, unless it was in response to questions posed by an Inspector via the online reporting system. The CNE stated that on a specific date they had replied to the questions asked two days prior. The CNE indicated they had not updated the report within 10 days with the long-term actions planned to correct the situation and prevention recurrence, with respect to resident #003's fall. [s. 107. (4) 4. ii.]

Issued on this 11th day of July, 2019

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

Original report signed by the inspector.