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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 01, 2019	2019_768693_0003 (A1)	028741-18, 028744-18, 028745-18, 028748-18, 028751-18	Follow up

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street 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

Amended by KATHERINE BARCA (625) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home has requested an extension to their compliance due date to achieve sustainable compliance. The due date for compliance order #001 will be extended to April 30, 2019.

Issued on this 1 st day of March, 2019 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 01, 2019	2019_768693_0003 (A1)	028741-18, 028744-18, 028745-18, 028748-18, 028751-18	Follow up

Licensee/Titulaire de permis

St. Joseph's Care Group
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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by KATHERINE BARCA (625) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 21 to 25, 2019 and January 28 to February 1, 2019.

The following intakes were inspected on during this Follow-Up Inspection:

-one log, related to CO #001 from inspection #2018_624196_0023, issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 19. (1);

-one log, related to CO #001, and DR from inspection #2018_624196_0024, issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 20. (1);

-one log, related to CO #001 from inspection #2018_624196_0022, issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 6. (7);

-one log, related to CO #003 from inspection #2018_624196_0024, issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 6. (9); and

-one log, related to CO #002 from inspection #2018_624196_0024 , issued pursuant to O.Reg 79/10, s. 49. (2).

Critical Incident System (CIS) inspection #2019_768693_0002 and Complaint inspection #2019_768693_0004 were conducted concurrently with this Follow-Up inspection.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), Regional Director Extendicare Assist, Clinical Managers (CMs), Infection Prevention and Control (IPAC) Facilitator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assessment Instrument (RAI) Coordinators,

Resident Home Workers (RHW), Therapeutic Recreationists, Staff Educator, Staffing Coordinator, Substitute Decision Makers (SDMs), residents and their family members.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, home's internal investigation notes and complaints, staff education records, as well as reviewed numerous licensee policies, procedure and programs.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

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

- **1 WN(s)**
- **1 VPC(s)**
- **1 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_624196_0023	196
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #001	2018_624196_0024	577
O.Reg 79/10 s. 49. (2)	CO #002	2018_624196_0024	621
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_624196_0022	693

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was

based on an assessment of the resident and the needs and preferences of that resident.

Inspector #693 was following up on outstanding compliance order #001 issued during Inspection #2018_624196_0022 with a compliance date of December 19, 2018. The home was ordered to:
a) Ensure resident #010's plan of care are followed specifically related to diet texture
b) Ensure that resident #025's and #026's plans of care are followed specifically, but not limited to falls prevention and management
c) Ensure that resident #001's plan of care are followed specifically, but not limited to bathing, nutrition and hydration and feeding assistance.

Inspector #693 observed resident #025 in their bed with an identified intervention in place on their bed.

A review of resident #025's most current care plan and kardex, effective on a specified date, did not identify that resident #025 utilized this identified intervention.

During interviews with PSW #108 and PSW#109, they stated that resident #025 utilized the intervention as a PASD (Personal Assistance Service Device) and that the use of the PASD should have been indicated on the resident's care plan and kardex. Together with the Inspector, PSW #108 and #109 reviewed resident #025's care plan and kardex that they had access to, effective on a specified date, and stated that both the care plan and kardex for resident #025 did not identify the use of the PASD.

Inspector #693 obtained a copy of the home's policy, from the ADOC, titled, "Extendicare; Care Planning; RC-05-01-10", last updated April 2017. The policy indicated that the care plan enhanced provision of individual care (resident's unique character and care needs were documented) as well that a care plan was a guide that directed care that was provided to the resident.

During an interview with RPN #110, they identified that resident #025 utilized the intervention as a PASD. RPN #110 identified that on the most current care plan, effective on a specified date, the use of the PASD was not indicated and it should have been as the resident needed this PASD.

In an interview with the ADOC, they stated that if a resident utilized the specific intervention for any reason it would be included in the resident's care plan. The ADOC and Inspector #693 reviewed resident #025's most current care plan, effective on a specified date, and the ADOC confirmed to the inspector that the use of the specific intervention was not identified in the care plan and should have been. [s. 6. (2)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Inspector #693 was following up on an outstanding compliance order #003 issued during Inspection #2018_624196_0024 with a compliance date of December 19, 2018. The home was ordered to:
a) Ensure the provision of the care set out in the plan of care for resident #025, specific to fall prevention interventions, is documented.
b) Ensure the provision of the care set out in the plan of care for resident #026, specific to fall prevention interventions and the use of Personal Assistance Service Devices (PASDs) is documented.
c) Conduct weekly audits of a sample of residents' health care records from each home area to ensure the provision of the care set out in the plan of care is documented.
d) Maintain written documentation of the weekly audits.

Specific to a:

Inspector #693 reviewed resident #025's most current care plan, effective on a specified date. The care plan identified that resident #025 had an identified number of fall prevention interventions in place.

Inspector #693 completed a record review of the Point of Care (POC) flow sheet documentation for resident #025 from an identified period of time, after the CO was due, to identify if the provision of the care care set out in the plan of care for resident #025, specific to fall prevention interventions, was documented. During this record review, the Inspector was unable to identify documentation of the specific fall prevention interventions resident #025 utilized. Inspector #693 identified an area in the POC flow sheet documentation titled, "Care Plan : Care has been provided as outlined in the care plan."

During interviews with PSW #108 and PSW #109 they stated that they completed

documentation for all care that they provided to residents in POC. They also stated that there was nowhere in POC to chart specific fall prevention interventions for residents, but that there used to be an area within the POC flow sheet charting to do so. They stated that one day they noticed that the charting area in the POC flow sheet for specific fall prevention interventions had disappeared and they were not sure when or why this was. The PSWs stated that they did not document specific fall prevention interventions as there was no place for them to do so. Inspector #693 inquired to the PSWs about an intervention listed in the flow sheet titled, "Care Plan: Care has been provided as outlined in the care plan", the PSWs stated that this specific intervention was added to the POC flow sheet recently and they did not know why. Both PSWs stated that they thought the intervention meant everything in the care plan was in place, but that they were not sure as they had not been informed of this. They stated that they sometimes documented this as being completed in the POC flow sheet as they thought that they were supposed to.

Inspector #693 reviewed the POC flow sheet documentation for resident #025 for the intervention that was titled, "Care Plan: Care has been provided as outlined in the care plan", from an identified period of time, after the CO was due, which encompassed an identified number of shifts in total. The Inspector identified that of the identified number of shifts within this date range, 68 per cent of shifts did not have documentation completed in POC for the intervention that was titled: "Care Plan: Care has been provided as outlined in the care plan", for resident #025.

During an interview with RPN #110, they stated that the provision of care set out in the plan of care was documented by PSWs in POC and by Registered Staff members in MedEcare. RPN #110 stated that it was the responsibility of the PSWs to document specific fall prevention interventions that were in place for each resident.

During an interview with the ADOC, they stated that the provision of care set out in the plan of care for resident #025, specific to fall prevention interventions was documented by the PSWs on the POC flow sheet under the intervention titled: "Care Plan: Care has been provided as outlined in the care plan." The ADOC stated that the home's process used to be for the PSWs to document each individual fall prevention intervention in the POC flow sheet, but that these specific interventions had now been replaced with the generalized care plan intervention. The ADOC stated that the intervention titled, "Care Plan: Care has been provided

as outlined in the care plan" meant that, if documented as it should have been, all of the care listed in the plan of care was provided to the resident on that shift. Together with the inspector, the ADOC reviewed the POC flow sheet charting for resident #025 and confirmed that there was a number of gaps in the documentation, specific to, the "Care Plan: Care has been provided as outlined in the care plan" intervention. [s. 6. (9) 1.]

3. Specific to b:

Inspector #693 reviewed resident #026's most current care plan, effective on a specified date. The care plan identified that resident #026 utilized an identified PASD and had a number of fall prevention interventions in place.

Inspector #693 completed a record review of the Point of Care (POC) flow sheet documentation for resident #026 from an identified period of time, after the CO was due, to identify if the provision of the care set out in the plan of care for resident #025, specific to fall prevention interventions, and the use of a PASD was documented. During this record review, Inspector #693 was unable to identify documentation of the specific fall prevention interventions and PASDs that resident #026 utilized. Inspector #693 identified an area on the POC flow sheet charting titled, "Care Plan: Care has been provided as outlined in the care plan."

During an interview with PSW #122 they stated that they documented the specific fall prevention interventions and the use of the identified PASD for resident #026 in the POC flow sheet under the heading "Special Needs." Inspector #693 and PSW #122 reviewed the POC documentation flow sheet for resident #026 together, and PSW #122 stated that the area of the POC flow sheet where the PASD and specific fall prevention interventions were to be documented was gone from the flow sheet. They stated that since these interventions were no longer listed on the flow sheet there was nowhere for the PSWs to document the provision of the care set out in the plan of care for resident #025, specific to fall prevention interventions, and the use of the PASD. Upon review of the POC flow sheet documentation for resident #026, Inspector #693 inquired to PSW #122 about an intervention listed on the flow sheet titled, "Care Plan: Care has been provided as outlined in the care plan." PSW #122 stated that they were not sure what this intervention was for, but assumed that it meant that the care plan was followed for resident #026. PSW #026 stated that they usually documented this intervention as being completed.

Inspector #693 reviewed the POC flow sheet documentation for resident #026 for the intervention that was titled, "Care Plan: Care has been provided as outlined in the care plan", from an identified period of time, after the CO was due, which encompassed an identified number of shifts in total. The Inspector identified that of the identified number of shifts within this date range, 41 per cent of shifts did not have documentation completed on POC for the intervention that was titled, "Care Plan: Care has been provided as outlined in the care plan", for resident #026.

During an interview with RPN #123, they stated that the provision of care set out in the plan of care, specific to fall prevention interventions and the the use of a PASD was documented by the PSWs each shift on POC and that this was the only place where it was documented.

During an interview with the ADOC, they stated that the provision of care set out in the plan of care for resident #026, specific to fall prevention interventions and the use of a PASD was documented by the PSWs on the POC flow sheet under the intervention titled, "Care Plan: Care has been provided as outlined in the care plan." The ADOC stated that the process used to be for the PSWs to document each individual fall prevention intervention and the use of a PASD in the POC flow sheet, but that these specific interventions had now been replaced with the generalized care plan intervention. The ADOC stated that the "Care Plan: Care has been provided as outlined in the care plan" intervention meant that, if documented as it should have been, all of the care listed in the plan of care was provided to the resident on that shift. Together with the inspector, the ADOC reviewed the POC flow sheet charting for resident #026 and confirmed that there was a number of gaps in the documentation, specific to, the "Care Plan: Care has been provided as outlined in the care plan" intervention. [s. 6. (9) 1.]

4. Specific to c:

Inspector #693 reviewed the home's compliance order documentation binder, titled "2018_624196_0024." In this binder the home provided documentation of the completion of weekly POC audits that occurred between a specified date range, for resident #010 who resided on an identified unit, resident #025 who resided on another identified unit, and resident #026 who resided on another identified unit. Inspector #693 reviewed the home's list of resident's in the home and identified that the home was made up of 15 home areas. In the "2018_624196_0024" binder, there was no evidence of weekly audits of a sample

of residents' health care records from each home area to ensure the provision of the care set out in the plan of care was documented.

During an interview with the ADOC they stated that prior to a specified date, the home had not completed any formal weekly audits relating to the documentation of care provided for any residents. The ADOC stated that the home only completed audits for resident #010, #025 and #026 as this represented a sample of residents from each home area.

After the interview with the ADOC, they provided the Inspector with more documentation relating to weekly audits of care documentation. They stated that the clinical managers had these in their offices, and these were all of the weekly care documentation audits that the home had completed. Inspector #693 reviewed this documentation and identified that weekly audits of a sample of residents' health care records to ensure the provision of the care set out in the plan of care were completed between an identified date range, for a sample of residents from 5 out of the 15 or 33 per cent of the home areas. The ADOC confirmed that these were the only audits of a sample of residents' health care records to ensure the provision of the care set out in the plan that were completed. [s. 6. (9) 1.]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

Issued on this 1 st day of March, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by KATHERINE BARCA (625) - (A1)
Inspection No. / No de l'inspection :	2019_768693_0003 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	028741-18, 028744-18, 028745-18, 028748-18, 028751-18 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 01, 2019(A1)
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, 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 :	Lina Johnson

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To St. Joseph's Care Group, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_624196_0024, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Order / Ordre :

The licensee must be compliant with s. 6. (9) of the LTCHA.
Specifically, the licensee must:

a) Ensure the provision of the care set out in the plan of care for resident #025, specific to fall prevention interventions, is documented.
b) Ensure the provision of the care set out in the plan of care for resident #026, specific to fall prevention interventions and the use of Personal Assistance Service Devices (PASDs) is documented.
c) Conduct weekly audits of a sample of residents' health care records from each home area to ensure the provision of the care set out in the plan of care is
documented.
d) Maintain written documentation of the weekly audits.

Grounds / Motifs :

1. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Inspector #693 was following up on an outstanding compliance order #003 issued during Inspection #2018_624196_0024 with a compliance date of December 19,

2018. The home was ordered to:
a) Ensure the provision of the care set out in the plan of care for resident #025, specific to fall prevention interventions, is documented.
b) Ensure the provision of the care set out in the plan of care for resident #026, specific to fall prevention interventions and the use of Personal Assistance Service Devices (PASDs) is documented.
c) Conduct weekly audits of a sample of residents' health care records from each home area to ensure the provision of the care set out in the plan of care is documented.
d) Maintain written documentation of the weekly audits.

Specific to a:

Inspector #693 reviewed resident #025's most current care plan, effective on a specified date. The care plan identified that resident #025 had an identified number of fall prevention interventions in place.

Inspector #693 completed a record review of the Point of Care (POC) flow sheet documentation for resident #025 from an identified period of time, after the CO was due, to identify if the provision of the care care set out in the plan of care for resident #025, specific to fall prevention interventions, was documented. During this record review, the Inspector was unable to identify documentation of the specific fall prevention interventions resident #025 utilized. Inspector #693 identified an area in the POC flow sheet documentation titled, "Care Plan : Care has been provided as outlined in the care plan."

During interviews with PSW #108 and PSW #109 they stated that they completed documentation for all care that they provided to residents in POC. They also stated that there was nowhere in POC to chart specific fall prevention interventions for residents, but that there used to be an area within the POC flow sheet charting to do so. They stated that one day they noticed that the charting area in the POC flow sheet for specific fall prevention interventions had disappeared and they were not sure when or why this was. The PSWs stated that they did not document specific fall prevention interventions as there was no place for them to do so. Inspector #693 inquired to the PSWs about an intervention listed in the flow sheet titled, "Care Plan: Care has been provided as outlined in the care plan", the PSWs stated that this specific intervention was added to the POC flow sheet recently and they did not know

why. Both PSWs stated that they thought the intervention meant everything in the care plan was in place, but that they were not sure as they had not been informed of this. They stated that they sometimes documented this as being completed in the POC flow sheet as they thought that they were supposed to.

Inspector #693 reviewed the POC flow sheet documentation for resident #025 for the intervention that was titled, "Care Plan: Care has been provided as outlined in the care plan", from an identified period of time, after the CO was due, which encompassed an identified number of shifts in total. The Inspector identified that of the identified number of shifts within this date range, 68 per cent of shifts did not have documentation completed in POC for the intervention that was titled: "Care Plan: Care has been provided as outlined in the care plan", for resident #025.

During an interview with RPN #110, they stated that the provision of care set out in the plan of care was documented by PSWs in POC and by Registered Staff members in MedEcare. RPN #110 stated that it was the responsibility of the PSWs to document specific fall prevention interventions that were in place for each resident.

During an interview with the ADOC, they stated that the provision of care set out in the plan of care for resident #025, specific to fall prevention interventions was documented by the PSWs on the POC flow sheet under the intervention titled: "Care Plan: Care has been provided as outlined in the care plan." The ADOC stated that the home's process used to be for the PSWs to document each individual fall prevention intervention in the POC flow sheet, but that these specific interventions had now been replaced with the generalized care plan intervention. The ADOC stated that the intervention titled, "Care Plan: Care has been provided as outlined in the care plan" meant that, if documented as it should have been, all of the care listed in the plan of care was provided to the resident on that shift. Together with the inspector, the ADOC reviewed the POC flow sheet charting for resident #025 and confirmed that there was a number of gaps in the documentation, specific to, the "Care Plan: Care has been provided as outlined in the care plan" intervention. (693)

2. Specific to b:

Inspector #693 reviewed resident #026's most current care plan, effective on a specified date. The care plan identified that resident #026 utilized an identified PASD and had a number of fall prevention interventions in place.

Inspector #693 completed a record review of the Point of Care (POC) flow sheet documentation for resident #026 from an identified period of time, after the CO was due, to identify if the provision of the care set out in the plan of care for resident #025, specific to fall prevention interventions, and the use of a PASD was documented. During this record review, Inspector #693 was unable to identify documentation of the specific fall prevention interventions and PASDs that resident #026 utilized. Inspector #693 identified an area on the POC flow sheet charting titled, "Care Plan: Care has been provided as outlined in the care plan."

During an interview with PSW #122 they stated that they documented the specific fall prevention interventions and the use of the identified PASD for resident #026 in the POC flow sheet under the heading "Special Needs." Inspector #693 and PSW #122 reviewed the POC documentation flow sheet for resident #026 together, and PSW #122 stated that the area of the POC flow sheet where the PASD and specific fall prevention interventions were to be documented was gone from the flow sheet. They stated that since these interventions were no longer listed on the flow sheet there was nowhere for the PSWs to document the provision of the care set out in the plan of care for resident #025, specific to fall prevention interventions, and the use of the PASD. Upon review of the POC flow sheet documentation for resident #026, Inspector #693 inquired to PSW #122 about an intervention listed on the flow sheet titled, "Care Plan: Care has been provided as outlined in the care plan." PSW #122 stated that they were not sure what this intervention was for, but assumed that it meant that the care plan was followed for resident #026. PSW #026 stated that they usually documented this intervention as being completed.

Inspector #693 reviewed the POC flow sheet documentation for resident #026 for the intervention that was titled, "Care Plan: Care has been provided as outlined in the care plan", from an identified period of time, after the CO was due, which encompassed an identified number of shifts in total. The Inspector identified that of the identified number of shifts within this date range, 41 per cent of shifts did not have documentation completed on POC for the intervention that was titled, "Care Plan: Care has been provided as outlined in the care plan", for resident #026.

During an interview with RPN #123, they stated that the provision of care set out in the plan of care, specific to fall prevention interventions and the use of a PASD was documented by the PSWs each shift on POC and that this was the only place where it was documented.

During an interview with the ADOC, they stated that the provision of care set out in the plan of care for resident #026, specific to fall prevention interventions and the use of a PASD was documented by the PSWs on the POC flow sheet under the intervention titled, "Care Plan: Care has been provided as outlined in the care plan." The ADOC stated that the process used to be for the PSWs to document each individual fall prevention intervention and the use of a PASD in the POC flow sheet, but that these specific interventions had now been replaced with the generalized care plan intervention. The ADOC stated that the "Care Plan: Care has been provided as outlined in the care plan" intervention meant that, if documented as it should have been, all of the care listed in the plan of care was provided to the resident on that shift. Together with the inspector, the ADOC reviewed the POC flow sheet charting for resident #026 and confirmed that there was a number of gaps in the documentation, specific to, the "Care Plan: Care has been provided as outlined in the care plan" intervention.
(693)

3. Specific to c:

Inspector #693 reviewed the home's compliance order documentation binder, titled "2018_624196_0024." In this binder the home provided documentation of the completion of weekly POC audits that occurred between a specified date range, for resident #010 who resided on an identified unit, resident #025 who resided on another identified unit, and resident #026 who resided on another identified unit. Inspector #693 reviewed the home's list of resident's in the home and identified that the home was made up of 15 home areas. In the "2018_624196_0024" binder, there was no evidence of weekly audits of a sample of residents' health care records from each home area to ensure the provision of the care set out in the plan of care was documented.

During an interview with the ADOC they stated that prior to a specified date, the home had not completed any formal weekly audits relating to the documentation of care provided for any residents. The ADOC stated that the home only completed audits for resident #010, #025 and #026 as this represented a sample of residents from each home area.

After the interview with the ADOC, they provided the Inspector with more documentation relating to weekly audits of care documentation. They stated that the

clinical managers had these in their offices, and these were all of the weekly care documentation audits that the home had completed. Inspector #693 reviewed this documentation and identified that weekly audits of a sample of residents' health care records to ensure the provision of the care set out in the plan of care were completed between an identified date range, for a sample of residents from 5 out of the 15 or 33 per cent of the home areas. The ADOC confirmed that these were the only audits of a sample of residents' health care records to ensure the provision of the care set out in the plan that were completed. [s. 6. (9) 1.]

The decision to issue a Compliance Order (CO) was based on the home's ongoing non-compliance with this section of the legislation, the severity was minimal harm or potential for actual harm, and the scope was a pattern of two residents that have been affected by repeated occurrences. The home has a history of non-compliance in this area of the legislation as follows:
- a CO was issued from a Critical Incident (CIS) inspection #2018_624196_0024, on October 11, 2018;
- a Voluntary Plan of Correction (VPC) was issued from a Complaint inspection #2018_740621_0014, on May 18, 2018;
- a VPC was issued from a Resident Quality Inspection (RQI) #2017_624196_0005, on May 16, 2017;
- a VPC was issued from a Complaint inspection #2016_391603_0023, on November 3, 2016;
- a VPC was issued from a RQI inspection #2016_435621_0012, on October 11, 2016;
- a VPC was issued from a Complaint inspection #2016_246196_0005, on May 12, 2016; and
- a Written Notification (WN) was issued from a Complaint inspection #2016_264609_0006, on March 7, 2016. (693)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 1 st day of March, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by KATHERINE BARCA (625) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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