Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 25, Jul 6, 2016	2016_333577_0011	009573-16	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX 3251 THUNDER BAY ON P7B 5G7

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

HOGARTH RIVERVIEW MANOR
300 LILLIE STREET THUNDER BAY ON P7C 4Y7

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

DEBBIE WARPULA (577), JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 17, 18, 19 and 20, 2016.

This purpose of this Inspection was to conduct a Complaint inspection, for logs: #013109-16 related to a complaint regarding allegations of abuse to a resident, #009573-16 related to a complaint regarding recreation activities, #011854-16 related to a complaint regarding an admission weight, #014423-16 related to a complaint regarding improper care, #012960-16 related to a complaint regarding falls, restraining, weight loss, skin and wounds and #012371-16 related to a complaint regarding medication.

This inspection was conducted concurrently with Follow-up inspection #2016_333577_0010.

During the course of the inspection, the inspector(s) toured the resident care areas, observed the provision of care and services to residents, observed interactions between staff and residents, reviewed policies, procedures and programs, various health care records, schedules and training records.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Resident Assessment Instrument (RAI) Coordinator, Clinical Managers, the Infection Control Lead (ICL), Manager of Regional Behavioural Health Services, Environmental Services Manager (ESM), Registered Dietitians (RD), Personal Support Workers (PSW), Registered Nurses (RN), Registered Practical Nurses (RPN), Occupational Therapist (OT), Physiotherapists (PT), the Clinical Educator, the Manager of Motion Specialties, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Falls Prevention
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Sufficient Staffing

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

- **6 WN(s)**
- **2 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 212. (1)	CO #902	2016_333577_0011	577
O.Reg 79/10 s. 213. (1)	CO #901	2016_333577_0011	577

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 O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

During an interview with Nursing Manager #100 in May 2016, they reported that the home's Administrator also works in the role of Director of Care.

During an interview with the Administrator #101 in May 2016, they reported that they were currently the Administrator for both Hogarth Riverview Manor and Bethammi long-term care home, and Acting Director of Care for Hogarth. They further confirmed that they were not working on site for both homes for 37.5 hours per week.

A previous VPC was issued on May 12, 2016, and on May 20, 2016, there had been no change and the home was not meeting the requirements. [s. 213. (1)]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Administrator worked regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week

During an interview with the Administrator #101 in May 2016, they reported that they were currently the Administrator for both Hogarth Riverview Manor and Bethammi long-term care home. They further confirmed that they were not working on site for both homes for 37.5 hours per week, and not working regularly as the Administrator in this home for 37.5 hours per week.

A previous VPC was issued on May 12, 2016, and no action has been taken. [s. 212. (1)]

Additional Required Actions:

CO # - 902 was 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. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that, where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A complaint was received by the Director in May 2016, alleging that resident #002 had numerous falls since admission in January 2016.

A review of resident #002's progress notes revealed that resident had many falls over a four month period. In March 2016, the resident had a fall and was injured.

A review of the home's "Falls Prevention and Management Toolkit", last revised date May 2012, indicated that as part of the follow up after a resident had fallen, the registered staff completed a post fall assessment form, reviewed the fall prevention interventions and modified the plan of care in collaboration with the interprofessional team.

The home's policy titled "Fall Prevention and Management Program - LTC 3-60" last revised April 2014, indicated that staff were to complete the post fall assessment following each resident fall.

A review of the health records for resident #002 revealed 14 per cent of the post fall assessment tool forms were completed. The resident did not have a post fall assessment using a clinical instrument for the following falls:

-nine falls in one month in 2016
-four falls in another month
-three falls in another month, and
-five falls in another month

During an interview with RN #101, they reported that the post fall assessment was done electronically and they could not locate any completed assessments for resident #002. RN #101 was able to find three paper post fall assessments for resident #002.

During an interview with RN #102, they reported that a paper post fall assessment was to be completed after every fall. They were unable to locate any paper or electronic post fall assessments for resident #002.

During an interview with Resident Assessment Instrument Coordinator (RAI) #100, they were unable to locate any electronic post fall assessments for resident #002.

During an interview with Manager of Regional Behavioral Health Services #103, they reported that an electronic post fall assessment was to be done after every fall.

During an interview with Clinical Manager #104, they confirmed that the electronic post fall assessment was the home's clinical tool and was to be completed after every fall. [s. 49. (2)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the programs include the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

A complaint received by the Director in April 2016, alleged that resident #001 was not weighed on their admission.

Inspector #621 reviewed a copy of the home's policy titled "Unintentional Weight Loss or Gain – LTC 5-10" last revised January 2013, which identified that baseline information related to weight was to be obtained on admission.

A record review of resident #001's Weight and Height History documentation identified a weight of 57 kg recorded for their admission weight, however information in the "notes" section of the weight record identified that this weight was based on documentation provided by the Long Term Care home that this resident had transferred from.

During an interview with Clinical Manager #105, they confirmed that resident #001 had not been weighed on admission and should have been. [s. 68. (2) (a)]

2. During a review of the homes electronic weight records, inspector #577 found that multiple residents did not have documented weights for one or more months.

A review of the electronic weight records found a pattern of resident weights not being completed during this time period:

Resident #002-had no weight completed for two months;
Resident #004-had no weight completed for two months;
Resident #005-had no weight completed for one month, and
Resident #006-had no weight completed for two months.

A review of the home's policy titled "Resident Weight/Height – DS C-05-115" last revised May 28, 2015, indicated that residents would be weighed monthly by nursing staff.

During an interview with Registered Dietitian #106, they reported that staff were required to weigh residents every month. [s. 68. (2) (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 to ensure that the nutrition care programs must implement a weight monitoring system to measure and record with respect to each resident and a weight on admission and monthly thereafter, specifically in regards to resident #002, #004, #005 and #006, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated: A change of 7.5 per cent of body weight, or more, over three months.

A complaint was received by the Director in May 2016, alleging that resident #002 had weight loss since admission and nothing was being done.

Inspector #577 reviewed resident #002's weight history, that included an admission weight of 77 kg. Upon further review, there was no documented weight for two other months. A weight of 71.1 kg was recorded a few months after their admission.This measurement represented a significant weight loss of 5.9 kg or 8.3 per cent.

A record review of resident #002's health care records found that the resident had an initial nutrition assessment completed in February 2016, by the Registered Dietitian (RD) #107, which determined that resident was a high nutritional risk.

A record review of resident #002's progress notes, found that an RD referral was sent in April 2016, due to family concerns of weight loss since admission.

During an interview with RD #106, they reported that they received a referral in April 2016, due to a family concern of weight loss. They further reported that staff are required to weigh residents every month and based on their calculation, the resident had a 7.66 per cent weight loss over a three month period.

A record review of the home's policy titled "Resident Weight/Height – DS C-05-115" revised date May 28, 2015, indicated that residents will be weighed monthly by nursing staff. It further indicated that if a weight loss was greater than or equal to 5% in one month, 7.5% in three months, or 10% in six months than the resident will be referred to the RD. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: A change of 7.5 per cent of body weight, or more, over three months, to be implemented voluntarily.

WN #6: 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 each resident that set out clear directions to staff and others who provide direct care to the resident.

Daily observations made over four days in May 2016, Inspector #577 observed resident #002 seated in their chair with a rear facing apparatus applied.

A review of resident #002's current care plan, during time of inspection, indicated the following:

-under a nursing focus, the resident used a special chair with a rear facing appartus on a daily basis;

-under another nursing focus, the resident used a different chair with rear facing apparatus on a daily basis;

-under another nursing focus, the resident used a special chair with rear facing apparatus on a daily basis;

-under another nursing focus, the resident used a different chair with rear facing apparatus on a daily basis;

-under another nursing focus, the resident used a special chair with rear facing apparatus on a daily basis, and

-under another nursing focus, the resident used a different chair with rear facing apparatus on a daily basis.

A review of resident #002's physician orders indicated that the special chair was ordered in March 2016 and discontinued in May 2016.

Resident #002's care plan was unclear regarding the use of their chair. [s. 6. (1) (c)]

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

Daily observations made over three days in May 2016, Inspector #577 observed resident #002 seated in a special chair.

A review of resident #002's current care plan indicated that due to an unsteady gait, the resident had a specialized chair with a rear facing apparatus.

A review of resident #002's physician orders, indicated that the specialized chair was ordered in March 2016 and discontinued in May 2016.

A review of resident #002's progress notes dated May 2016, indicated that the resident was now in their own seating chair with a rear facing seat apparatus. [s. 6. (10) (b)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

A complaint was received by the Director in May 2016, alleging that resident #002 had numerous falls since admission.

Upon record review of resident #002's progress notes, Inspector #577 found that resident had 22 falls from their admission date to the present. As follows:

-nine falls in one month
-five falls in another month
-three falls in another month
-five falls in another month

In February 2016, the resident had four falls and in March 2016, the resident fell and had an injury.

The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator #100 provided Inspector #577 with the resident's care plans in effect from admission to May 2016. Resident's admission care plan, included safety interventions related to ambulation.

The care plan was updated one month later to include bed safety interventions and a specialized chair with a rear facing apparatus.

The care plan updated three months later, included a different type of chair with a rear facing apparatus to be applied on a daily basis.

Care plans reviewed over the following three consecutive months indicated that there were no additional revisions and reassessments, even though resident had many falls

during this period of time. The care planned interventions were not effective in meeting the care planned goal of resident to remain free of falls.

A review of the home’s policy titled “"Fall Prevention and Management Program - LTC 3-60" last revised April 2014, indicated that the registered staff were to update the plan of care with changes in resident condition.

A review of the home’s “Falls Prevention and Management Toolkit”, last revised date May 2012, indicated that the registered staff were to review the fall prevention interventions and modify the plan of care in collaboration with the interprofessional team. [s. 6. (10) (c)]

Issued on this 6th day of July, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBBIE WARPULA (577), JULIE KUORIKOSKI (621)
Inspection No. / No de l'inspection :	2016_333577_0011
Log No. / Registre no:	009573-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 25, Jul 6, 2016
Licensee / Titulaire de permis :	ST. JOSEPH'S CARE GROUP 35 NORTH ALGOMA STREET, P.O. BOX 3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	HOGARTH RIVERVIEW MANOR 300 LILLIE STREET, THUNDER BAY, ON, P7C-4Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Meaghan Sharp

To ST. JOSEPH'S CARE GROUP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week.
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week.
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week.
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Order / Ordre :

The licensee will take immediate action to ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

Grounds / Motifs :

1. The licensee failed to ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

During an interview with Nursing Manager #100 in May 2016, they reported that the home's Administrator also works in the role of Director of Care.

During an interview with the Administrator #101 in May 2016, they reported that they were currently the Administrator for both Hogarth Riverview Manor and Bethammi long-term care home, and Acting Director of Care for Hogarth. They further confirmed that they were not working on site for both homes for 35 hours per week.

Despite being made aware of the non compliance in regards to the required hours for the Director of Care on April 1, 2016, during the exit debrief and again on May 13, 2016, the Licensee remains in non compliance with the LTCHA.

The decision to issue this immediate order was based on the scope which was widespread, the severity which indicates actual harm/risk and the compliancy history which included a VPC in inspection #2016_246196_0006. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2016

Order # / Ordre no : 902

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:

1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week.
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week.
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Order / Ordre :

The licensee will take immediate action to ensure that that the home's Administrator works regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week.

Grounds / Motifs :

1. The licensee failed to ensure that the home's Administrator worked regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week

During an interview with the Administrator #101 in May 2016, they reported that they were currently the Administrator for both Hogarth Riverview Manor and Bethammi long-term care home. They further confirmed that they were not working on site for both homes for 37.5 hours per week, and not working regularly as the Administrator in this home for 35 hours per week.

Despite the Licensee being aware that there was non compliance with the required on site hours as indicated on April 1, 2016, during the exit debrief and again by the Sudbury SAO Manager in a meeting on May 13, 2016, the Licensee remains non compliant.

The decision to issue this immediate order was based on the scope which was widespread, the severity which indicates actual harm/risk and the compliancy history which included a VPC in inspection #2016_246196_0006. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2016

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall:

a) Ensure that resident #002 and all other residents who have fallen, receive a post fall assessment using a clinically appropriate assessment instrument.

b) Put into place a system to conduct routinely scheduled audits to ensure that residents who have fallen, are receiving a post fall assessment.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that, where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A complaint was received by the Director in May 2016, alleging that resident #002 had numerous falls since admission in January 2016.

A review of resident #002's progress notes revealed that resident had many falls over a four month period. In March 2016, the resident had a fall and was injured.

A review of the home's "Falls Prevention and Management Toolkit", last revised date May 2012, indicated that as part of the follow up after a resident had fallen, the registered staff completed a post fall assessment form, reviewed the fall prevention interventions and modified the plan of care in collaboration with the interprofessional team.

The home's policy titled "Fall Prevention and Management Program - LTC 3-60" last revised April 2014, indicated that staff were to complete the post fall assessment following each resident fall.

A review of the health records for resident #002 revealed 14 per cent of the post fall assessment tool forms were completed. The resident did not have a post fall assessment using a clinical instrument for the following falls:

-nine falls in one month in 2016
-four falls in another month
-three falls in another month, and
-five falls in another month

During an interview with RN #101, they reported that the post fall assessment was done electronically and they could not locate any completed assessments for resident #002. RN #101 was able to find three paper post fall assessments for resident #002.

During an interview with RN #102, they reported that a paper post fall assessment was to be completed after every fall. They were unable to locate any paper or electronic post fall assessments for resident #002.

During an interview with Resident Assessment Instrument Coordinator (RAI) #100, they were unable to locate any electronic post fall assessments for resident #002.

During an interview with Manager of Regional Behavioral Health Services #103, they reported that an electronic post fall assessment was to be done after every fall.

During an interview with Clinical Manager #104, they confirmed that the electronic post fall assessment was the home's clinical tool and was to be completed after every fall. [s. 49. (2)]

The decision to issue this compliance order was based on the severity which indicated actual harm/risk, the scope which indicated a pattern and the compliance history which indicates previous non-compliance (NC) issued including a VPC for inspection 2015_333577_0012 on October 29, 2015. (577)

(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2016

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 25th day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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