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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 10, 2015	2015_341583_0015	H-002879-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF HALDIMAND COUNTY
45 Munsee Street Box 400 Cayuga ON N0A 1E0

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

GRANDVIEW LODGE / DUNNVILLE
657 LOCK STREET WEST DUNNVILLE ON N1A 1V9

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

KELLY HAYES (583), CATHY FEDIASH (214), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 16, 17, 20, 21, 22, 23, 24, 27, 28, 29, 30, 31 and August 4, 2015.

The inspection was conducted simultaneously with critical incident inspection H-00038-14; H-001035-14; H-001437-14; H-001937-15; H-002687-15; H-002724-15; H-001959-15; complaint inspection H-000270-14; H-002412-14; H-002419-15; follow up inspection H-001868-15 and H-002654-15.

During the course of the inspection, the inspector(s) spoke with Administrator; Director of Nursing (DON); Administrative Assistant; Accounts Clerk; Resident Services Clerk; RAI Coordinator; Scheduling Clerk; Registered Nurse (RN); Registered Practical Nurse (RPN); Personal Support Worker (PSW); Registered Dietitian (RD); Dietary Supervisor; Dietary Aid; Facility Operations Supervisor; Nursing Quality Assurance; Recreational Therapist; residents and families. Inspectors also reviewed relevant clinical records; policies and procedures; training records; menus; critical incidents submitted by the home; the homes complaints and maintenance logs; and observed the provision of care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

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

16 WN(s)
5 VPC(s)
3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (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 failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A) A review of resident #100's Bed System Assessment completed on an identified date in February 2015 and confirmed by the Director of Nursing (DON) as being current, indicated that the resident required the use of side rails and that the bed rails were being used as a Personal Assistance Services Device (PASD) while in bed. A review of the resident's quarterly Minimum Data Set (MDS) coding completed on an identified date in April 2015, indicated under section P4, that the resident was coded as not using any other types of side rails.

An interview with the DON confirmed that the resident was using side rails and that staff had not collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented each other. (#214)

B) A review of resident #103's Bed System Assessment completed on an identified date in December 2014 and confirmed by the DON as being current, indicated that the resident required the use of side rails and that the bed rails were being used as a Personal Assistance Services Device (PASD) while in bed. A review of the resident's quarterly Minimum Data Set (MDS) coding completed on an identified date in May 2015, indicated under section P4, that the resident was coded as not using any other types of side rails.

An interview with the DON confirmed that the resident was currently using two quarter side rails and that staff had not collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented each other.(#214)

C) A review of resident #204's quarterly assessment was completed. The Activity Daily Living (ADL)Assessment Summary completed by a registered staff member on an identified date in March 2015, identified that resident #204 was independent with ADL's but weak at times. The Falls Assessment Summary completed by another registered staff member on the same identified date in March 2015, identified resident #204 had deteriorated and required total care with staff providing assistance with all ADL's. In an interview with the DON on August 3 2015, it was confirmed resident #204's assessments were not integrated and consistent and did not complement each other. (#583) [s. 6. (4) (a)]

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

A) Resident #401 was identified as having hearing loss due to physiological changes related to the aging process. The resident's plan of care directed staff to ensure that the resident had hearing aids in prior to AM care.

In October 2014, during AM care, a staff member provided the resident with directions during a transfer. It was witnessed by another staff person that the resident became frustrated during the transfer as they could not hear the staff members instructions. After the resident had been transferred it was identified by staff that the resident did not have

their hearing aids put in prior to AM care as directed in the plan of care. It was confirmed by the DON that the care set out in the plan of care was not provided to the resident as specified in the plan. (#508)

B) A review of the Critical Incident System (CIS) that was submitted by the home indicated that on an identified date in 2015, resident #305 was found in their bed, unresponsive, following a medication related event. At the time of this incident, a capillary blood glucose test (CBG) was performed with documented results of 2.5 Millimoles per Liter (mmol/L). The physician was contacted and the resident was transferred to hospital. The resident was assessed and treated and sent back to the home on an identified date in 2015. A review of the Emergency Record indicated that this episode was a result of a medication related event.

i) A review of resident #305's written plan of care in place at the time of this incident indicated under Blood/Endocrine Disorders that the registered staff were to hold the medication if meals were skipped. A review of the resident's "Daily Food & Fluid Intake Record" for the same identified date in 2015, indicated that the resident refused their food and fluid intake at breakfast and refused their food at supper. A review of the resident's Medication Administration Record/Treatment Administration Record on the identified date in 2015, indicated that the resident's medication was not held.

ii) A review of resident #305's written plan of care completed on an identified date in 2015, indicated under Diabetes-alteration in nutrition that nursing staff would report intake of less than 50 percent food and fluid to charge nurse and Food Service Manager (FSM) and that a meal replacement would be determined by the FSS or substitute. A review of the resident's "Daily Food & Fluid Intake Record" for the same identified date in 2015, indicated that the resident refused their food and fluid intake at breakfast and refused their food at supper.

An interview with the DON confirmed that the medication was not held for the resident on an identified date of the incident in 2015, at the breakfast and supper times when they refused these meals as the medication was administered prior to the meals taking place. The DON also confirmed that the FSM was not notified on an identified date in 2015, when the resident refused their breakfast and supper and consequently, a meal replacement had not been provided. The DON confirmed that the care set out in the plan of care had not been provided to the resident as specified in their plan. (#214)

C) A review of the plan of care for resident #204 identified that on an identified date in

February 2015, they fell after attempting an independent unsafe transfer. The fall resulted in an injury. Resident #204 had an intervention in place to reduce their risk of falls as they had a history of falls related to transferring independently and required one staff for assistance. It was confirmed by the DON on August 4, 2015, that the intervention was not in place at the time of the fall as directed in the plan of care. (#583) [s. 6. (7)]

3. The licensee failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) A review of the plan of care for resident #200 identified they had a fall with injury on an identified date in May 2015. Prior to the fall resident #200's care plan identified they were independent and required no help or oversight for toileting, transferring, bed mobility, and walking and required one person for limited assistance during dressing and personal hygiene. After the fall resident #200 required extensive assistance from two staff for toileting, transferring, bed mobility, dressing and personal hygiene. Resident #200 required a wheelchair for locomotion on the unit. In an interview with the Director of Nursing (DON) on August 4, 2015, it was confirmed that resident #200's care needs changed on an identified date 2015 and the care plan was not updated and revised.

B) A review of the care plan for resident #204 identified they had falls on identified dates in 2015, resulting in injury. Prior to the falls on identified dates in 2015 resident #204's care plan identified they were independent with transfers with supervision and were independent with a walker on and off the unit with supervision. The quarterly Falls Assessment Summary completed on an identified date in 2015, identified resident #204's independence deteriorated and that the resident required total care with staff assistance for all activities of daily living. It was identified in the assessment that since the falls resident #204 was being transferred most of the time with a wheel chair and when walking in their room with a walker required physical assistance with one person. In an interview with the DON on August 4, 2015, it was confirmed that resident #204's care needs changed after their falls, and that the care plan was not updated or revised. (#583) [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complemented each other and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

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

On an identified date in 2015, resident #405 had a fall in the common area bathroom and required two staff to assist them back to their bedroom using a mechanical lift. A registered staff member and a Personal Support Worker (PSW) transported the resident back to their room and then two PSW's assisted the resident with cleaning up.

One of the PSW's had reported that while providing care to the resident, their co-worker was being verbally abusive to resident #405 and provided specific details of the incident.

It was confirmed by the Director of Nursing during an interview that resident #405 had been verbally abused by a PSW in 2015. [s. 19. (1)]

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 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

A review of the home's policy titled, Falls Prevention and Management (policy number: 11-1.11 and 11-1.11-1 with a revision date of April 2014) indicated the following:

i) Registered staff will complete a "Risk for fall assessment" within 24 hours of admission, following any sudden change of status and with quarterly documentation.

ii) Develop and implement interventions for those residents identified as at risk for falling.

iii) Interventions/Strategies to reduce risk for falls:
- Bed alarms or chair alarms may be used to alert staff of attempts to transfer self.
-Consider use of hip protectors to protect against injury related to a fall.

iv) Determine the resident's risk level as Low, Moderate or High. Any risk should be care planned and treated.

v) Notify the attending physician.

A) A review of resident #301's clinical record indicated that they were admitted to the home in 2014. The resident's clinical record was reviewed over an identified period of three months in 2015 and indicated that the resident sustained three falls during this time. The first fall indicated that the resident had slipped from a chair in their room onto the floor. The second fall indicated that the resident slid from their bed onto the floor. The third fall indicated that the resident was found on the floor in their bedroom and as a result of this fall, sustained an injury. The resident passed away in hospital three days later. A review of the Risk for Fall Assessments that were completed for the resident indicated that an assessment was not completed on admission or during the resident's first quarterly review during an identified period of time in 2015. The most recent Risk for Fall Assessment that was completed on an identified date in 2015, identified the resident as being a high risk for falling. A review of the resident's plan of care that was in place at this time had not identified the resident as a high risk for falling and only indicated that the resident had a potential for falls. A review of the resident's plan of care over an identified time period of three months indicated that no interventions/strategies to reduce the residents risk for falling including a bed alarm, chair alarm or hip protectors, had been implemented. An interview with the Quality Assurance lead confirmed that the Risk for Fall Assessments had not been completed on admission or for each quarterly resident review; the resident's level of fall risk was not identified and care planned and interventions/strategies to reduce the risk for falls for this resident had not been implemented. The Quality Assurance lead confirmed that the home had not complied with their policy in relation to Falls Prevention and Management. (214)

B) A review of resident #302's clinical record indicated that they were admitted to the home in 2013. A review of the Risk for Fall Assessments that were completed for the resident indicated that an assessment was not completed on admission or during the resident's first quarterly review. A review of the Critical Incident System (CIS) that was submitted by the home indicated that the resident sustained a fall on an identified date in 2014, which resulted in injuries and that the physician had not been notified when this incident occurred. A review of the home's Fall Education materials indicated that the physician was to be notified the same day as the incident. An interview with the Quality Assurance lead confirmed that the physician was not notified on the day of the incident and became aware on their next visit to the home. The Quality Assurance lead confirmed that the Risk for Fall Assessments had not been completed on admission or

for each quarterly resident review and that the home had not complied with their policy in relation to Falls Prevention and Management. An interview with the DON confirmed that the falls policy in place prior to the current policy was unable to be located. The DON confirmed that only the wording in the policy was revised and that the expectations in the current policy would have been the same expectations in place for the policy(s) in place during the resident's stay in the home. (214)

C) A review of resident #303's clinical record indicated that they were admitted to the home in 2011. A review of the Risk for Fall Assessments that were to be completed for the resident indicated that assessment's had not been completed on admission or during any of the resident's quarterly reviews. A review of the Critical Incident System (CIS) that was submitted by the home indicated that the physician was not notified. A review of the home's Fall Education materials indicated that the physician was to be notified the same day as the incident. An interview with the Quality Assurance lead confirmed that the physician was not notified on the day of the incident and became aware on their next visit to the home. An interview with the DON confirmed that the Risk for Fall Assessments had not been completed on admission or for any of the resident's quarterly reviews. An interview with the DON confirmed that the falls policy in place prior to the current policy was unable to be located. The DON confirmed that only the wording in the policy was revised and that the expectations in the current policy would have been the same expectations in place for the policy(s) in place during the resident's stay in the home. The DON confirmed that the home had not complied with their policy in relation to Falls Prevention and Management (214)

D) Resident #406's plan of care identified the resident as a low risk for falls in 2014. Resident #406 had a number of witnessed and unwitnessed falls over a period of two consecutive months in 2014. On an identified date in 2014, resident #406 had a fall which resulted in an injury. A review of the resident's clinical record indicated that staff had never conducted a Fall Risk Assessment for resident #406. It was confirmed during an interview with the DON that staff had never conducted a Fall Risk Assessment for resident #406. (#508)

E) A review of resident #200's plan of care identified they had a fall on an identified date in 2015, and sustained an injury. In an interview with the DON on a specified date in 2015, it was confirmed that resident #200 had a sudden change in status and a falls risk assessment was not completed by registered staff. (#583)

F) A review of resident #204's plan of care identified they had a fall on an identified date

in 2015, and sustained injuries. In an interview with the DON on an identified date in 2015, it was confirmed that resident #204 had a sudden change in status and a falls risk assessment was not completed by registered staff. (#583) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 that promotes zero tolerance of abuse and neglect of residents was complied with.

On an identified date in 2015, resident #405 had a fall and had soiled their clothing. Two staff members assisted the resident with personal care and assisted the resident to bed. While providing care, one of the PSW's alleged that their co-worker was being verbally abusive to resident #405.

The home's policy titled Resident Abuse - Investigating and Reporting, policy # A - 1.2, directs that all staff, residents, family members, students or volunteers who discovered, witnessed or have reason to believe that resident abuse had taken place were required to immediately report this to the Home's Administrator or designate.

This incident of alleged verbal abuse was not been reported to the Director until three days after the incident. It was confirmed with the DON that this incident had not been reported immediately as directed in the 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 the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

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 failed to ensure that the falls prevention and management program as an interdisciplinary program required under section 48 of this Regulation: 3. was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

An interview with the Director of Nursing (DON)confirmed that the home had not evaluated the falls prevention and management program for 2014 in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. (#214) [s. 30. (1) 3.]

2. The licensee 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.

A) A review of resident #100's written plan of care dated May 2015, indicated under bed mobility that the resident used bed rails for bed mobility as a PASD. A review of the home's Consenting to Implement PASD indicated that the use of bed rails as a PASD was required; however; the reason for use was blank. The form indicated that the risk/benefits of this PASD were reviewed. The consent form was not signed and indicated that verbal consent was obtained by the Substitute Decision Maker (SDM) on an identified date in February, 2015. An interview with the DON confirmed that verbal consent is obtained until the SDM is able to sign the form. The DON also confirmed that when verbal consent is obtained, documentation is completed in the resident's clinical record indicating that verbal consent has been obtained, the reason(s) for the use of the PASD and that the associated risk and benefits have been reviewed with the SDM. A review of the resident's clinical record over an identified time period from February - March 2015, did not contain any documentation indicating that verbal consent for the use of this PASD including the reason for use and the risk and benefits associated with this PASD, were documented.

The DON confirmed that actions taken with respect to consent for the use of this resident's PASD, had not been documented. (#214)

B) A review of resident #301's clinical record indicated that the resident sustained a fall on an identified date in 2015, which resulted in an injury. Three days following this incident, the resident passed away. A review of the Critical Incident System (CIS) that

was submitted by the home indicated that the cause of death was confirmed by the hospital as being related to this fall incident; however; a review of the resident's progress notes indicated that this information had not been documented in their clinical record. An interview with the Quality Assurance lead confirmed that the cause of death had been obtained; however; had not been documented.

A review of resident #301's clinical record indicated that the resident sustained falls on two identified dates in 2015. A review of the resident's written plan of care in place at the time of these two falls indicated under Falls/Balance interventions that hourly checks were in place to ensure the resident had not fallen. An interview with the Quality Assurance lead confirmed that hourly checks had been conducted; however; the home only documented these hourly checks on the "Night Shift Rounds Report" between the hours of 2300 – 0600 hours and no documentation had been completed for the hourly checks conducted on the day and evening shifts. (#214)

C) A review of resident #302's clinical record indicated that they sustained a fall on an identified date in 2014, which resulted in the resident sustaining injuries. A review of the Critical Incident System (CIS) that was submitted by the home as well as a post fall assessment that was completed following the resident's fall indicated that the floor in the resident's room was very sticky due to humidity. The CIS indicated that an email had been sent to the Supervisor of Support Services to assess the environment and provide direction. An interview with the Facility Operations Supervisor indicated that they recalled assessing the resident's room and the floor was noted not to be sticky; however; they confirmed that no documentation had been completed regarding this assessment. (#214)

D) A review of resident #303's clinical record indicated that they sustained a fall on an identified date in 2014, that resulted in an injury. The resident was transferred to the hospital, admitted and returned back to the home. During the day of the resident's return to the home, their condition deteriorated and they passed away the following day. A review of the resident's progress notes on an identified date in 2014, indicated that the home contacted the coroner's office as directed by the home's physician; however; no further documentation was noted regarding the outcome of this contact. An interview with the DON confirmed that no documentation had been completed. (#214) [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 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received as a condition of continuing to have contact with residents annual retraining in accordance with O. Reg. 79/10, s. 219(1) in the area of falls prevention and management.

An interview with the DON confirmed that a total of 46 out of 91 direct care staff received training in the area of falls prevention and management and that not all staff who provided direct care to residents received this training in 2014. (#214) [s. 76. (7) 6.]

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 all staff who provide direct care to residents receive as a condition of continuing to have contact with residents annual retraining in accordance with O. Reg. 79/10, s. 219(1) in the area of falls prevention and management, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program.

1. During a tour of the home on July 16, 2015, the following was observed:

Creek View Unit:
A) Two unlabeled hairbrushes were observed in the bathing spa, both with strands of hair in them.

B) In the bathing spa a used emery board was observed in a box that contained unused emery boards.

C) Three unlabeled combs were observed in the bathing spa with strands of hair in each of them.

D) The bottom of the spa tub was observed to be wet and brown material resembling dirt was observed on the bottom of the tub.

E) Unlabeled nail clippers were observed in an unlabeled box in a drawer inside the bathing spa. The box contained nail clippings.

F) A used disposable razor was observed on the top of the spa tub ledge and was unlabeled.

Marsh View unit:
A) An unlabeled comb with strands of hair in it was observed on the shelf in the bathing spa.

B) A bar of soap was observed sitting on a ledge in the shower with no resident identifiers.

C) In the bathing spa, a white storage bin was observed to contain nail clippers and a comb with strands of hair in it. Both were unlabeled.

Bridge View unit:
A) An unlabeled comb with strands of hair in it was observed on a shelf in the bathing spa.

B) In the bathing spa, unlabeled nail clippers with nail clippings in them was observed to be sitting on the top of the nail clipper caddy.

C) A hairbrush with strands of hair was observed to be in a container on a shelf in the bathing spa. The hairbrush was not labeled.

A tour of the above areas was conducted with the Resident Assessment Instrument (RAI) Coordinator who confirmed that resident's personal hygiene items were to be clean, individually labeled and that the spa bathtub was to be cleaned following each resident

bath. (#214) [s. 229. (4)]

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 all staff participate in the implementation of the Infection Prevention and Control Program, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During a tour of the Creek View unit on July 16, 2015, a housekeeping room at the end of this secured unit was observed to have an entrance door with no locking mechanism or door handle in place. The area on the door that was designed to have the door handle and locking mechanism in place was observed to be covered with duct tape. The door was able to be pushed open and a bottle of carpet cleaner, washroom cleaner and all-purpose cleaner were observed to be sitting on a shelf. No staff were present in this area, at the time. An interview with the RAI Coordinator confirmed that the home had purchased a locking mechanism for this door; however; it was the incorrect locking mechanism and the home was awaiting delivery of the correct locking mechanism. The RAI Coordinator confirmed that the door leading to this housekeeping room was to be locked. The home installed a locking mechanism on the same day. (#214) [s. 9. (1) 2.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if the following are satisfied: 4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

A review of resident #103's current written plan of care indicated that they required the use of bed rails that were being used as a personal assistance services device (PASD) for the purpose of turning and repositioning while in bed. A review of the resident's clinical record indicated that no consent had been obtained for the use of the PASD.

An interview with the DON confirmed that consent had not been obtained for the use of the resident's side rails that were being used as a PASD. (#214) [s. 33. (4) 4.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were provided oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening and/or the cleaning of dentures.

In an interview with resident #103 on July 2015, it was shared that staff provided oral care once per day. Resident #103's plan of care identified they wore dentures, required extensive assistance with oral care and staff were to remove and rinse the resident's dentures after each meal. In an interview with front line nursing staff in July 2015, at 1030 hours it was confirmed that resident #103 did not receive morning oral care. Staff shared resident #103 did not receive oral care using a toothette or soft brush to cleanse their teeth, tongue and the roof of their mouth, that the residents dentures were not brushed during morning care and resident #103's dentures were not rinsed after their breakfast meal as directed in their plan of care. (#214) [s. 34. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of laundry services procedures were implemented to ensure that there was a process to report and locate residents' lost personal items.

During interviews with front nursing staff on July 29, 2015, related to a missing items compliant for resident #202 it was identified that the process for reporting and locating lost items was not clear to staff. The homes "Missing Personal Items/Resident's money" procedure (M-5.1), last reviewed July 2007, was reviewed. In an interview with the Administrator on July 29, 2015, it was confirmed procedures were developed but not being implemented for reporting and locating residents' lost personal items. (#583) [s. 89. (1) (a) (iv)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy under section 29 of the Act dealt with, (e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act was to be obtained and documented.

A review of the home's policy titled, Minimizing Restraints (38-1.5 and dated with a revised date of November 2014) indicated that there was no written policy that addressed how consent for the use of PASDs as set out in section 33 of the Act was to be obtained and documented. An interview with the DON confirmed that the home did not currently have a written policy that addressed any aspects regarding the use of PASDs. (#214) [s. 109. (e)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.

During a tour of the home in July 2015, resident #304 was observed to be sitting in their wheelchair with a physical device applied. The device was loose enough that at least a four finger width spread between the device and the resident's abdomen was present. A review of the manufacturer's directions for this physical device indicated that the device should fit snug so that the user's pelvis is secure. An interview with front line nursing staff confirmed that the device was too loose and was to be applied so that only two fingers were between the device and the resident's abdomen. (#214) [s. 110. (1) 1.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the annual evaluation of the medication management system was undertaken using an assessment instrument designed specifically for this purpose.

An interview with the DON on July 31, 2015, indicated that the home had conducted an annual evaluation of their medication management system; however; the evaluation was not undertaken using an assessment instrument designed specifically for this purpose. (#214) [s. 116. (3) (b)]

WN #15: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

On an identified date in 2015, it was identified that resident #305 was to receive a prescribed medication daily at the lunch hour. A review of the resident's Medication/Treatment Administration Record (MAR/TAR) indicated that on a specified date in 2015 at the lunch hour this resident's prescribed medication was documented as not delivered. A review of the resident's progress notes indicated that on this same identified date the medication was not administered as the medication was on hold. An interview with the DON confirmed that the prescription for the medication was not on hold and was to be administered as prescribed. The DON confirmed that the home did not ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber. (#214) [s. 131. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the package of information provided for in section 78 of the Act included information about the following: 1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1).

A review of the LTCH Licensee Confirmation Checklist Admission Process that was completed on July 16, 2015, indicated that the home had not included the resident's ability to retain a physician or registered nurse in the extended class to perform the services, in their admission package. An interview with the Administrator confirmed that the home had not included this information in their admission packages to residents. (#583) [s. 224. (1) 1.]

Issued on this 14th day of September, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY HAYES (583), CATHY FEDIASH (214), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2015_341583_0015
Log No. / Registre no:	H-002879-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 10, 2015
Licensee / Titulaire de permis :	THE CORPORATION OF HALDIMAND COUNTY 45 Munsee Street, Box 400, Cayuga, ON, N0A-1E0
LTC Home / Foyer de SLD :	GRANDVIEW LODGE / DUNNVILLE 657 LOCK STREET WEST, DUNNVILLE, ON, N1A-1V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOANNE JACKSON

To THE CORPORATION OF HALDIMAND COUNTY, 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)

Linked to Existing Order / Lien vers ordre existant: 2014_214146_0024, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall ensure that the plan of care is reviewed and revised when a resident has a change in condition and the resident's care needs change.

Grounds / Motifs :

1. Previous order was issued with a compliance date of January 30, 2015.

The licensee failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) A review of the plan of care for resident #200 identified they had a fall with injury on an identified date in 2015. Prior to the fall resident #200's care plan identified they were independent and required no help or oversight for toileting, transferring, bed mobility, and walking and required one person for limited assistance during dressing and personal hygiene. After the fall resident #200 required extensive assistance from two staff for toileting, transferring, bed mobility, dressing and personal hygiene. Resident #200 required a wheelchair for locomotion on the unit. In an interview with the Director of Nursing (DON) on August 4, 2015, it was confirmed that resident #200's care needs changed on an identified date in 2015, and the care plan was not updated and revised at that time.

B) A review of the care plan for resident #204 identified they had falls on identified dates in 2015, resulting in injury. Prior to the falls in February resident #204's care plan identified they were independent with transfers with supervision and were independent with a walker on and off the unit with supervision. The quarterly Falls Assessment Summary completed on an identified date in 2015, identified resident #204's independence deteriorated and that the resident required total care with staff assistance for all activities of daily living. It was identified in the assessment that since the falls resident #204 was being transferred most of the time with a wheel chair and when walking in their room with a walker required physical assistance with one person. In an interview with the DON on August 4, 2015, it was confirmed that resident #204's care needs changed after their falls, and that the care plan was not updated or revised. (#583) (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_214146_0007, CO #001;

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 the home protects residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. Previous order was issued with a compliance date of June 12, 2015.

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

On an identified date in 2015, resident #405 had a fall in the common area bathroom and required two staff to assist them back to their bedroom using a mechanical lift. A registered staff member and a Personal Support Worker (PSW) transported the resident back to their room and then two PSW's assisted the resident with cleaning up.

One of the PSW's had reported that while providing care to the resident, their co-worker was being verbally abusive to resident #405 and provided specific details of the incident.

It was confirmed by the Director of Nursing during an interview that resident #405 had been verbally abused by a PSW in 2015. (508)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the Falls Prevention and Management policy is complied with including but not limited to the following:

i) Registered staff will complete a "Risk for fall assessment" within 24 hours of admission, following any sudden change of status and with quarterly documentation.
ii) Develop and implement interventions for those residents identified as at risk for falling.
iii) Interventions/Strategies to reduce risk for falls:
- Bed alarms or chair alarms may be used to alert staff of attempts to transfer self.
-Consider use of hip protectors to protect against injury related to a fall.
iv) Determine the resident's risk level as Low, Moderate or High. Any risk should be care planned and treated.
v) Notify the attending physician.

Grounds / Motifs :

1. 1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

A review of the home's policy titled, Falls Prevention and Management (policy number: 11-1.11 and 11-1.11-1 with a revision date of April 2014) indicated the

following:

i) Registered staff will complete a "Risk for fall assessment" within 24 hours of admission, following any sudden change of status and with quarterly documentation.

ii) Develop and implement interventions for those residents identified as at risk for falling.

iii) Interventions/Strategies to reduce risk for falls:
- Bed alarms or chair alarms may be used to alert staff of attempts to transfer self.
-Consider use of hip protectors to protect against injury related to a fall.

iv) Determine the resident's risk level as Low, Moderate or High. Any risk should be care planned and treated.

v) Notify the attending physician.

A) A review of resident #301's clinical record indicated that they were admitted to the home in 2014. The resident's clinical record was reviewed over an identified period of three months in 2015 and indicated that the resident sustained three falls during this time. The first fall indicated that the resident had slipped from a chair in their room onto the floor. The second fall indicated that the resident slid from their bed onto the floor. The third fall indicated that the resident was found on the floor in their bedroom and as a result of this fall, sustained an injury. The resident passed away in hospital three days later. A review of the Risk for Fall Assessments that were completed for the resident indicated that an assessment was not completed on admission or during the resident's first quarterly review during an identified period of time in 2015. The most recent Risk for Fall Assessment that was completed on an identified date in 2015, identified the resident as being a high risk for falling. A review of the resident's plan of care that was in place at this time had not identified the resident as a high risk for falling and only indicated that the resident had a potential for falls. A review of the resident's plan of care over an identified time period of three months indicated that no interventions/strategies to reduce the residents risk for falling including a bed alarm, chair alarm or hip protectors, had been implemented. An interview with the Quality Assurance lead confirmed that

the Risk for Fall Assessments had not been completed on admission or for each quarterly resident review; the resident's level of fall risk was not identified and care planned and interventions/strategies to reduce the risk for falls for this resident had not been implemented. The Quality Assurance lead confirmed that the home had not complied with their policy in relation to Falls Prevention and Management. (214)

B) A review of resident #302's clinical record indicated that they were admitted to the home in 2013. A review of the Risk for Fall Assessments that were completed for the resident indicated that an assessment was not completed on admission or during the resident's first quarterly review. A review of the Critical Incident System (CIS) that was submitted by the home indicated that the resident sustained a fall on an identified date in 2014, which resulted in injuries and that the physician had not been notified when this incident occurred. A review of the home's Fall Education materials indicated that the physician was to be notified the same day as the incident. An interview with the Quality Assurance lead confirmed that the physician was not notified on the day of the incident and became aware on their next visit to the home. The Quality Assurance lead confirmed that the Risk for Fall Assessments had not been completed on admission or for each quarterly resident review and that the home had not complied with their policy in relation to Falls Prevention and Management. An interview with the DON confirmed that the falls policy in place prior to the current policy was unable to be located. The DON confirmed that only the wording in the policy was revised and that the expectations in the current policy would have been the same expectations in place for the policy(s) in place during the resident's stay in the home. (214)

C) A review of resident #303's clinical record indicated that they were admitted to the home in 2011. A review of the Risk for Fall Assessments that were to be completed for the resident indicated that assessment's had not been completed on admission or during any of the resident's quarterly reviews. A review of the Critical Incident System (CIS) that was submitted by the home indicated that the physician was not notified. A review of the home's Fall Education materials indicated that the physician was to be notified the same day as the incident. An interview with the Quality Assurance lead confirmed that the physician was not notified on the day of the incident and became aware on their next visit to the home. An interview with the DON confirmed that the Risk for Fall Assessments had not been completed on admission or for any of the resident's quarterly reviews. An interview with the DON confirmed that the falls policy in place prior

to the current policy was unable to be located. The DON confirmed that only the wording in the policy was revised and that the expectations in the current policy would have been the same expectations in place for the policy(s) in place during the resident's stay in the home. The DON confirmed that the home had not complied with their policy in relation to Falls Prevention and Management (214)

D) Resident #406's plan of care identified the resident as a low risk for falls in 2014. Resident #406 had a number of witnessed and unwitnessed falls over a period of two consecutive months in 2014. On an identified date in 2014, resident #406 had a fall which resulted in an injury. A review of the resident's clinical record indicated that staff had never conducted a Fall Risk Assessment for resident #406. It was confirmed during an interview with the DON that staff had never conducted a Fall Risk Assessment for resident #406. (#508)

E) A review of resident #200's plan of care identified they had a fall on an identified date in 2015, and sustained an injury. In an interview with the DON on a specified date in 2015, it was confirmed that resident #200 had a sudden change in status and a falls risk assessment was not completed by registered staff. (#583)

F) A review of resident #204's plan of care identified they had a fall on an identified date in 2015, and sustained injuries. In an interview with the DON on an identified date in 2015, it was confirmed that resident #204 had a sudden change in status and a falls risk assessment was not completed by registered staff. (#583) (214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 10th day of September, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Hayes

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