Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 3, 2019	2019_643111_0014	010181-17, 012240-17, 003003-18, 023215-18, 027955-18, 030921-18, 000475-19, 000476-19, 000477-19, 000478-19, 007639-19, 008303-19, 008332-19	Critical Incident System

Licensee/Titulaire de permis

Haliburton Highlands Health Services Corporation
7199 Gelert Road Box 115 HALIBURTON ON K0M 1S0

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

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 13, 14, 16, 22-24, 27-30, 2019.

The following follow-up intakes were completed concurrently:
-Log # 00475-19 related to lingering offensive odours.
-Log #000476-19 related resident-staff communication systems.
-Log #000477-19 and Log # 000478-19 related to the home being clean and in a good state of repair.

The following critical incident inspections were completed concurrently:
-Log #030921-18 (CIR #M542-000021-18), Log #027955-18 (CIR #M542-000020-18) and Log #023215-18 (CIR # M542-000017-18) were related to falls with injury. Log #010181-17 (CIR # M542-000007-17) and Log # 012240-17 (CIR # M542-000009-17) related to falls with injury were bundled as per the policy.
-Log # 010705-18 (CIR # M542-000010-18), Log # 019960-18 (CIR # M542-000016-18), Log #008303-19 (CIR # M542-000007-19), Log # 007639-19 (CIR # M542-000005-19), Log # 008332-19 (CIR # M542-000006-19) related to resident to resident abuse.
-Log # 003003-18 (CIR #M542-000003-18) related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator/DOC, the Resident Care Coordinator (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), Life Enrichment Manager (LEM), Environmental Manager (EM),RAI Coordinator, Activity Aide and residents.

During the course of the inspection, the inspector completed an observation of both the upper and lower level common areas and secured outdoor areas, reviewed resident health records, reviewed employee and training records and reviewed the following licensee policies: Zero Tolerance of Abuse and Neglect, Pain and Symptom-Assessment and Management, Responsive Behaviours, Medications and Falls Prevention and Management Program.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Critical Incident Response
Falls Prevention
Medication
Pain
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **9 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. 15. (2)	CO #001	2018_591623_0010	111
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #004	2018_591623_0010	111
O.Reg 79/10 s. 17. (1)	CO #002	2018_591623_0010	111
O.Reg 79/10 s. 87. (2)	CO #003	2018_591623_0010	111

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the falls prevention and management program was implemented in the home with the aim to reduce the incidence of falls and the risk of injury.

Review of the Fall Prevention and Management Program Policy (revised October 22, 2018) indicated the Resident Safety Committee will be comprised of the Physiotherapist (PT), Registered staff, PSWs and activation staff to develop, implement and educate about fall management strategies. Under procedure:
-The Physiotherapist will compile fall data, identify action plans to address trends and conduct post-fall assessments, document finding in progress notes and update care plan as necessary.
-The DOC will determine a communication process by which residents at moderate or high risk for falling are easily identified to the entire care team (Falling Leaf Program).
-In the event of a fall, an initial post-fall assessment note by the RN/RPN must include the following physical assessments for injuries: assessment of damage to the hip joint (i.e. extreme pain, shortened and/or abduction of externally rotated leg, inability to weight bear). Limited range of motion of joint and assessment for pain (i.e. guarding, facial expressions, grimacing and verbal report of pain).
-If there is suspicion or evidence of injury, the Registered Staff should not move the resident, the physician should be contacted and/or arrange for immediate transfer to the hospital and the POA/Substitute Decision Maker (SDM) will be notified. Complete a Falls Incident Report under Risk Management section on PCC.

-Document the care that was provided or interventions that were in place according to the care plan, re-evaluate the resident's care plan and document appropriate interventions to be taken.

Relate to resident #001:

There were two critical incident reports submitted to the Director for falls that caused an injury to a specified area, for which resident #001 was taken to hospital.

Review of the written plan of care for resident #001 indicated the resident was at risk for falls. There were also specified interventions noted. There was no indication the plan of care was revised related to toileting needs, despite the resident frequently falling related to toileting. In addition, some of the interventions were inconsistently implemented.

Review of the progress notes for resident #001 indicated the resident had sustained a specified number of falls over a specified period, with most of the falls having minor injuries. After the fall on a specified date, the resident had complained of pain to a specified area. The resident was diagnosed with an injury to a specified area several days after the initial fall. The resident sustained an injury to a specified area after another fall on a specified date and died two days later. The progress notes indicated the falls were related to the resident attempting to self-toilet. An alarming and restraining device were put in place after the second fall, but on multiple occasions, the resident was found without the devices in place. Staff noted the resident was able to remove the restraining device. Another falls prevention intervention was put in place, after the fifth fall. After the sixth fall, the staff indicated the alarming device was ineffective for falls prevention. PT had assessed the resident after each fall and no action plans were identified, until after the resident's eighth fall, when the resident sustained an injury to a specified area. The progress notes indicated the SDM was notified of the ongoing falls, remained upset regarding the frequent falls and wanted to know what the home was doing to prevent the falls. The SDM was notified of other falls prevention devices that could be implemented. The SDM also requested the use of a specified restraining device but the restraining device was not implemented until approximately one month later. The staff noted the resident was often at risk for falls “related to toileting" needs.

Review of the falls incident reports (risk management) for resident #001 indicated they were not completed for a number of the falls that occurred.

During an interview with the PT, they indicated they were familiar with resident #001, was

aware the resident was a high risk for falls and had frequent falls. The PT indicated they were not involved in the Resident Falls Prevention Committee to discuss possible interventions to prevent falls or reduce risk of injury.

During an Interview with RPN #105, they indicated when a resident sustained a fall, they completed a head to toe assessment for any pain or injury, notify the physician if there is any injuries, notify the family, the DOC and the PT. The RPN indicated if the resident was complaining of extreme pain and had a suspected serious injury, that they would call 911. The RPN indicated they would document the fall, the assessment and who was notified on the resident's progress note. The RPN indicated they would also complete a fall incident report. The RPN indicated resident #001 was at risk for falls and had several falls. The RPN indicated the home used to use the falling leaf symbol to indicate residents at high risk for falls, but the home was not using a method that would identify residents at high risk for falls.

The licensee has failed to ensure that the falls prevention and management program was implemented in the home with the aim to reduce the incidence of falls and the risk of injury to resident #001. The PT was not involved in the falls prevention committee to discuss possible interventions to prevent falls or reduce risk of injury as per the falls prevention and management policy. A Falls Incident report was not completed after each fall and when resident #001 sustained a fall on a specified date, the physician should have been contacted and/or arrangement made for immediate transfer to the hospital as per the policy.

Related to resident #002:

A critical incident report (CIR) was submitted to the Director on a specified date, for a fall incident that caused an injury, for which resident #002 was taken to hospital and resulted in a significant change in condition.

Observation of resident #002 on a specified date by the Inspector, indicated the resident was in a mobility aid with an alarming device in place. The resident was not interviewable. The resident's room had specified falls prevention devices in place.

Review of the 24 Hour Care Plan for resident #002 indicated the resident was at risk for falls and recently sustained a fall. Review of the written plan of care for resident #002 indicated the resident was at risk for falls and identified specified interventions. The plan of care was updated on a specified date with an additional intervention. There was no

indication the care plan was updated to include the use of alarming or restraining devices, the risk of a specified device to the resident or the use of a toileting program.

The progress notes indicated the resident sustained a number of falls over a specified period, with most of the falls incurring minor injuries. One of the falls resulted in an injury to a specified area for which the resident was taken to hospital and resulted in a significant change in condition. After the resident returned from hospital, the resident had specified interventions put in place and the SDM requested the use of a restraining device. The specified restraining device was not implemented until approximately one month later. A number of days after the specified restraining device was implemented, the resident had a near miss incident with the device as the device was not properly installed and the device was removed. Additional interventions were implemented. The progress notes also had no description of one of the falls that occurred on a specified date, to indicate what time the fall occurred, where the fall occurred, the circumstances surrounding the fall or whether the resident was assessed for pain or injury, as per the policy. After a number of falls, the SDM had expressed concerns as they had requested the use of a specified restraining device to be used and were unaware that the resident was using a different restraining device. There were also multiple incidents when staff noted one of the interventions for falls prevention had not been implemented or the resident would remove.There was no indication the SDM or the physician were notified of a number of the falls and they were notified the day after one of the falls occurred.

Review of the post-fall assessments completed by PT after each fall indicated that strategies were identified after the first fall.

Review of the fall incident reports (risk management) for resident #002 indicated there were no fall incident reports completed for a number of falls, as per the policy.

During an interview with PSW #104, they indicated resident #002 was at risk for falls and identified specified interventions for falls prevention.

The Inspector was unable to interview Activity Aide #117, as they were off on leave.

During an interview with Resident Care Coordinator (RCC) #101, they indicated they were the lead for the Resident Safety Committee (Falls Prevention Committee). The RCC indicated they met monthly to discuss residents who have fallen, identify possible causes and identify interventions to be implemented to reduce falls or risk of injury and complete the resident fall prevention and management form for residents that are

moderate to high risk for falls. The RCC indicated the members included registered nursing staff, PSWs and Restorative Care Coordinator (RCC). The RCC confirmed that there were no PT staff that were involved in the falls prevention committee. The RCC also confirmed that they previously used the falling leaf to identify which residents were at moderate to high risk for falls, but they no longer use it and don't have any other system in place.

During an interview with the PT, they confirmed that they were not a part of the resident safety committee and did not attend any of the meetings. They indicated they review all residents who have fallen, when they receive notice from the risk management report alerts or from verbal reports by the Physiotherapy Assistants (PTA) and nursing staff. The PT indicated they complete a progress note to indicate their post-fall assessment and possible strategies to prevent further falls or injury. The PT confirmed they do not update the resident's care plan related to falls risk, only related to the physiotherapy program.

During an interview with RPN #106, they indicated when a resident has fallen, the resident was to be immediately assessed for injuries, if they suspect there is an actual injury, they would call the emergency department for possible transfer and notify the SDM. They indicated if the resident complained of pain, they would administer analgesic and if the fall occurred during a specified time and there was no pain or injury, they would have the next shift call notify the family. The RPN indicated they would complete a risk management report for falls, complete a progress note of the assessment and who was notified. The RPN indicated the home previously used the falling leaves program to identify which residents were at high risk for falls, but there was currently no process in place and indicated it was the nurse's responsibility to update the resident's care plan related to falls. The RPN indicated resident #002 was at risk for falls and confirmed on a specified date, when the resident had fallen, that although the resident was complaining of pain to a specified area, they did not transfer the resident to hospital, did not notify the SDM or the physician and were not familiar with the homes falls prevention and management policy.

During an interview with Life Enrichment Manager (LEM), they indicated the activity staff/restorative care staff were responsible for notifying the Occupational Therapist (OT) through their supplier for any mobility aid assessments and ordering of restraining devices. The LEM indicated the home did not have specified restraining devices and took approximately one to two weeks, for the restraining devices to be implemented.

During an interview with the Administrator, they indicated the home had an after-hours number to call the physician in an emergency. The Administrator indicated their expectation was that when a resident had sustained a fall and had a suspected serious injury, the resident was to be immediately sent to the hospital, the physician, the SDM and the Administrator were to be notified. The Administrator indicated all restraints were ordered by the LEM but the home also had restraining devices available in the home. The Administrator confirmed the home generally did not have specified falls preventions devices in the home and the alarming devices were kept in the Administrators office.

The licensee failed to ensure the falls prevention and management program was implemented in the home, as the falls prevention committee was not interdisciplinary, the Falls Incident Report was not completed for resident #002 after each fall, or when there was an injury or a suspected injury. After resident #002 sustained a fall with a suspected injury to a specified area, the physician was not contacted and/or immediately transported to the hospital. In addition, the Falling Leaf Program, by which residents at moderate or high risk for falling were easily identified to the care team was not implemented.

2. The licensee has failed to ensure that the pain management program was implemented in the home to identify and manage pain in residents.

Review of the Pain and Symptom-Assessment and Management Policy (revised October 22, 2018) indicated under procedure, the Registered Staff will:
-conduct and document a formal pain assessment under the assessments tab on PCC for each resident upon re-admission, when behaviours exhibited by resident may be an indicator of the onset of pain;
-initiate a 24 hour Pain and Symptom Monitoring Tool (VII-G-70.00) when pain persists regardless of the interventions, an empiric trial of analgesics is started.
-ensure that pain management is addressed on plan of care with pharmacological and non-pharmacological interventions.

Related to resident #001:

There were two critical incident reports (CIR) that were submitted to the Director on specified dates, for falls that caused an injury for which resident #001 was taken to hospital and resulted in a significant change in condition.

Review of the health care record for resident #001 indicated in the progress notes and

risk management reports, the resident had sustained a number of falls over a specified period. The resident sustained an injury to a specified area after two of the falls for which the resident was transferred to hospital and upon return from hospital, there were no pain assessments completed. The resident also complained of pain after a number of the falls and there was no indication a pain assessment was completed, the resident was provided with effective pain management, or the care plan updated, as per the home's policy. After the last fall, the resident sustained an injury to a specified area, was transferred to hospital and passed away a few days later.

Review of the pain assessments for resident #001 indicated the resident sustained a number of falls and on two specified dates, had pain, and a pain assessment was not completed until a number of days later. The resident was hospitalized for injuries to specified areas, a pain assessment was not completed until a number of weeks later.

Review of the written plan of care for resident #001 related to pain, indicated there was no direction provided for pain management, until a number of weeks later, after the resident was transferred to hospital. There were specified interventions included but the plan of care was not revised when the resident sustained another fall on a specified date, with a new injury to an identified area and after the last fall.

During an interview with the Administrator, they indicated resident #001 should have had a pain assessment completed when they experienced new pain post falls, when the resident was ordered new analgesics and when their condition became palliative. The Administrator indicated the resident should have had pain in the written care plan revised to address the pain and confirmed the home's policy for pain management was not implemented for resident #001.

Related to resident #002:

A critical incident report (CIR) was submitted to the Director for a fall that occurred on a specified date and time. Resident #002 complained of pain to a specified area, was transferred to hospital and diagnosed with an injury to a specified area.

Observation of resident #002 on a specified date, by the Inspector, indicated the resident appeared comfortable in their mobility aid. The resident denied any discomfort.

Review of the health care record for resident #002 indicated the resident was admitted with diagnoses that included chronic pain and was prescribed a specified analgesic as

needed (PRN) for pain.

Review of the progress notes for resident #001 related to pain, indicated the resident had ongoing pain post falls and no pain assessments were completed as per the policy, to ensure the residents pain was managed. There was also no indication the physician was contacted when the resident's pain was not managed. There was no pain assessments completed when the resident returned from hospital on a specified date, with an injury and a nor when new pain medication was prescribed. On another specified date, the resident developed a pressure ulcer and complained of pain to a specified area and no documented pain assessments were completed. On another specified date, the resident was noted to have severe pain to a specified area while being toileted and the physician was not contacted when the pain was uncontrolled and there was no documented pain assessment completed.

Review of the pain assessments for resident #002 indicated a pain assessment was not completed until a number of weeks after the resident sustained a fall with an injury to a specified area and had new pain.

There was no documented evidence that a 24 hour Pain and Symptom monitoring tool was used for resident #002, as per the policy.

Review of the written plan of care for resident #002 indicated there was no care plan in place related to pain, as per the policy.

During an interview with RPN #106, they indicated when a resident sustained a fall, the resident was to be immediately assessed for injuries or pain, if the resident was complaining of mild pain, they would administer analgesic as ordered. The RPN indicated if the pain was not relieved with the analgesic, they would call the physician for additional analgesic. The RPN indicated on specified date when resident #002 had fallen, the resident was complaining of ongoing pain to a specified area, they gave the resident analgesic and called the emergency department. The RPN confirmed they were not familiar with the home's pain policy and was not aware of all their responsibilities when the resident had pain, including which assessments were to be completed.

During an interview with RPN #110, they confirmed they were working on a specified date, when resident #002 returned from the hospital post fall. The RPN confirmed the resident had pain to a specified area, received a new order for analgesic and no pain assessment or a 24 hour pain and symptom management tool was completed, as per the

home's pain policy.

During an interview with the Administrator, they indicated the home had on-call physician's posted which the nurses were to call during after-hours, for any medical emergency and for reassessment of analgesic. The Administrator confirmed a pain assessment was not completed for resident #002 until a specified date, the 24 hour pain and symptom monitoring tool was never completed for resident #002, despite the resident having pain, as per the home's pain policy. The Administrator was unaware that resident #002's care plan was never revised to include pain management related to pain in specified areas.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

The licensee has failed to ensure that the SDM of the resident had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A critical incident report (CIR) was submitted to the Director on a specified date, for a fall incident that caused an injury, for which the resident was taken to hospital and resulted in a significant change in condition. The CIR indicated on a specified date and time, resident #002 sustained a fall and had complained of pain to a specified area. The resident was transferred to hospital the following morning and diagnosed with a specified

injury.

Review of the progress notes for resident #002 indicated the resident sustained a number of falls, on specified dates and times and the SDM was not immediately informed. After the first fall, the resident complained of pain to a specified area and the RPN left a note for the next shift to notify the SDM of the fall.

During an interview with RPN #116, the RPN indicated when a resident has fallen and sustains pain or injury, they would immediately notify the family. The RPN indicated if the resident did not have any injury or pain, they would still notify the family of the fall. The RPN confirmed that they worked on four dates when resident #002 sustained falls and confirmed that they did not notified the SDM.

During an interview with RPN #106, the RPN indicated when a resident has fallen and they suspect there is an injury, they would transfer the resident to hospital and notify the SDM. The RPN indicated if the fall occurs during a specified time, they would not notify the SDM, but pass on to the next shift to notify the SDM. The RPN indicated on a specified date, resident #002 sustained a fall, complained of pain to a specified area and they suspected an injury to a specified area. The RPN indicated they called the emergency department, confirmed they did not notify the resident's SDM and passed onto the next shift to inform the SDM.

During an interview with RN #111, the RN indicated when a resident has sustained a fall and they suspect any injury/pain, they would also notify the SDM. The RN confirmed they were working on three separate dates, when resident #002 sustained falls and confirmed they did not inform the SDM of the falls because they suspected the resident had just lowered them self to the floor. The RN confirmed that they did not document this suspicion with each fall.

During an interview with the Administrator, they confirmed the expectation is that whenever a resident has sustained a fall with injury and/or pain, the SDM is to be notified immediately. The DOC indicated if the resident has sustained a fall during the night and no pain or injury and the SDM is agreeable, they will notify the SDM in the morning.

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

A critical incident report (CIR) was submitted to the Director for an alleged, staff to

resident abuse incident that occurred on a specified date and time. The CIR indicated PSW #119 reported witnessing PSW #120 being abusive towards resident #004, during care and resulted in pain to the resident.

Observation an interview of resident #004 on a specified date, indicated the resident was not interviewable.

Review of the written care plan for resident #004 indicated the resident required two staff assistance with personal care and required specified interventions when the resident demonstrated specified responsive behaviours.

During an interview with the Administrator, they indicated they determined the alleged staff to resident abuse incident by PSW #120 was founded and PSW #120 no longer worked in the home.

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 the plan of care is based on an assessment of the resident and the resident's needs; the SDM of the resident is provided an opportunity to participate fully in the development and implementation of the plan; to ensure the care set out in the plan is provided to resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that residents were protected from physical abuse, by

resident #005.

Under O.Reg. 79/10, s. 2(1)(c), physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.

There were three critical incident reports (CIR) submitted to the Director for a resident to resident abuse incidents on specified dates and times. The first CIR involved resident #005 towards resident #006 and resulted in an injury to a specified area to resident #006. The second CIR involved resident #005 towards resident #007 and resulted in an injury to a specified area to resident #007. The third CIR involved resident #005 towards resident #002.

Review of the health care records for resident #005 over a specified period, indicated their were ongoing altercations and incidents of resident to resident abuse by resident #005 towards residents #002 (on two occasions), #005, #006, #008, #010 and families. On a specified date, resident #005 was involved in an abuse incident towards resident #008, which resulted in an injury to resident #008 and the incident was not reported to either resident's SDMs, the physician or the MLTC. and the incident was not documented in the progress notes for resident #008. The BSO staff (RPN #106) completed a referral to a specialized resource after the second abuse incident, despite ongoing altercations occurring. There was two altercations involving resident #005 towards two separate families, there was no indication which resident's family members that were involved and no indication that these incidents were reported to the SDM of resident #005. The altercation that occurred on a specified date and time, involving resident #005 towards resident #010 had no indication the SDM of resident #005 was notified of the incident or any other actions taken to prevent a recurrence. There was no indication resident #002 was assessed for any injury after the second altercation, the physician and the MLTC were not informed of the incident until the following day. An abuse incident that occurred on a specified date, involving resident #005 towards resident #007 was not documented until a number of days after the incident occurred and no indication the SDM of resident #005 was notified. A responsive behaviour assessment tool was not put in place until two days after the incident occurred and three days after the incident occurred, heightened monitoring was initiated for resident #005.

Review of the written plan of care for resident #005 related to responsive behaviours, indicated the plan was not revised until approximately a number of months after the resident was displaying abusive and/or altercations with other residents. There were specified responsive behaviours, triggers and interventions identified. Most of the

interventions were not identified on the written plan of care until after the resident had already had a number of resident to resident abuse incidents and ongoing altercations between other residents and visitors.

The Behavioural Assessment Tool (BAT) for resident #005, was completed but not dated and identified specified responsive behaviours. triggers and interventions.

During an interview with PSW #128, they indicated resident #005 had responsive behaviours towards residents and staff. The PSW identified specified triggers and interventions that were in place. The PSW was not aware of resident #005 having an altercation with resident #006.

During an interview with RPN #106, they indicated they were the BSO (Behavioural Support Ontario) lead for the home. The RPN indicated they complete the BAT tools, update responsive behaviour care plans for residents exhibiting high risk responsive behaviours and completed referrals to specialized resources. The RPN indicated they also update the whiteboard on each unit at the nursing station which provided a quick reference for all staff regarding which residents are exhibiting high risk responsive behaviours and interventions. The RPN indicated resident #005 demonstrated responsive behaviours towards staff and residents. The RPN indicated awareness of two resident to resident abuse incidents involving resident #005. The RPN indicated the residents responsive behaviours were unprovoked and unpredictable at times. The RPN indicated they recently identified a possible trigger and identified a number of interventions used. The RPN indicated they had completed several assessments for resident #005. The RPN indicated they were also aware of altercations with resident #005 towards #006 and #007. The RPN indicated a specified intervention was implemented for resident #006 and #007 as a result of the altercations. The RPN indicated resident #007 was fearful of resident #005. The RPN indicated awareness of resident #005 having altercations with resident #002 and a specified intervention was put in place for resident #002.

During an interview with RPN #125, they indicated resident #005 demonstrated specified responsive behaviours towards staff and residents. The RPN indicated specified triggers and interventions. The RPN indicated they are to document responsive behaviours in the resident's progress notes. The RPN indicated awareness that resident #002 was a possible trigger for resident #005.

During an interview with the Administrator, they indicated resident #005 was placed on

enhanced monitoring on a specified date, for specified hours as a result of altercations with other residents and responsive behaviours towards staff. The Administrator indicated the staff were to complete a daily DOS documentation to track the residents responsive behaviours. The Administrator was not aware that the written plan of care was not updated until approximately two months after the altercations and abuse incidents had occurred.

There were ongoing incidents of abuse and ongoing altercations by resident #005 towards multiple residents and altercations towards residents family members (visitors). One resident to resident abuse incident was not reported to the Director or the residents SDM's. There were no investigations completed into any of the abuse incidents. There were incidents that were not documented in the either residents health records to indicate who was involved in the incidents, what had occurred, what interventions were put in place to prevent a recurrence and whether the residents were assessed for any injury. One intervention that included heightened monitoring was not implemented until approximately a few months after the ongoing altercation and/or abuse incidents had occurred. Most of the interventions were not identified on the written plan of care until after the resident had already had a number of resident to resident abuse incidents and ongoing altercations between other residents and visitors.

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 are protected from physical abuse, by resident #005., to be implemented voluntarily.

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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse of residents was complied with.

A critical incident report was submitted to the Director on a specified date, for an alleged, staff to resident abuse incident. The CIR indicated on a specified date, the DOC received a letter from PSW #119, who reported witnessing PSW #120 being abusive towards resident #004, causing the resident pain approximately two weeks earlier.

Review of the licensee's policy Zero Tolerance of Abuse and Neglect-Pol #20658, (reviewed October 22, 2018) indicated:
-on page 1 of 9, all staff members have an obligation to report any incident, suspected

incident, or alleged incident of resident abuse and further, if a staff member is found guilty of not having reported such an incident, he/she will be severally reprimanded and/or terminated.
-on page 3 of 9, if a staff member becomes aware of potential, actual , or alleged abuse, be it by a staff member, the following steps must be taken: notify the charge nurse.
-on page 5 of 9, included appendices VII-G-10.00, checklist for investigating alleged abuse which included immediate actions taken, who the checklist was completed by and date.

Review of the home's investigation indicated the investigation checklist had been completed for this incident, but indicated under the immediate actions and who the checklist was completed by, were both left blank.

During an interview with the Administrator, they indicated PSW #119 did not immediately report the alleged staff to resident abuse incident to their charge nurse as per the home's abuse prevention policy. The Administrator indicated they took appropriate action with PSW #119 for late reporting, but had no documented evidence of the action taken, as per the policy. The Administrator indicated PSW#119 and #120 no longer worked in the home.

2. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents, and when the abuser was a staff member.

Review of the licensee's policy Zero Tolerance of Abuse and Neglect-Pol #20658, (reviewed October 22, 2018) indicated, "HHHS will investigate and respond to all such concerns, complaints, or reports and employees found guilty of abuse or neglect will be disciplined and may be terminated".

This policy does not contain actual procedures for investigating and responding to alleged, suspected or witnessed abuse of residents as the policy does not indicate when the investigation is to begin, who will initiate the investigation or how the investigation is to be completed. A checklist was included for investigating a report of an alleged, suspected or witnessed abuse of a resident, but did not include an area that indicated the SDM was to be contacted following the completion of the investigation of the outcome.

During an interview with the Admin/DOC, they confirmed the policy did not provide clear

directions on when the investigation was to occur, who was responsible for completing the investigation, what documents were to be used for completing the investigation.

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 the zero tolerance of abuse of residents policy is complied with and the policy meets the legislative requirements, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

There were three critical incident reports that were submitted to the Director on specified dates, for resident to resident abuse incidents, all involving resident #005.

In addition, a critical incident report was submitted to the Director on a specified date, for a resident to resident abuse incident that occurred on a specified date and time. The CIR indicated RN #114 responded to the incident and placed an after hours call to the Director, the day after the incident occurred.

Review of the progress notes and risk management reports for resident #005 indicated there was an additional incident of resident to resident abuse that occurred on a specified date and time, as documented by RN #116 and resulted in resident #008 sustaining an injury to a specified area as a result. There was no indication the Director was notified.

During an interview with RN #116, they confirmed the resident to resident abuse incident involving resident #005 towards resident #008, that occurred on a specified date and time, resulted in an injury to resident #008. RN #166 confirmed they did not report the resident to resident abuse incident to the Director.

During an interview with the Administrator, they indicated they were not aware of the resident to resident physical abuse incident involving resident #005 towards resident #008, that occurred on a specified date and confirmed the Director was not informed. The Administrator also confirmed the Director was not informed of the second incident until the day after the incident occurred.

During an interview with the Administrator, they confirmed that the resident to resident abuse incident involving resident #005 towards resident #002, was not reported until the day after the incident occurred.

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

WN #6: 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. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

The licensee has failed to ensure that equipment and devices for the falls prevention and management program were readily available at the home.

Review of the health care record for resident #002 indicated the resident was admitted to the home with a history of falls. Review of the progress notes indicated for a specified period, the resident had sustained a number of falls. The first fall resulted in an injury to a specified area and transfer to hospital. Upon return from hospital, the SDM requested the use of a specified restraining device for falls prevention. The restraining device was not implemented for approximately one month and the resident sustained additional falls during that time period.

During an interview with RPN #106 (falls prevention lead), they identified specific falls prevention devices utilized in the home and included the use of alarming devices. The RPN indicated the Life Enrichment Manager (LEM) was directly involved with the falls prevention devices process.

During an interview with the LEM, they indicated that nursing staff would request falls prevention equipment from the activity/restorative care staff and the Occupation Therapist (OT) was notified. The LEM indicated they would also notify the home's supplier to order specified restraining devices if required. The LEM confirmed that the specified falls prevention devices were currently unavailable in the home. The LEM indicated it usually took between one to two weeks for the specified falls prevention devices to be implemented. The LEM confirmed the specified restraining device for resident #002 was not implemented for approximately one month.

Observation of all the storage rooms (with the LEC present) on a specified date and time, indicated there were no specified falls preventions equipment readily available in the home.

During an interview with the Administrator, regarding falls prevention equipment readily available, they indicated that restraining devices were ordered by the LEM, the home did not use other specified falls prevention equipment or were not available in the home. The Administrator indicated they had recently purchased specified falls preventions devices.. The Administrator was aware of concerns related to the availability of restraining device for resident #002 but was not aware that resident #002 had waited approximately one month for a specified restraining device.

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 equipment and devices for the falls prevention and management program are readily available at the home, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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

Findings/Faits saillants :

The licensee has failed to ensure that the resident exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Review of the licensee's policy Skin and Wound Care Management Program Policy (revised October 22, 2018) indicated the Registered Staff will:
-complete each resident's skin assessments (head to toe assessment) upon any return of resident from hospital.
-for a resident exhibiting altered skin integrity, including pressure ulcers or wounds, conduct a skin assessment and document on the skin and wound tracking record.

Related to resident #001:

A critical incident report was submitted to the Director, for a fall that occurred on a specified date, that caused an injury to resident #001 and for which the resident was taken to hospital.

Review of the health care record for resident #001 indicated the resident had sustained a number of falls during a specified period and was transferred to hospital, after two of the falls.

Review of the skin and wound assessments for resident #001, indicated there were no skin and wound assessments completed when the resident returned from hospital on both occasions.

During an interview with the DOC, they confirmed resident #001 did not have any skin and wound assessments completed as per the home's policy, when resident #001 returned from hospital on two separate dates, and the resident had alterations in skin integrity.

Related to resident #002:

A critical incident report was received by the Director for a fall that occurred on a specified date, that resulted in an injury to resident #002 and for which the resident was transferred to hospital.

Review of the health care record for resident #002 indicated the resident was admitted to the home on a specified date with diagnoses that would increase risk for skin impairment.

The progress notes by RPN #110, indicated the resident returned from hospital on a specified date, with a specified alteration in skin integrity to a specified area. A few days later, the resident was found with a pressure ulcer to another specified area.

Review of the skin assessments for resident #002 indicated there was no documented evidence the resident received a skin assessment by the registered nursing staff upon their return from hospital on a specified date, or when the resident developed a pressure ulcer to a specified area. There was no documented skin and wound tracking records completed for resident #002, until six months later.

During an interview with RPN #110, they indicated when a resident returned from hospital, they were to complete an electronic head to toe skin assessment and confirmed when resident #002 had returned from hospital, the resident had an alteration in skin integrity and they did not complete the skin and wound assessments, as per the home's policy.

During an interview with the Administrator, they confirmed the resident did not have a skin and wound assessment completed as per the policy, when resident #002 returned from hospital, despite returning with an alteration in skin integrity or when the resident developed a pressure ulcer to a specified area, four days later. The DOC also confirmed there were no skin and wound tracking records completed for resident #002, as per the policy.

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

Review of the licensee's policy Skin and Wound Care Management Program Policy (revised October 22, 2018) indicated, for a resident exhibiting altered skin integrity, the Registered Staff will conduct a skin assessment and document on the skin and wound tracking record. Provide immediate treatment and interventions and document in the individualized plan of care, the development of a pressure ulcer and location of any pressure ulcers, skin tears, etc.

Related to resident #001:

Review of the progress notes and risk management reports for resident #001, indicated

the resident had sustained a number of falls during a specified period. Most of the falls resulted in altered skin integrity. The resident was also transferred to hospital after one of the falls.

Review of the skin and wound assessments for resident #001, indicated there were a number of falls that resulted in alteration in skin integrity and there was no indication of a skin and wound assessment completed. In addition, there were no wound care tracking sheets completed for the alteration in skin integrity post falls, to indicate treatments that were provided to promote wound healing.

During an interview with the Administrator, they confirmed resident #002, returned from hospital with altered skin integrity to specified areas and did not receive a skin assessment by a member of the registered nursing staff, or the skin and wound tracking form as per the home's policy.

3. The licensee also failed to ensure that those resident's received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection, as required.

Review of the health care record for resident #002 indicated the resident sustained a fall, was transferred to hospital and sustained an injury to a specified area. The resident returned from hospital on a specified date and four days later, the resident was noted to have a pressure ulcer to a specified area. The physician assessed the resident and ordered a specified treatment six days later.

Review of the electronic Treatment Administration Record (eTAR) for a specified month for resident #002, indicated the specified treatment to the specified area was not initiated until they day after the physician's order was received and ten days after the pressure ulcer was discovered.

Review of resident #002's written plan of care under skin integrity, indicated ulceration of skin to a specified area and specified identified interventions.

During an interview with RPN #110, the RPN confirmed they were working when resident #002 returned from hospital. The RPN confirmed the resident returned from hospital with an altered skin integrity and did not complete a head to toe skin assessment, did not complete a skin and wound tracking record for weekly reassessments or assessed the resident for any other wounds or pressure ulcers.

During an interview with the Administrator, they confirmed resident #002, returned from hospital exhibiting altered skin integrity and also had a pressure ulcer to a specified area and did not receive immediate treatment and interventions to promote healing and prevent infection as required, until ten days after the pressure ulcer was discovered. The Administrator confirmed the resident's plan of care had also not been updated as required, as per the home's policy.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, receive a skin assessment by a member of the registered nursing staff upon any return from hospital, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the resident's SDM and any other person specified by the resident, were immediately notified upon becoming aware of an alleged incident of abuse of the resident that resulted in a physical injury or pain to the resident.

There were three critical incident reports submitted to the Director on specified dates, for resident to resident abuse incidents, all involving resident #005.

Review of the progress notes and risk management report for resident #005 and #008, indicated there was an additional resident to resident abuse incident that occurred on a specified date and time, documented by RN #116. Resident #008 had reported that resident #005 had been abusive towards them and resulted in an injury to resident #008 to a specified area. There was no indication the SDM of either resident was notified of the incident.

During an interview with RN #116, they confirmed the incident that occurred on a specified date, involving resident #005 towards resident #008, resulted in resident #008 sustaining an injury as a result. The RN also confirmed they did not inform the SDM of either resident, of the incident.

During an interview with the Administrator, they confirmed the resident to resident abuse incident that occurred on a specified date, involving resident #005 towards resident #008 should have been reported to both resident's SDM, by RN #116.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's SDM and any other person specified by the resident, are immediately notified upon becoming aware of an alleged, suspected or witnessed incident of abuse of a resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

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

Findings/Faits saillants :

The licensee has failed to ensure that a report was made to the Director and included a description of the incident, area or location of the incident and events leading up to the incident.

Review of the progress notes for resident #005 indicated there was documentation completed by RN #116 on a specified date, regarding an altercation that had occurred between resident #008 and resident #005. There was no description of the incident, events that led up to the incident or whether the residents were assessed for injury. There was also no indication the Director was notified.

Review of the progress note for resident #008 on the same specified date had no documented evidence of the altercation incident between resident #005 and resident #008.

Review of the risk management report for resident #005 completed by RN #116

indicated, on a specified date and time, resident #008 reported being abuse by resident #005 and had sustained an injury.

During an interview with RN #116, they confirmed that the abuse incident that occurred on a specified date, involved resident #005 towards resident #008, confirmed resident #008 sustained an injury as a result of the incident and confirmed a report was not made to the Director.

During an interview with the Administrator, they confirmed that a report to the Director was not completed for this abuse incident and should have been submitted by RN #116.

2. The licensee has failed to ensure that the report to the Director, included the names of any staff members who were present at or discovered the incident.

Critical incident report was submitted to the Director for a resident to resident abuse incident. The CIR indicated on a specified date and time, a PSW reported that resident #006 reported that resident #005 had been abusive towards them and resulted in resident #006 being upset, fearful of resident #005 and sustained an injury to a specified area. The CIR indicated RN #125 responded to the incident, but there was no indication which PSW reported the incident.

Review of the progress notes and risk management report for the resident to resident abuse incident that occurred between resident #005 towards resident #006, had no indication which PSW responded to incident.

During an interview with RN #125, the RN indicated the resident to resident abuse incident that occurred on a specified date, between resident #005 towards resident #006, was discovered by PSW #104.

During an interview with the Administrator, they confirmed the name of the PSW who discovered the incident was not indicated in the report to the Director.

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 report to the Director includes a description of the incident, area or location of the incident, events leading up to the incident and the names of any staff members who were present at or discovered the incident, to be implemented voluntarily.

WN #10: 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 :

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

A critical incident report was received by the Director for a fall incident that occurred on a specified date and resulted in injury to resident #002, for which the resident was transferred to hospital.

Review of the health care record for resident #002 indicated the resident returned to the home from hospital on another specified date, with an new physicians order for a specified medication and a specified dose. The electronic Medication Administration record (eMAR) indicated the new physician's order was not administered to the resident until a specified number of days later, when the medication incident was discovered.

During an interview with the Administrator, they confirmed resident #002 did not receive the specified medication as prescribed by the physician for a number of days.

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 drugs are administered to residents in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

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

Findings/Faits saillants :

The licensee failed to ensure that an incident that caused an injury to a resident, for which the resident is taken to a hospital and where the licensee determined that the injury had resulted in a significant change in the resident's health condition, informed the Director of the incident, no later than three business days after the occurrence of the incident.

Related to resident #001:

There were two critical incident reports for resident #001, that were submitted to the Director for a fall resulting in an injury, for which the resident was transferred to hospital and resulted in a significant change in condition.

Review of the health care record for resident #001 indicated the sustained a fall with a specified injury, was transferred to hospital and died a number of days later. There was no documented evidence the Director was notified of the fall incident.

During an interview with the Administrator, they confirmed that the Director was not informed of the fall incident with resident #001, that resulted in an injury and for which the resident was transferred to hospital and confirmed the resident had a significant change in condition.

2. The licensee has failed to ensure that the report in writing to the Director of a fall incident, that resulted in injury and for which the resident was taken to hospital, provided a description of the incident, including the area or location of the incident and the events leading up to the incident.

Related to resident #002:

A critical incident report (CIR) was submitted to the Director on a specified date, for a fall incident involving resident #002, that resulted in injury and for which the resident was taken to hospital. There was no description of the incident, including the events leading up to the incident. The CIR was not amended until three months later, providing a description of the incident, included events leading up to the incident and indicated the resident was transferred to hospital the following morning and diagnosed with an injury to a specified area.

During an interview, the Administrator could not indicate why the initial CIR did not provide a full description or the events leading up to the incident. The Administrator

confirmed the CIR did not provide a description of the incident until three months later, when the CIR was amended.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

The licensee has failed to ensure that all medication incidents were documented, reviewed, analyzed, corrective action was taken and a written record was kept.

A critical incident report was received by the Director for a fall incident involving resident #002, that resulted in an injury on a specified date.

Review of the health care record for resident #002 indicated the resident was sent to hospital as a result of the fall incident and returned from the hospital on another specified date. The resident had a new physician's order for upon return from hospital. The new order was not transcribed onto the physician's order form or to the electronic Medication Administration record (eMAR) and the pharmacy was not informed. The medication incident was discovered four days later. The progress notes indicated RPN #126 discovered the medication incident. There was no documented evidence of a medication incident report.

RPN #126 was not available for an interview.

During an interview with the Administrator, they confirmed that RPN #126 discovered the medication incident. The Administrator indicated there was no documented medication incident report, as per their policy and confirmed there was no documented record kept to indicate the medication incident was reviewed, analyzed and any corrective actions taken as necessary.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 215. Police record check

Specifically failed to comply with the following:

s. 215. (2) The police record check must be,
(a) conducted by a police record check provider within the meaning of the Police Record Checks Reform Act, 2015; and
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. O. Reg. 451/18, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the police record check was conducted prior to hiring a staff member.

A critical incident report was submitted to the Director for a witnessed, staff to resident abuse incident that occurred on a specified date and time. The CIR indicated PSW #119 reported witnessing PSW #120 abusing resident #004 causing pain to a specified area to the resident.

Review of the employee file of PSW #120 indicated the PSW was hired on a specified date and the police screen was completed six months after the PSW was hired.

During an interview with the Administrator, they confirmed the police check was completed six months after the PSW was hired.

The police record check for PSW #120 was not completed prior to the staff member being hired.

Issued on this 27th day of September, 2019

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l’inspection :	2019_643111_0014
Log No. / No de registre :	010181-17, 012240-17, 003003-18, 023215-18, 027955-18, 030921-18, 000475-19, 000476-19, 000477-19, 000478-19, 007639-19, 008303-19, 008332-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 3, 2019
Licensee / Titulaire de permis :	Haliburton Highlands Health Services Corporation 7199 Gelert Road, Box 115, HALIBURTON, ON, K0M-1S0
LTC Home / Foyer de SLD :	Hyland Crest 6 McPherson Street, P.O. Box 30, Minden, ON, K0M-2K0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	April DeCarlo

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 Haliburton Highlands Health Services Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee shall comply with O.Reg. 79/10, s.48(1)1 and 4.

Specifically, the licensee shall complete the following:

1. Ensure that all aspects of the falls prevention and management program is implemented to reduce the incidence of falls and risk of injury. Educate all staff who provide direct care and keep a documented record.

2.Conduct weekly audits over three-month period to ensure that falls assessments are being conducted and the licensee's falls prevention program process is being followed. A documented record of these audits must be kept.

3. Ensure that all aspects of the pain management program are implemented to assess and manage the residents' pain. Educate all staff who provide direct care and keep a documented record.

4.Conduct weekly audits over three-month period to ensure the pain management process is being followed. A documented record of these audits must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that the falls prevention and management program was implemented in the home with the aim to reduce the incidence of falls and the risk of injury.

Review of the Fall Prevention and Management Program Policy (revised October 22, 2018) indicated the Resident Safety Committee will be comprised of the Physiotherapist (PT), Registered staff, PSWs and activation staff to develop, implement and educate about fall management strategies. Under procedure:
-The Physiotherapist will compile fall data, identify action plans to address trends and conduct post-fall assessments, document finding in progress notes and update care plan as necessary.
-The DOC will determine a communication process by which residents at moderate or high risk for falling are easily identified to the entire care team (Falling Leaf Program).
-In the event of a fall, an initial post-fall assessment note by the RN/RPN must include the following physical assessments for injuries: assessment of damage

to the hip joint (i.e. extreme pain, shortened and/or abduction of externally rotated leg, inability to weight bear). Limited range of motion of joint and assessment for pain (i.e. guarding, facial expressions, grimacing and verbal report of pain).
-If there is suspicion or evidence of injury, the Registered Staff should not move the resident, the physician should be contacted and/or arrange for immediate transfer to the hospital and the POA/Substitute Decision Maker (SDM) will be notified. Complete a Falls Incident Report under Risk Management section on PCC.
-Document the care that was provided or interventions that were in place according to the care plan, re-evaluate the resident's care plan and document appropriate interventions to be taken.

Relate to resident #001:

There were two critical incident reports submitted to the Director for falls that caused an injury to a specified area, for which resident #001 was taken to hospital.

Review of the written plan of care for resident #001 indicated the resident was at risk for falls. There were also specified interventions noted. There was no indication the plan of care was revised related to toileting needs, despite the resident frequently falling related to toileting. In addition, some of the interventions were inconsistently implemented.

Review of the progress notes for resident #001 indicated the resident had sustained a specified number of falls over a specified period, with most of the falls having minor injuries. After the fall on a specified date, the resident had complained of pain to a specified area. The resident was diagnosed with an injury to a specified area several days after the initial fall. The resident sustained an injury to a specified area after another fall on a specified date and died two days later. The progress notes indicated the falls were related to the resident attempting to self-toilet. An alarming and restraining device were put in place after the second fall, but on multiple occasions, the resident was found without the devices in place. Staff noted the resident was able to remove the restraining device. Another falls prevention intervention was put in place, after the fifth fall. After the sixth fall, the staff indicated the alarming device was ineffective for falls

prevention. PT had assessed the resident after each fall and no action plans were identified, until after the resident's eighth fall, when the resident sustained an injury to a specified area. The progress notes indicated the SDM was notified of the ongoing falls, remained upset regarding the frequent falls and wanted to know what the home was doing to prevent the falls. The SDM was notified of other falls prevention devices that could be implemented. The SDM also requested the use of a specified restraining device but the restraining device was not implemented until approximately one month later. The staff noted the resident was often at risk for falls "related to toileting" needs.

Review of the falls incident reports (risk management) for resident #001 indicated they were not completed for a number of the falls that occurred.

During an interview with the PT, they indicated they were familiar with resident #001, was aware the resident was a high risk for falls and had frequent falls. The PT indicated they were not involved in the Resident Falls Prevention Committee to discuss possible interventions to prevent falls or reduce risk of injury.

During an Interview with RPN #105, they indicated when a resident sustained a fall, they completed a head to toe assessment for any pain or injury, notify the physician if there is any injuries, notify the family, the DOC and the PT. The RPN indicated if the resident was complaining of extreme pain and had a suspected serious injury, that they would call 911. The RPN indicated they would document the fall, the assessment and who was notified on the resident's progress note. The RPN indicated they would also complete a fall incident report. The RPN indicated resident #001 was at risk for falls and had several falls. The RPN indicated the home used to use the falling leaf symbol to indicate residents at high risk for falls, but the home was not using a method that would identify residents at high risk for falls.

The licensee has failed to ensure that the falls prevention and management program was implemented in the home with the aim to reduce the incidence of falls and the risk of injury to resident #001. The PT was not involved in the falls prevention committee to discuss possible interventions to prevent falls or reduce risk of injury as per the falls prevention and management policy. A Falls Incident report was not completed after each fall and when resident #001 sustained a fall on a specified date, the physician should have been contacted and/or

arrangement made for immediate transfer to the hospital as per the policy.

Related to resident #002:

A critical incident report (CIR) was submitted to the Director on a specified date, for a fall incident that caused an injury, for which resident #002 was taken to hospital and resulted in a significant change in condition.

Observation of resident #002 on a specified date by the Inspector, indicated the resident was in a mobility aid with an alarming device in place. The resident was not interviewable. The resident's room had specified falls prevention devices in place.

Review of the 24 Hour Care Plan for resident #002 indicated the resident was at risk for falls and recently sustained a fall. Review of the written plan of care for resident #002 indicated the resident was at risk for falls and identified specified interventions. The plan of care was updated on a specified date with an additional intervention. There was no indication the care plan was updated to include the use of alarming or restraining devices, the risk of a specified device to the resident or the use of a toileting program.

The progress notes indicated the resident sustained a number of falls over a specified period, with most of the falls incurring minor injuries. One of the falls resulted in an injury to a specified area for which the resident was taken to hospital and resulted in a significant change in condition. After the resident returned from hospital, the resident had specified interventions put in place and the SDM requested the use of a restraining device. The specified restraining device was not implemented until approximately one month later. A number of days after the specified restraining device was implemented, the resident had a near miss incident with the device as the device was not properly installed and the device was removed. Additional interventions were implemented. The progress notes also had no description of one of the falls that occurred on a specified date, to indicate what time the fall occurred, where the fall occurred, the circumstances surrounding the fall or whether the resident was assessed for pain or injury, as per the policy. After a number of falls, the SDM had expressed concerns as they had requested the use of a specified restraining device to be used and were unaware that the resident was using a different restraining

device. There were also multiple incidents when staff noted one of the interventions for falls prevention had not been implemented or the resident would remove.There was no indication the SDM or the physician were notified of a number of the falls and they were notified the day after one of the falls occurred.

Review of the post-fall assessments completed by PT after each fall indicated that strategies were identified after the first fall.

Review of the fall incident reports (risk management) for resident #002 indicated there were no fall incident reports completed for a number of falls, as per the policy.

During an interview with PSW #104, they indicated resident #002 was at risk for falls and identified specified interventions for falls prevention.

The Inspector was unable to interview Activity Aide #117, as they were off on leave.

During an interview with Resident Care Coordinator (RCC) #101, they indicated they were the lead for the Resident Safety Committee (Falls Prevention Committee). The RCC indicated they met monthly to discuss residents who have fallen, identify possible causes and identify interventions to be implemented to reduce falls or risk of injury and complete the resident fall prevention and management form for residents that are moderate to high risk for falls. The RCC indicated the members included registered nursing staff, PSWs and Restorative Care Coordinator (RCC). The RCC confirmed that there were no PT staff that were involved in the falls prevention committee. The RCC also confirmed that they previously used the falling leaf to identify which residents were at moderate to high risk for falls, but they no longer use it and don't have any other system in place.

During an interview with the PT, they confirmed that they were not a part of the resident safety committee and did not attend any of the meetings. They indicated they review all residents who have fallen, when they receive notice from the risk management report alerts or from verbal reports by the Physiotherapy Assistants (PTA) and nursing staff. The PT indicated they

complete a progress note to indicate their post-fall assessment and possible strategies to prevent further falls or injury. The PT confirmed they do not update the resident's care plan related to falls risk, only related to the physiotherapy program.

During an interview with RPN #106, they indicated when a resident has fallen, the resident was to be immediately assessed for injuries, if they suspect there is an actual injury, they would call the emergency department for possible transfer and notify the SDM. They indicated if the resident complained of pain, they would administer analgesic and if the fall occurred during a specified time and there was no pain or injury, they would have the next shift call notify the family. The RPN indicated they would complete a risk management report for falls, complete a progress note of the assessment and who was notified. The RPN indicated the home previously used the falling leaves program to identify which residents were at high risk for falls, but there was currently no process in place and indicated it was the nurse's responsibility to update the resident's care plan related to falls. The RPN indicated resident #002 was at risk for falls and confirmed on a specified date, when the resident had fallen, that although the resident was complaining of pain to a specified area, they did not transfer the resident to hospital, did not notify the SDM or the physician and were not familiar with the homes falls prevention and management policy.

During an interview with Life Enrichment Manager (LEM), they indicated the activity staff/restorative care staff were responsible for notifying the Occupational Therapist (OT) through their supplier for any mobility aid assessments and ordering of restraining devices. The LEM indicated the home did not have specified restraining devices and took approximately one to two weeks, for the restraining devices to be implemented.

During an interview with the Administrator, they indicated the home had an after-hours number to call the physician in an emergency. The Administrator indicated their expectation was that when a resident had sustained a fall and had a suspected serious injury, the resident was to be immediately sent to the hospital, the physician, the SDM and the Administrator were to be notified. The Administrator indicated all restraints were ordered by the LEM but the home also had restraining devices available in the home. The Administrator confirmed the home generally did not have specified falls preventions devices in the home and

the alarming devices were kept in the Administrators office.

The licensee failed to ensure the falls prevention and management program was implemented in the home, as the falls prevention committee was not interdisciplinary, the Falls Incident Report was not completed for resident #002 after each fall, or when there was an injury or a suspected injury. After resident #002 sustained a fall with a suspected injury to a specified area, the physician was not contacted and/or immediately transported to the hospital. In addition, the Falling Leaf Program, by which residents at moderate or high risk for falling were easily identified to the care team was not implemented.

The scope was a level 2, pattern as two out of three residents at high risk for falls that were reviewed did not have the falls prevention and management policy implemented. The severity was a level 3, actual harm/risk as both residents sustained serious injuries. The compliance history was a level 2, as the home has one or more non-compliances with a different subsection as follows:
-a Voluntary Plan of Correction (VPC) was issued on May 18, 2016 for O.Reg. 9/10, s.49(2) during inspection # 2016_360111_008. (111)

2. 2. The licensee has failed to ensure that the pain management program was implemented in the home to identify and manage pain in residents.

Review of the Pain and Symptom-Assessment and Management Policy (revised October 22, 2018) indicated under procedure, the Registered Staff will:
-conduct and document a formal pain assessment under the assessments tab on PCC for each resident upon re-admission, when behaviours exhibited by resident may be an indicator of the onset of pain;
-initiate a 24 hour Pain and Symptom Monitoring Tool (VII-G-70.00) when pain persists regardless of the interventions, an empiric trial of analgesics is started.
-ensure that pain management is addressed on plan of care with pharmacological and non-pharmacological interventions.

Related to resident #001:

There were two critical incident reports (CIR) that were submitted to the Director on specified dates, for falls that caused an injury for which resident #001 was

taken to hospital and resulted in a significant change in condition.

Review of the health care record for resident #001 indicated in the progress notes and risk management reports, the resident had sustained a number of falls over a specified period. The resident sustained an injury to a specified area after two of the falls for which the resident was transferred to hospital and upon return from hospital, there were no pain assessments completed. The resident also complained of pain after a number of the falls and there was no indication a pain assessment was completed, the resident was provided with effective pain management, or the care plan updated, as per the home's policy. After the last fall, the resident sustained an injury to a specified area, was transferred to hospital and passed away a few days later.

Review of the pain assessments for resident #001 indicated the resident sustained a number of falls and on two specified dates, had pain, and a pain assessment was not completed until a number of days later. The resident was hospitalized for injuries to specified areas, a pain assessment was not completed until a number of weeks later.

Review of the written plan of care for resident #001 related to pain, indicated there was no direction provided for pain management, until a number of weeks later, after the resident was transferred to hospital. There were specified interventions included but the plan of care was not revised when the resident sustained another fall on a specified date, with a new injury to an identified area and after the last fall.

During an interview with the Administrator, they indicated resident #001 should have had a pain assessment completed when they experienced new pain post falls, when the resident was ordered new analgesics and when their condition became palliative. The Administrator indicated the resident should have had pain in the written care plan revised to address the pain and confirmed the home's policy for pain management was not implemented for resident #001.

Related to resident #002:

A critical incident report (CIR) was submitted to the Director for a fall that occurred on a specified date and time. Resident #002 complained of pain to a

specified area, was transferred to hospital and diagnosed with an injury to a specified area.

Observation of resident #002 on a specified date, by the Inspector, indicated the resident appeared comfortable in their mobility aid. The resident denied any discomfort.

Review of the health care record for resident #002 indicated the resident was admitted with diagnoses that included chronic pain and was prescribed a specified analgesic as needed (PRN) for pain.

Review of the progress notes for resident #001 related to pain, indicated the resident had ongoing pain post falls and no pain assessments were completed as per the policy, to ensure the residents pain was managed. There was also no indication the physician was contacted when the resident's pain was not managed. There was no pain assessments completed when the resident returned from hospital on a specified date, with an injury and a nor when new pain medication was prescribed. On another specified date, the resident developed a pressure ulcer and complained of pain to a specified area and no documented pain assessments were completed. On another specified date, the resident was noted to have severe pain to a specified area while being toileted and the physician was not contacted when the pain was uncontrolled and there was no documented pain assessment completed.

Review of the pain assessments for resident #002 indicated a pain assessment was not completed until a number of weeks after the resident sustained a fall with an injury to a specified area and had new pain.

There was no documented evidence that a 24 hour Pain and Symptom monitoring tool was used for resident #002, as per the policy.

Review of the written plan of care for resident #002 indicated there was no care plan in place related to pain, as per the policy.

During an interview with RPN #106, they indicated when a resident sustained a fall, the resident was to be immediately assessed for injuries or pain, if the resident was complaining of mild pain, they would administer analgesic as

ordered. The RPN indicated if the pain was not relieved with the analgesic, they would call the physician for additional analgesic. The RPN indicated on specified date when resident #002 had fallen, the resident was complaining of ongoing pain to a specified area, they gave the resident analgesic and called the emergency department. The RPN confirmed they were not familiar with the home's pain policy and was not aware of all their responsibilities when the resident had pain, including which assessments were to be completed.

During an interview with RPN #110, they confirmed they were working on a specified date, when resident #002 returned from the hospital post fall. The RPN confirmed the resident had pain to a specified area, received a new order for analgesic and no pain assessment or a 24 hour pain and symptom management tool was completed, as per the home's pain policy.

During an interview with the Administrator, they indicated the home had on-call physician's posted which the nurses were to call during after-hours, for any medical emergency and for reassessment of analgesic. The Administrator confirmed a pain assessment was not completed for resident #002 until a specified date, the 24 hour pain and symptom monitoring tool was never completed for resident #002, despite the resident having pain, as per the home's pain policy. The Administrator was unaware that resident #002's care plan was never revised to include pain management related to pain in specified areas.

The scope was a level 2, pattern as two out of three residents with new or ongoing pain that were reviewed did not have the pain policy implemented. The severity was a level 3, actual harm/risk as both residents had pain and were not assessed as per the policy. The compliance history was a level 2, one or more non-compliances with a different subsection as follows:
-a Voluntary Plan of Correction (VPC) was issued on May 18, 2016 for O.Reg. 9/10, s.49(2) during inspection # 2016_360111_008. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 18, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
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 3rd day of September, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Central East Service Area Office