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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Aug 20, 2019	2019_725522_0007 (A1)	001385-18, 005542-18, 006800-18, 006874-18, 008471-18, 016942-18, 020247-18, 023941-18, 026469-18, 032187-18	Critical Incident System

Licensee/Titulaire de permis

City of Hamilton
28 James Street North 4th Floor HAMILTON ON L8R 2K1

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

Macassa Lodge
701 Upper Sherman Avenue HAMILTON ON L8V 3M7

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

Amended by JULIE LAMPMAN (522) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

As requested by the licensee, the compliance due date for compliance orders #001, #002, #003 and #005 has been changed to November 16, 2019.

Issued on this 20th day of August, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 20, 2019	2019_725522_0007 (A1)	001385-18, 005542-18, 006800-18, 006874-18, 008471-18, 016942-18, 020247-18, 023941-18, 026469-18, 032187-18	Critical Incident System

Licensee/Titulaire de permis

City of Hamilton
28 James Street North 4th Floor HAMILTON ON L8R 2K1

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

Macassa Lodge
701 Upper Sherman Avenue HAMILTON ON L8V 3M7

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

Amended by JULIE LAMPMAN (522) - (A1)

Amended 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 27, 28, 29, 30, June 4, 5, 6, 7, 10 and 11, 2019.

The following Critical Incidents were inspected during this inspection:

Critical Incident System (CIS) report #M552-000014-18/Log #006874-18 related to financial abuse;

CIS #M552-000012-18/Log #005542-18 related to alleged neglect;

CIS #M552-000036-18/Log #026469-18 related to resident to resident abuse;

CIS #M552-000041-18/Log #032187-18 related to resident to resident abuse;

CIS #M552-000033-18/Log #023941-18 related to falls prevention;

CIS # M552-000018-18/Log #008471-18 related to falls prevention;

CIS #M552-000013-18/Log #006800-18 related to falls prevention;

CIS #M552-000001-18/Log #001385-18 related to falls prevention;

CIS #M552-000024-18/Log #016942-18 related to falls prevention;

CIS #M552-000028-18/Log #020247-18 related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Nurse Managers, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and residents.

The inspector(s) also observed the provision of resident care and staff to resident interactions. Resident clinical records, the home's investigative records, training records, program evaluations and policies and procedures related to the inspection were reviewed.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

- **12 WN(s)**
- **2 VPC(s)**
- **5 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #005 collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term on a specified date, related to the fall of resident #005.

A review of resident #005's electronic clinical record in Point Click Care (PCC) noted the following assessments:

An Admission Fall Risk Assessment completed six months prior to resident #005's fall noted resident #005 had issues with transfers, gait and balance and did not have any sensory deficits. The assessment indicated that resident #005 used a mobility aid.

A Quarterly Fall Risk Assessment completed two months prior to resident #005's fall noted resident #005 had an uncorrected sensory deficit that limited their functional ability. There was no equipment required by resident #005 indicated on the assessment.

A Minimum Data Set (MDS) Assessment completed the same date as the Quarterly Fall Risk Assessment noted resident #005 had sensory issues and used a mobility aid.

A review of resident #005's clinical record in PCC noted after resident #005's fall they had an order for a restraint to be applied for safety.

A Significant Change Fall Risk Assessment completed after resident #005's fall noted resident #005 did not use any equipment and no referrals were made for resident #005 after their significant fall.

A review of resident #005's electronic progress notes in PCC noted referrals were made to the Dietitian, Physiotherapist and Occupational Therapist after resident #005's fall.

A Change in Status Lift and Transfer Assessment noted after resident #005's fall, noted the resident used an assistive device for transfers.

After resident #005's fall specific fall prevention measures were added to the resident's plan of care. The falls plan of care did not indicate that resident #005 used a restraint for safety.

A MDS Significant Change in Status Assessment completed after resident #005's fall noted the resident had limited mobility and used a wheelchair. The assessment noted the resident had a restraint for safety.

Two months later, resident #005 had an additional restraint ordered for safety.

A Quarterly Fall Risk Assessment completed at that time, did not indicate resident

#005 used the additional restraint.

An Assessment for the Use of Restraint completed at that time, noted resident #005 only used one restraint. The following two quarterly Assessments for the Use of Restraints noted resident #005 only used one restraint.

The next Quarterly Fall Risk Assessment noted resident #005 required a high low bed and a mobility aid.

The next Quarterly Fall Risk Assessment noted resident #005 did not have any issues with transfers, gait and balance and there was no equipment noted as required for resident #005.

The most recent Quarterly Minimum Data Set Assessment noted resident #005 had an unsteady gait and used a restraint daily and had a sensory issue.

The Fall Risk Assessment completed at the same time noted resident #005 had issues with transfers, gait and balance and did not have any sensory issues. The assessment noted resident #005 used a high low bed and a mobility aid.

In an interview, Registered Nurse (RN) #109 stated staff did not usually indicate the equipment a resident used on the Fall Risk Assessment unless it was a new intervention. RN #109 stated the Fall Risk Assessment completed after the resident's fall should have indicated that the resident was using a restraint and should have indicated referrals made to the physician, Dietitian, Occupational Therapist and Physiotherapist. RN #109 reviewed resident #005's progress notes and stated the referrals were indicated in the resident's progress notes and they should have been indicated in the Fall Risk Assessment. RN #109 stated resident #005's sensory issue was not really a problem so that was probably why it was not documented consistently.

RN #109 acknowledged that transfers, gait and balance were not documented consistently on resident #005's Fall Risk Assessments. RN #109 stated those areas were confusing to some staff as some staff considered resident #005 immobile, in which the assessment stated to answer 'no', but some staff did not consider the resident immobile and they answered 'yes' to the questions related to transfers, gait and balance. RN #109 stated they had brought forward the issue at the Fall Committee meetings and the Committee was going to revise the Fall Risk Assessment.

In an interview, Director of Care #100 reviewed Fall Risk Assessments with inspector. DOC #100 stated that staff should consistently indicate that resident #005 had issues with gait, transfers, and balance. DOC #100 stated if resident #005's MDS Assessments indicated that resident #005 had a sensory issue then that should be reflected as a sensory issue on resident #005's Fall Risk Assessment. DOC #100 stated that any referrals made and all equipment used by resident #005, not just new equipment, should be indicated in resident #005's Fall Risk Assessments. DOC #100 acknowledged that the assessments for resident #005 were not consistent and did not reflect resident #005's needs. [s. 6. (4) (a)]

The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #005 collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term on a specified, related to the fall of resident #005.

A review of resident #005's most recent care plan related to restraints noted a specific identifier was to be applied to resident #005's mobility device.

An observation of resident #005 noted the resident did not have the specific identifier attached to their mobility device.

In an interview, Personal Support Worker (PSW) #103 acknowledged that resident #005 did not have the specific identifier on their mobility device. PSW #103 stated resident #005 may not have the identifier as they had a restraint to prevent them from falling.

In an interview, Registered Practical Nurse (RPN) #107 stated that resident #005 should have the specific identifier on their mobility device. RPN #107 stated that resident #005 recently received a new mobility device and staff must have forgotten to put the identifier on the new device.

In an interview, Director of Care #100 stated that resident #005 should have the

specific identifier attached to their mobility device as per their care plan.

The licensee has failed to ensure that the care set out in the restraint plan of care was provided to resident #005 as specified in the plan. [s. 6. (7)]

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

A. Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, related to an incident with resident #011.

Upon further review of the resident's clinical record during this inspection it was noticed that the provision of care set out in the care plan was not documented.

A review of resident #011's most recent care plan on Point Click Care (PCC) noted that incontinence checks were to be completed every two hours.

A review of the listed 'Tasks' on PCC for a specific month, documented that the resident would be checked every shift for urinary incontinence and not every two hours as set out in the plan of care.

In interviews, Director of Care (DOC) #100, Registered Nurse (RN) #119 and Registered Practical Nurse (RPN) #118 stated in part, that the urinary incontinence checks to be done every two hours were not documented and should have been documented under the 'Tasks' tab on PCC.

B. In a clinical record review for resident #008, the plan of care identified that staff were to check resident #008 every two hours for incontinence.

A review of the Point of Care (POC) task record for resident #008 identified that staff documented the monitoring for incontinence once every shift. No records were identified to indicate that resident #008 was checked every two hours for incontinence.

In an interview with RPN #118, when asked what was indicated in the plan of care for resident #008 related to monitoring for incontinence, RPN #118 stated that staff were to check resident #008 every two hours for incontinence. When asked where the checks would be documented, RPN #118 stated in the POC. When

asked if the checks were documented in the POC as per the plan of care, RPN stated the checks were documented each shift.

The licensee failed to ensure that the provision of care set out in the plan of care related to incontinence checks was documented. [s. 6. (9) 1.]

4. The licensee has failed to ensure that the resident was reassessed, and their plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed, or care set out in the plan had not been effective.

A. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specified date, related to the fall of resident #006.

Review of resident #006's care plan noted a focus "Risk for falls characterized by falls/injury, multiple risk factors" initiated on a specified date, with a goal to reduce the number of falls and no injury from falls.

The interventions initiated on a specified date, were to encourage activities that promoted exercise, physical activity for strengthening and improve mobility, ensure resident wore glasses and that they were clean and resident to wear proper non-slip footwear.

Review of resident #006's electronic clinical records and risk management in Point Click Care (PCC) noted resident #006 had four falls in less than two months in 2018.

A review of the falls incidents in risk management in PCC noted that under 'Action' care plan review had not been checked off. There was no documented evidence in the resident's progress notes that the resident's plan of care had been reviewed after the above mentioned falls. No further falls interventions were initiated for resident #006 after each fall.

Resident #006 fell again on four separate occasions the next month. Resident #006's last fall resulted in significant injury. Review of resident #006's care plan noted specific falls interventions were initiated at that time.

Resident #006 had five falls in a two week period two months after the significant

fall. A review of the falls incidents in risk management in PCC noted under Action that resident #006's care plan was not checked as reviewed. The were no new falls interventions initiated until the fifth fall.

Resident #006 fell again the next month. Review of the falls incident in risk management noted resident #006's care plan was reviewed.

The next month resident #006 had another fall. Review of the falls incident in risk management noted resident #006's care plan was not checked as reviewed.

In an interview, Registered Nurse (RN) #109 stated that they would review a resident's care plan with the Personal Support Workers after a resident had a fall. RN #109 stated that they do not document the review of the care plan anywhere but that it would be reflected in the resident's care plan if there were any new interventions initiated or if current interventions were revised.

In an interview, Registered Practical Nurse (RPN) #112 stated a resident's care plan would be reviewed after each fall, but if the fall was minor staff may not review the care plan. RPN #112 stated if they reviewed a resident's care plan they would make a note in the resident's progress notes. RPN #112 reviewed resident falls incidents in risk management in PCC. RPN #112 stated registered staff should have checked that resident #006's care plan was reviewed after each fall.

In an interview, Director of Care #100 stated a resident's care plan should be reviewed after every fall but that the home was not doing that, and staff were not documenting the review. DOC #100 stated that staff should document that a resident's care plan was reviewed after each fall, and if everything was already in place for a resident, then registered staff should document that.

B. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term on a specified date, related to the fall of resident #005.

Review of resident #005's care plan noted a focus for falls "Risk for falls characterized by history of falls/injury, multiple risk factors…" initiated on a specified date, with a goal of no injury from falls.

The interventions initiated on the specified date, were to ensure the call bell was close within reach and instruct resident how to use it; encourage activities that

promoted exercise, physical activity for strengthening and improve mobility; and resident to wear proper non-slip footwear.

Review of resident #005's electronic clinical records and risk management in Point Click Care (PCC) noted resident #005 had four falls in a four month time frame.

A review of the falls incidents in risk management in PCC noted that under 'Action' care plan review had not been checked off. There was no documented evidence in the resident's progress notes that the resident's plan of care had been reviewed after the above mentioned falls. No further falls interventions were initiated for resident #005 after each fall.

Resident #005 fell on a specified date, which resulted in a significant injury. New falls intervetions were initiated at that time.

Two months later, resident #005 had three falls. Resident #005's care plan was noted as reviewed after each fall. There were no new falls interventions initiated at that time.

Resident #005 had ten falls over a nine month period of time. A review of the falls incidents in risk management in PCC noted under 'Action' that resident #005's care plan had only been checked as reviewed once during that time, after the fourth fall. There were no new falls interventions initiated at that time.

In an interview, Registered Nurse (RN) #109 stated that they would review a resident's care plan with the Personal Support Workers after a resident had a fall. RN #109 stated that they do not document the review of the care plan anywhere but that it would be reflected in the resident's care plan if there were any new interventions initiated or if current interventions were revised.

In an interview, Registered Practical Nurse (RPN) #112 stated a resident's care plan would be reviewed after each fall, but if the fall was minor staff may not review the care plan. RPN #112 stated if they reviewed a resident's care plan they would make a note in the resident's progress notes.

In an interview, Director of Care (DOC) #100 stated a resident's care plan should be reviewed after every fall but that the home was not doing that, and staff were not documenting the review. In reviewing resident #005's number of falls and

interventions, DOC #100 stated staff could have initiated extra monitoring for resident #005 as this intervention was part of their falls program. DOC #100 stated that staff should document that a resident's care plan was reviewed after each fall and if everything was already in place for a resident then registered staff should document that.

The licensee has failed to ensure that resident #005 and resident #006 were reassessed and their plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan related to falls had not been effective. [s. 6. (10) (b)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Ontario Regulation 79/10, s. 48. (1) states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

Ontario Regulation 79/10, s. 30 (1) states, "Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required."

Review of the home's policy "Falls Management Program" Policy NM 03-02-08, last updated September 14, 2018, stated in part:

"Initiated Head Injury Routine (HIR) for all unwitnessed falls (yellow paper copy-double sided with Post Fall Assessment) and witnessed falls that have resulted in a possible head injury…"

"Registered staff will initiate a Post Fall Assessment to be completed every shift for 48 hours after a fall. With a head injury or suspected, a Post Fall Assessment and a Head Injury assessment are to be completed. Yellow paper copy – double sided with Post Fall Assessment."

Review of the home's Post Fall with Head Injury and Post Fall - No Head Injury Assessments noted that the assessment was to be completed every shift for 48 hours and then a "Post 7 Day Assessment" was to be completed.

The Post Fall Assessment stated "As per policy registered staff to complete post fall physical assessment q shift x 48 hours for all residents who have had a fall. Continue with the post fall physical assessment monitoring for an additional 48 hours for those residents who have had a significant fall, a significant injury or for

those who are displaying an alteration in pain, behaviour, function or level of consciousness as a consequence of the fall."

The Head Injury Routine Assessment which was on the back of the Post Fall with Head Injury Assessment stated, "As per policy registered staff to complete all elements of the Head Injury Routine Assessment." The HIR Assessment noted the assessment was to be completed at time of injury, every one hour for the first four hours, then every four hours for 24 hours, and one week post head injury.

A. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specified date, related to the fall of resident #004.

Review of resident #004's hard copy clinical record noted the Post Falls and Head Injury Routine Assessments were not completed in full for four of resident #004's falls.

One of the falls, which was unwitnessed, did not have a Head Injury Routine Assessment completed.

In an interview, Registered Nurse (RN) #109 noted the Post Fall and Head Injury Routine assessments were incomplete for resident #004. RN #109 stated that residents should have a HIR Assessment for all unwitnessed falls.

B. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specified date, related to the fall of resident #006.

Review of resident #006's hard copy clinical records noted the Post Falls and Head Injury Routine Assessments were not completed in full for ten of resident #006's falls

Review of resident #006's clinical record noted resident #006 had three unwitnessed falls on specified dates.

Review of resident #006's hard copy chart noted a Post Fall - No Head Injury Assessment was initiated for the falls. There was no documentation to support that a HIR Assessment was completed for the unwitnessed falls.

In an interview, Registered Practical Nurse #112, noted the Post Fall and Head Injury Routine assessments were incomplete for resident #006. RPN #109 stated that resident #006 should have had a HIR Assessment for unwitnessed falls. RPN #112 stated residents should have a HIR Assessment for all unwitnessed falls, unless the resident was cognitive and capable of telling staff they did not hit their head.

C. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term on a specified date, related to the fall of resident #005.

A review of risk management and resident #005's electronic clinical record in PCC noted resident #005 had 19 falls since their admission.

A review of resident #005's hard copy chart noted the Post Falls and Head Injury Routine Assessments were not completed in full for all 19 of resident #005's falls.

In an interview, Registered Practical Nurse #107 stated that the Post Fall Assessments were to be completed every shift and acknowledged that documentation was missing. RPN #107 acknowledged that sleeping had been entered on the HIR Assessments and stated that sleeping was not an appropriate entry. RPN #107 stated when staff were completing neuro vitals they needed to rouse the resident, and if the resident refused or was uncooperative then staff would note that and make a progress note.

In an interview, Registered Nurse (RN) #109 stated that they considered 48 hours on the Post Fall Assessment to be six shifts. Inspector and RN #109 reviewed the assessment and counted the hours per shift. RN #109 acknowledged that the assessments should be completed for seven shifts.

RN #109 reviewed resident #005's post fall assessments and HIR assessments with inspector. RN #109 acknowledged that the assessments were not completed in full and there were missing assessments. RN #109 stated that a HIR should be completed on any unwitnessed fall unless the resident was cognitively well.

In an interview, Director of Care (DOC) #100 stated that all Post Fall Assessments and HIR Assessments should be completed in full. DOC #100 stated that A Post Fall Assessment should be completed for 48 hours, which was considered seven shifts. DOC #100 stated that a HIR Assessment should have

been completed for all unwitnessed falls, unless the resident was cognitively well and capable of telling staff they did not hit their head. DOC #100 stated sleeping was not considered an appropriated notation on the HIR Assessment.

The licensee has failed to ensure that home's falls management program policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home's written policy to minimize the restraining of residents was complied with.

Review of the home's policy "Minimizing Use of Restraints and Safe Restraint Use" with a review date of January 28, 2019, stated in part:

"For initial implementation of the restraint, registered staff to fully complete 'Assessment for the Use of Restraints (rev. 2013)' in Point Click Care. This assessment tool when completed will demonstrate our full assessment…"

"All restraints shall be reassessed quarterly at a minimum, reviewing with resident, family/SDM & Physician/Nurse Practitioner the ongoing need. The 'Assessment for Use of Restraints' is completed quarterly and the care plan reviewed and revised as needed."

A. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term on a specified date, related to the fall of resident #005.

A review of resident #005's clinical record in Point Click Care (PCC) noted resident #005 had an order for two restraints to be applied for safety.

In an interview, Registered Practical Nurse (RPN) #107 stated that resident #005 used two restraints for falls prevention. RPN #107 stated the first restraint was ordered after resident #005's fall, and the second restraint was ordered three months later.

RPN #107 stated all registered staff would be responsible to complete an assessment for the use of a restraint. RPN #107 stated that the restraint assessments were completed in the assessment tab in PCC and were completed on initiating a restraint and then the restraints were reassessed quarterly after that.

A review of resident #005's restraint assessments in PCC with RPN #107 noted that an initial assessment for the use of the second restraint had not been completed when the restraint was initiated. An assessment for the use of the second restraint had not been completed until ten months later, when RPN #107 completed a quarterly assessment for the use of both restraints.

In an interview, Director of Care #100 stated resident #005 should have had an assessment for the use of the second restraint when it was initiated and then quarterly reassessments for the use of the restraint after that.

B. A Critical Incident System (CIS) report was submitted by the home to the

Ministry of Health and Long-Term Care on a specified date, related to the fall of resident #006.

A review of resident #006's clinical record in Point Click Care (PCC) noted resident #006 had an order for a restraint to be applied for safety. The restraint was ordered after the resident's fall.

Further review of resident #006's clinical record noted no documentation related to the assessment for the use of the restraint prior to the initiation of the restraint. There was no documentation indicating resident #006 would suffer serious bodily harm if the resident was not restrained and no documentation related to the alternatives that had been considered and tried where appropriate.

In an interview, Registered Nurse (RN) #115 stated that resident #006 used a restraint and confirmed the restraint was initiated after the resident's fall.

RN #115 stated the assessments for the use of restraints were documented under the assessment tab in Point Click Care (PCC). RN #115 stated an assessment for the use of restraints was completed by registered staff when the restraint was initiated and then the restraints were reassessed quarterly after that.

RN #115 reviewed resident #006's assessments in PCC with inspector. RN #115 acknowledged that resident #006 did not have an assessment completed for the use of the restraint. RN #115 acknowledged that an initial assessment for the use of the restraint was completed six months after the restraint was initiated.

In an interview, Director of Care #100 stated that resident #006 should have had an assessment for the use of the restraint when the restraint was initiated.

C. On a specified date, resident #009 was observed with a potential restraint applied.

Review of resident #009's clinical record in PCC noted resident #009 had an order for a restraint for safety.

Further review of resident #009's assessments in PCC noted the resident had an initial assessment for the use of the restraint on a specified date.

In an interview, Registered Nurse (RN) #109 stated that resident #009 used a

restraint. RN #109 stated that restraint assessments were completed initially when a restraint was started and then the restraint was reassessed quarterly after that. RN #109 stated that restraint assessments were completed electronically under the assessment tab in PCC.

RN #109 reviewed resident #009's electronic assessments in PCC with inspector. RN #109 stated resident #009 should have had a quarterly restraint assessment completed, and confirmed that resident #009 had not had a quarterly assessment completed.

In an interview, Director of Care #100 stated resident #009 should have had a quarterly restraint assessment completed.

The licensee has failed to ensure that the home's written policy to minimize the restraining of residents was complied with. [s. 29. (1) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the plan of care for resident #005 was based on an interdisciplinary assessment with respect to the resident's safety risks.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term, related to the fall of resident #005.

A review of resident #005's clinical record in Point Click Care (PCC) noted resident #005 had an order for two restraints to be applied for safety.

On a specified date, the door to resident #005's room was observed to be closed and resident #005 could be heard yelling in their room. When inspector entered resident #005's room, resident #005 was observed to not to have one of their restraints in place and the other restraint was not applied appropriately.

Inspector called Personal Support Worker (PSW) #103, who was in the hallway, for assistance. PSW #103 applied both restraints to resident #005 appropriately.

PSW #103 stated that staff tried to keep a close eye on resident #005, but resident #012, would take resident #005 into their room and close the door. PSW #103 stated resident #005 would ask resident #012 to remove the restraints and due to resident #012's cognitive deficits they would do what resident #005 requested as they did not understand this put resident #005 at risk.

A review of resident #005's most recent care plan noted no interventions related to resident #012 removing resident #005's restraints.

In an interview, Registered Practical Nurse (RPN) #107 stated that staff had to watch resident #012 as they would remove resident #005's restraints. RPN #107 stated there was a note in resident #012's progress notes on a specified date, that resident #012 removed resident #005's restraints. RPN #107 stated they had told the staff they needed to be extra vigilant about this and monitor resident #005.

RPN #107 reviewed resident 005's care plan with inspector. RPN #107 confirmed there were no interventions in resident #005's care plan related to resident #012 removing resident #005's restraints.

RPN #107 stated there should be interventions related to resident #012 removing

resident #005's restraints due to the risk to resident #005. RPN #107 stated that they would speak with staff and put it in both resident #005 and #012's care plans.

In an interview, Registered Nurse (RN) #109 stated they had spoken to resident #012 about removing resident #005's restraints. RN #109 stated staff should be monitoring the residents closely to prevent resident #012 from removing the restraints from resident #005. RN #109 reviewed resident #005's care plan with inspector and noted there was nothing noted in resident #005's care plan related to resident #012 removing resident #005's restraints.

Seven days after the first observation, inspector observed the door to resident #005's room to be closed. Inspector knocked the door and went inside and found resident #005 seated without both their restraints in place. Inspector immediately pulled the call bell which was on the floor by the resident's bed.

Personal Support Worker (PSW) #110 entered the room and turned off the call bell. Inspector explained how resident was found when inspector entered the room. PSW #110 stated that resident #012 would often remove resident #005's restraints. PSW #110 applied both restraints to resident #005. PSW #110 stated the staff were completing report and they would take resident #005 with them so they could watch resident #005.

Inspector spoke with Director of Care (DOC) #100 regarding both incidents related to resident #005's restraints. DOC #100 stated there should be interventions in resident #005's care plan related to resident #012 removing resident #005's restraints and that staff should have updated resident #005's care plan when inspector identified with registered staff on two occasions, that there were no interventions documented related to this.

The licensee has failed to ensure that the plan of care for resident #005 was based on an interdisciplinary assessment with respect to the resident's safety risks related to resident #012 removing resident #005's restraints. [s. 26. (3) 19.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specified date, related to the fall of resident #004.

In an interview Registered Practical Nurse #107 stated that Post Falls Assessments were completed on a Post Fall No Head Injury or Post Fall with Head Injury Assessment form and filed in the resident's hard copy chart.

Review of resident #004's hard copy clinical record noted a Post Fall With Head Injury Assessment, the head injury routine was noted as initiated at a specified date and time. The post fall assessment was not completed.

In an interview, Registered Nurse #109, noted a post fall assessment was not completed for resident #004.

B. A Critical Incident System (CIS) report was submitted by the home to the

Ministry of Health and Long-Term on a specified date, related to the fall of resident #005.

Review of resident #005's hard copy clinical record noted a post fall assessment was not completed for resident #005's fall.

Further review of resident #005's electronic record and risk management in Point Click Care noted resident #005 had a total of 19 falls in the past year and a half. Review of resident #005's hard copy clinical record noted no documented post fall assessments for three of those falls.

In an interview, Registered Nurse #109 acknowledged that the post fall assessments were not completed for resident #005 for the three falls.

In an interview, Director of Care #100 stated that a post fall assessment should be completed after every fall.

The licensee has failed to ensure that when resident #005 and resident #004 had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 005

WN #6: 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 suspicion of abuse of a resident by anyone that resulted in harm or risk of harm to the resident was immediately reported to the Director.

A. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date, regarding an altercation of physical abuse by resident #001 towards resident #003.

In a clinical record review for resident #001, the progress notes in Point Click Care (PCC) noted that the altercation between resident #001 and co-resident #003 occurred the day prior to the date that was indicated on the CIS report.

In an interview with Registered Nurse (RN) #106, when asked about the incident between resident #001 and resident #003, RN #106 stated that resident #001 punched resident #003 and although resident #003 was physically unharmed, they were emotionally upset.

In separate interviews with Personal Support Worker (PSW) #104 and Registered Practical Nurse (RPN) #105, when asked what the expectation was in the home related to reporting alleged incidents of abuse or neglect, both staff members stated that any incidents of abuse or neglect should be reported immediately to the registered nurse or management in the home.

In an interview with Director of Care (DOC) #100, when asked if they were aware of the reporting requirements for reporting incidents of abuse or neglect to the Director, DOC #100 stated 'yes', and that allegations of abuse or neglect should be reported immediately. When asked if the home met the reporting requirements for the CIS report, DOC #100 stated the home did not meet the reporting requirements.

The licensee failed to ensure that the altercation of physical abuse by resident #001 towards resident #003 was immediately reported to the Director.

B. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date, regarding allegations of financial abuse toward resident #010.

In a clinical record review for resident #010, the progress notes in Point Click Care (PCC) stated that four months prior to the submission of the CIS report, resident #010 was visibly distraught and asked to see the Social Worker about the allegations of financial abuse.

In separate interviews with Personal Support Worker (PSW) #104 and Registered Practical Nurse (RPN) #105, when asked what the expectation was in the home related to reporting alleged incidents of abuse or neglect, both staff members stated that any incidents of abuse or neglect should be reported immediately to the registered nurse or management in the home.

In an interview with Director of Care (DOC) #100, when asked if they were aware of the reporting requirements for reporting incidents of abuse or neglect to the Director, DOC #100 stated 'yes', and that allegations of abuse or neglect should be reported immediately. When asked what date the CIS report was submitted to the MOHLTC, DOC #100 stated the CIS report was submitted four months after the home became aware of the allegations of financial abuse. When asked if the home met the reporting requirements for the CIS report, DOC #100 stated the home did not meet the reporting requirements.

The licensee failed to ensure that the suspicion of financial abuse towards resident #010 was immediately reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the suspicion of abuse of a resident by anyone that resulted in harm or risk of harm to the resident is immediately reported to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act was undertaken on a monthly basis.

In an interview, Director of Care (DOC) #100 stated the monthly analysis of the use of restraints in the home was a monthly audit the DOC completed.

A review of the audit titled 'Restraints 2018' which was attached to the home's restraint evaluation dated January 15, 2019, listed the type and number of restraints used per month and indicated if a new restraint was started or if a restraint was discontinued that month. There was no documentation related to an analysis of the restraints used monthly.

A review of the minutes from the Falls/Restraint Management meetings for January, February and April 2019, with DOC #100 noted no discussion or documentation related to the analysis of the use of restraints from January to May 2019.

DOC #100 acknowledged that the home was not completing an analysis of the use of restraints on a monthly basis.

The licensee has failed to ensure that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act was undertaken on a monthly basis. [s. 113. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation.

Ontario Regulation 79/10 s. 48 (1) 1 states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Ontario Regulation 79/10 s. 30 (1) 3 states, "The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices."

In an interview, inspector requested the annual falls program evaluation from Director of Care (DOC) #100.

A review of "Program Evaluation: Falls 2018", noted the absence of a date of when the evaluation was completed.

In an interview, DOC #100 stated that the Falls Program evaluation was completed in January 2019, and acknowledged that the program evaluation did not indicate the date that the evaluation occurred.

The licensee has failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation. [s. 30. (1) 4.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specified date, related to the fall of resident #004.

Review of resident #004's progress notes in Point Click Care (PCC) noted on a specified date, resident #004 had an assessment and a Personal Assistance Services Device (PASD) was recommended. Further review of resident #004's clinical record noted that a message was left for resident #004's Substitute Decision-Maker (SDM) regarding the PASD.

In an interview, Registered Nurse #109 stated that resident #004 used the PASD.

Review of resident #004's electronic and hard copy chart noted there was no documented consent obtained from resident #004's SDM for the PASD.

In an interview, Director of Care #100 reviewed resident #004's electronic chart and noted that there was no documented consent for the use of the PASD. DOC #100 stated that registered staff should have spoken with resident #004's SDM and documented the consent in resident #004's progress notes.

The licensee has failed to ensure that the use of a PASD was included in resident #004's plan of care only if the use of the PASD had been consented to by the SDM of the resident with authority to give that consent. [s. 33. (4) 4.]

WN #10: 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 :

1. The licensee has failed to ensure that the date and time of the alleged incident of neglect of a resident by staff was included in the report to the Director.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date, regarding an allegation of neglect towards resident #008.

A review of the CIS report indicated that the alleged incident of neglect towards resident #008 occurred on a specific date and time. In a clinical record review for resident #008, the progress notes identified that the reported alleged incident occurred the day prior to the date noted in the CIS report. In a review of the home's investigation documentation it was documented that the alleged incident of neglect occurred the day prior to the date noted in the CIS report.

In an interview with Director of Care (DOC) #100, when asked if they were aware of the reporting requirements for reporting incidents of abuse or neglect to the

Director, DOC #100 stated 'yes'. When asked the date and time the alleged incident of neglect occurred, DOC #100 stated that the home received an email on a specified date, in the evening, but that the alleged incident occurred earlier on the same date. When asked if the home met the reporting requirements for the CIS report to include the date and time the alleged incident of neglect towards resident #008 occurred, DOC #100 stated 'no'.

The licensee failed to ensure that the date and time of the alleged incident of neglect towards resident #008 was included in the report to the director. [s. 104. (1) 1.]

2. The licensee has failed to ensure that the names of any staff members who were involved in the alleged incident of neglect of a resident were included in the report to the Director.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date, regarding an allegation of neglect towards resident #008.

A review of the CIS report identified that no staff names were indicated in the report. In a clinical record review for resident #008, the progress notes identified that RPN #114 was present at the time of the alleged incident. In a review of the home's investigation documentation it was documented that RPN #114 was involved in the alleged incident of neglect towards resident #008.

In an interview with Director of Care (DOC) #100, when asked if they were aware of the reporting requirements for reporting incidents of abuse or neglect to the Director, DOC #100 stated 'yes'. When asked which staff member was involved in the allegation of neglect, DOC #100 stated RPN #114. When asked if the home met the reporting requirements for the CIS report to include the names of any staff members who were involved in the alleged incident of neglect towards resident #008, DOC #100 stated 'no'.

The licensee failed to ensure that the names of any staff members who were involved in the alleged incident of neglect towards resident #008 were included in the report to the Director. [s. 104. (1) 2.]

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. (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 has failed to ensure that when the licensee was required to inform the Director of an incident under subsection (3) that 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 date and time of the incident.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specified date, related to the fall of resident #006.

Review of the CIS report noted the critical incident date and time as a specified date.
Review of resident #006's electronic and hard copy clinical records noted no documentation related to a fall on the date specified in the CIS report.

Review of resident #006's electronic progress notes in Point Click Care noted resident #006 had a fall the day prior to the date that was noted on the CIS report.

In an interview, Director of Care #100 reviewed the CIS report and resident #006's electronic progress notes and acknowledged that the date and time of resident #006's fall on the CIS report was incorrect.

The licensee has failed to ensure that the date and time of resident #006's fall was included in the Critical Incident System report to the Director. [s. 107. (4) 1.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

The licensee has failed to ensure that resident #005's written record was kept up to date at all times.

A review of resident #005's clinical record in Point Click Care (PCC) noted resident #005 had an order for two restraints to be applied for safety.

On a specified date, the door to resident #005's room was observed to be closed and resident #005 could be heard yelling in their room. When inspector entered resident #005's room, resident #005 was observed to not to have one of their restraints in place and the other restraint was not applied appropriately.

Inspector called Personal Support Worker (PSW) #103, who was in the hallway, for assistance. PSW #103 applied both restraints to resident #005 appropriately.

In an interview, inspector informed Registered Practical Nurse (RPN) #107 of the incident, where resident #005 was found without one restraint in place and the other restraint was not applied appropriately. RPN #107 stated that staff had to watch resident #012 as they would remove resident #005's restraints. RPN #107 stated there was a note in resident #012's progress notes on a specified date, that resident #012 removed resident #005's restraints.

In an interview, inspector informed Registered Nurse (RN) #109 of the incident, where resident #005 was found without their restraint in place and the other restraint was not applied appropriately. RN #109 stated they had spoken to resident #012 about removing resident #005's restraints.

Seven days after the first observation, inspector observed the door to resident #005's room to be closed. Inspector knocked the door and went inside and found resident #005 seated without both their restraints in place. Inspector immediately pulled the call bell which was on the floor by the resident's bed.

Personal Support Worker (PSW) #110 entered the room and turned off the call bell. Inspector explained how resident was found when inspector entered the room. PSW #110 stated that resident #012 would often remove resident #005's restraints. PSW #110 applied both restraints to resident #005. PSW #110 stated

the staff were completing report and they would take resident #005 with them so they could watch resident #005.

On the same day, inspector spoke with Director of Care (DOC) #100 regarding both incidents. DOC #100 stated they would follow up with staff.

A review of resident #005's electronic progress notes in Point Click Care noted no documentation related to resident #012 removing resident #005's restraints as reported to staff by the inspector on three separate dates. There was also no documentation related to resident #012 removing resident #005's restraints on a specified date, as reported to the inspector by RPN #107.

In an interview, Director of Care #100 reviewed resident #005's progress notes with inspector and acknowledged that there was no documentation related to the above incidents where resident #012 removed resident #005's restraints. DOC #100 stated the incidents should be documented in resident #005's progress notes as this put resident #005 at risk.

The licensee has failed to ensure that resident #005's written record was kept up to date at all times. [s. 231. (b)]

Issued on this 20th day of August, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JULIE LAMPMAN (522) - (A1)
Inspection No. / No de l'inspection :	2019_725522_0007 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	001385-18, 005542-18, 006800-18, 006874-18, 008471-18, 016942-18, 020247-18, 023941-18, 026469-18, 032187-18 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 20, 2019(A1)
Licensee / Titulaire de permis :	City of Hamilton 28 James Street North, 4th Floor, HAMILTON, ON, L8R-2K1
LTC Home / Foyer de SLD :	Macassa Lodge 701 Upper Sherman Avenue, HAMILTON, ON, L8V-3M7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Holly Odoardi

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 City of Hamilton, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must be compliant with s. 6(10)(b) of the LTCHA 2007.

Specifically, the licensee must ensure that resident #005 and any other resident is reassessed and their plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan related to falls prevention has not been effective.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed and their plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed, or care set out in the plan had not been effective.

A. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specified date, related to the fall of resident #006.

Review of resident #006's care plan noted a focus "Risk for falls characterized by falls/injury, multiple risk factors" initiated on a specified date, with a goal to reduce

the number of falls and no injury from falls.

The interventions initiated on a specified date, were to encourage activities that promoted exercise, physical activity for strengthening and improve mobility, ensure resident wore glasses and that they were clean and resident to wear proper non-slip footwear.

Review of resident #006's electronic clinical records and risk management in Point Click Care (PCC) noted resident #006 had four falls in less than two months in 2018.

A review of the falls incidents in risk management in PCC noted that under 'Action' care plan review had not been checked off. There was no documented evidence in the resident's progress notes that the resident's plan of care had been reviewed after the above mentioned falls. No further falls interventions were initiated for resident #006 after each fall.

Resident #006 fell again on four separate occasions the next month. Resident #006's last fall resulted in significant injury. Review of resident #006's care plan noted specific falls interventions were initiated at that time.

Resident #006 had five falls in a two week period two months after the significant fall. A review of the falls incidents in risk management in PCC noted under Action that resident #006's care plan was not checked as reviewed. The were no new falls interventions initiated until the fifth fall.

Resident #006 fell again the next month. Review of the falls incident in risk management noted resident #006's care plan was reviewed.

The next month resident #006 had another fall. Review of the falls incident in risk management noted resident #006's care plan was not checked as reviewed.

In an interview, Registered Nurse (RN) #109 stated that they would review a resident's care plan with the Personal Support Workers after a resident had a fall. RN #109 stated that they do not document the review of the care plan anywhere but that it would be reflected in the resident's care plan if there were any new interventions initiated or if current interventions were revised.

In an interview, Registered Practical Nurse (RPN) #112 stated a resident's care plan would be reviewed after each fall, but if the fall was minor staff may not review the care plan. RPN #112 stated if they reviewed a resident's care plan they would make a note in the resident's progress notes. RPN #112 reviewed resident falls incidents in risk management in PCC. RPN #112 stated registered staff should have checked that resident #006's care plan was reviewed after each fall.

In an interview, Director of Care #100 stated a resident's care plan should be reviewed after every fall but that the home was not doing that, and staff were not documenting the review. DOC #100 stated that staff should document that a resident's care plan was reviewed after each fall, and if everything was already in place for a resident, then registered staff should document that.

B. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term on a specified date, related to the fall of resident #005.

Review of resident #005's care plan noted a focus for falls "Risk for falls characterized by history of falls/injury, multiple risk factors…" initiated on a specified date, with a goal of no injury from falls.

The interventions initiated on the specified date, were to ensure the call bell was close within reach and instruct resident how to use it; encourage activities that promoted exercise, physical activity for strengthening and improve mobility; and resident to wear proper non-slip footwear.

Review of resident #005's electronic clinical records and risk management in Point Click Care (PCC) noted resident #005 had four falls in a four month time frame.

A review of the falls incidents in risk management in PCC noted that under 'Action' care plan review had not been checked off. There was no documented evidence in the resident's progress notes that the resident's plan of care had been reviewed after the above mentioned falls. No further falls interventions were initiated for resident #005 after each fall.

Resident #005 fell on a specified date, which resulted in a significant injury. New falls intervetions were initiated at that time.

Two months later, resident #005 had three falls. Resident #005's care plan was noted as reviewed after each fall. There were no new falls interventions initiated at that time.

Resident #005 had ten falls over a nine month period of time. A review of the falls incidents in risk management in PCC noted under 'Action' that resident #005's care plan had only been checked as reviewed once during that time, after the fourth fall. There were no new falls interventions initiated at that time.

In an interview, Registered Nurse (RN) #109 stated that they would review a resident's care plan with the Personal Support Workers after a resident had a fall. RN #109 stated that they do not document the review of the care plan anywhere but that it would be reflected in the resident's care plan if there were any new interventions initiated or if current interventions were revised.

In an interview, Registered Practical Nurse (RPN) #112 stated a resident's care plan would be reviewed after each fall, but if the fall was minor staff may not review the care plan. RPN #112 stated if they reviewed a resident's care plan they would make a note in the resident's progress notes.

In an interview, Director of Care (DOC) #100 stated a resident's care plan should be reviewed after every fall but that the home was not doing that, and staff were not documenting the review. In reviewing resident #005's number of falls and interventions, DOC #100 stated staff could have initiated extra monitoring for resident #005 as this intervention was part of their falls program. DOC #100 stated that staff should document that a resident's care plan was reviewed after each fall and if everything was already in place for a resident then registered staff should document that.

The licensee has failed to ensure that resident #005 and resident #006 were reassessed and their plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan related to falls had not been effective.

The severity of this issue was determined to be a level 3 as there was actual harm/risk to the resident. The scope of the issue was a level 2 as it was a pattern. The home had a level 3 history of previous noncompliance to the same subsection of

the LTCHA 2007, that included a Voluntary Plan of Correction (VPC) issued April 4, 2019 (2019_587129_0004) and a VPC issued November 29, 2017 (2017_689586_0010). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 16, 2019(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 8 (1)(b) of Ontario Regulation 79/10.

Specifically, the licensee must ensure that:

a) The home's 'Falls Management Program' policy is complied with;
b) A Post Fall with Head Injury Assessment or Post Fall - No Head Injury Assessment is completed in full for resident #005 and any other resident that has a fall;
c) A resident that has an unwitnessed fall receives a Head Injury Routine Assessment, as required by the home's Falls Management Program policy .

Grounds / Motifs :

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

Ontario Regulation 79/10, s. 48. (1) states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

Ontario Regulation 79/10, s. 30 (1) states, "Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required."

Review of the home's policy "Falls Management Program" Policy NM 03-02-08, last updated September 14, 2018, stated in part:

"Initiated Head Injury Routine (HIR) for all unwitnessed falls (yellow paper copy-double sided with Post Fall Assessment) and witnessed falls that have resulted in a possible head injury…"

"Registered staff will initiate a Post Fall Assessment to be completed every shift for 48 hours after a fall. With a head injury or suspected, a Post Fall Assessment and a Head Injury assessment are to be completed. Yellow paper copy – double sided with Post Fall Assessment."

Review of the home's Post Fall with Head Injury and Post Fall - No Head Injury Assessments noted that the assessment was to be completed every shift for 48 hours and then a "Post 7 Day Assessment" was to be completed.

The Post Fall Assessment stated "As per policy registered staff to complete post fall physical assessment q shift x 48 hours for all residents who have had a fall. Continue with the post fall physical assessment monitoring for an additional 48 hours for those residents who have had a significant fall, a significant injury or for those who are displaying an alteration in pain, behaviour, function or level of consciousness as a consequence of the fall."

The Head Injury Routine Assessment which was on the back of the Post Fall with Head Injury Assessment stated, "As per policy registered staff to complete all elements of the Head Injury Routine Assessment." The HIR Assessment noted the assessment was to be completed at time of injury, every one hour for the first four hours, then every four hours for 24 hours, and one week post head injury.

A. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specified date, related to the fall of resident #004.

Review of resident #004's hard copy clinical record noted the Post Falls and Head Injury Routine Assessments were not completed in full for four of resident #004's falls.

One of the falls, which was unwitnessed, did not have a Head Injury Routine Assessment completed.

In an interview, Registered Nurse (RN) #109 noted the Post Fall and Head Injury Routine assessments were incomplete for resident #004. RN #109 stated that residents should have a HIR Assessment for all unwitnessed falls.

B. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specified date, related to the fall of resident #006.

Review of resident #006's hard copy clinical records noted the Post Falls and Head Injury Routine Assessments were not completed in full for ten of resident #006's falls

Review of resident #006's clinical record noted resident #006 had three unwitnessed falls on specified dates.

Review of resident #006's hard copy chart noted a Post Fall - No Head Injury Assessment was initiated for the falls. There was no documentation to support that a HIR Assessment was completed for the unwitnessed falls.

In an interview, Registered Practical Nurse #112, noted the Post Fall and Head Injury Routine assessments were incomplete for resident #006. RPN #109 stated that resident #006 should have had a HIR Assessment for unwitnessed falls. RPN #112 stated residents should have a HIR Assessment for all unwitnessed falls, unless the resident was cognitive and capable of telling staff they did not hit their head.

C. A Critical Incident System (CIS) report was submitted by the home to the Ministry

of Health and Long-Term on a specified date, related to the fall of resident #005.

A review of risk management and resident #005's electronic clinical record in PCC noted resident #005 had 19 falls since their admission.

A review of resident #005's hard copy chart noted the Post Falls and Head Injury Routine Assessments were not completed in full for all 19 of resident #005's falls.

In an interview, Registered Practical Nurse #107 stated that the Post Fall Assessments were to be completed every shift and acknowledged that documentation was missing. RPN #107 acknowledged that sleeping had been entered on the HIR Assessments and stated that sleeping was not an appropriate entry. RPN #107 stated when staff were completing neuro vitals they needed to rouse the resident, and if the resident refused or was uncooperative then staff would note that and make a progress note.

In an interview, Registered Nurse (RN) #109 stated that they considered 48 hours on the Post Fall Assessment to be six shifts. Inspector and RN #109 reviewed the assessment and counted the hours per shift. RN #109 acknowledged that the assessments should be completed for seven shifts.

RN #109 reviewed resident #005's post fall assessments and HIR assessments with inspector. RN #109 acknowledged that the assessments were not completed in full and there were missing assessments. RN #109 stated that a HIR should be completed on any unwitnessed fall unless the resident was cognitively well.

In an interview, Director of Care (DOC) #100 stated that all Post Fall Assessments and HIR Assessments should be completed in full. DOC #100 stated that A Post Fall Assessment should be completed for 48 hours, which was considered seven shifts. DOC #100 stated that a HIR Assessment should have been completed for all unwitnessed falls, unless the resident was cognitively well and capable of telling staff they did not hit their head. DOC #100 stated sleeping was not considered an appropriated notation on the HIR Assessment.

The licensee has failed to ensure that home's falls management program policy was complied with.

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

The severity of this issue was determined to be a level 2 as there was minimal risk to the resident. The scope of the issue was a level 3 as it was widespread. The home had a level 3 history of previous noncompliance to the same subsection of Ontario Regulation 79/10, which included a Voluntary Plan of Correction (VPC) issued on November 29, 2017 (2017_689586_0010). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 16, 2019(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 29. (1) Every licensee of a long-term care home,

(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and

(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Order / Ordre :

The licensee must comply with s. 29 (1) (b) of Ontario Regulation 79/10.

Specifically, the licensee must ensure:

a) The home's "Minimizing Use of Restraints and Safe Restraint Use" policy is complied with;

b) Resident #005, #009 and any other resident that uses a restraint has an initial assessment for the use of restraints prior to the use of the restraint and a quarterly restraint assessment there after.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's written policy to minimize the restraining of residents was complied with.

Review of the home's policy "Minimizing Use of Restraints and Safe Restraint Use" with a review date of January 28, 2019, stated in part:

"For initial implementation of the restraint, registered staff to fully complete 'Assessment for the Use of Restraints (rev. 2013)' in Point Click Care. This assessment tool when completed will demonstrate our full assessment…"

"All restraints shall be reassessed quarterly at a minimum, reviewing with resident, family/SDM & Physician/Nurse Practitioner the ongoing need. The 'Assessment for Use of Restraints' is completed quarterly and the care plan reviewed and revised as needed."

A. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term on a specified date, related to the fall of resident #005.

A review of resident #005's clinical record in Point Click Care (PCC) noted resident #005 had an order for two restraints to be applied for safety.

In an interview, Registered Practical Nurse (RPN) #107 stated that resident #005 used two restraints for falls prevention. RPN #107 stated the first restraint was ordered after resident #005's fall, and the second restraint was ordered three months later.

RPN #107 stated all registered staff would be responsible to complete an assessment for the use of a restraint. RPN #107 stated that the restraint assessments were completed in the assessment tab in PCC and were completed on initiating a restraint and then the restraints were reassessed quarterly after that.

A review of resident #005's restraint assessments in PCC with RPN #107 noted that an initial assessment for the use of the second restraint had not been completed when the restraint was initiated. An assessment for the use of the second restraint had not been completed until ten months later, when RPN #107 completed a quarterly assessment for the use of both restraints.

In an interview, Director of Care #100 stated resident #005 should have had an assessment for the use of the second restraint when it was initiated and then quarterly reassessments for the use of the restraint after that.

B. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specified date, related to the fall of resident #006.

A review of resident #006's clinical record in Point Click Care (PCC) noted resident

#006 had an order for a restraint to be applied for safety. The restraint was ordered after the resident's fall.

Further review of resident #006's clinical record noted no documentation related to the assessment for the use of the restraint prior to the initiation of the restraint. There was no documentation indicating resident #006 would suffer serious bodily harm if the resident was not restrained and no documentation related to the alternatives that had been considered and tried where appropriate.

In an interview, Registered Nurse (RN) #115 stated that resident #006 used a restraint and confirmed the restraint was initiated after the resident's fall.

RN #115 stated the assessments for the use of restraints were documented under the assessment tab in Point Click Care (PCC). RN #115 stated an assessment for the use of restraints was completed by registered staff when the restraint was initiated and then the restraints were reassessed quarterly after that.

RN #115 reviewed resident #006's assessments in PCC with inspector. RN #115 acknowledged that resident #006 did not have an assessment completed for the use of the restraint. RN #115 acknowledged that an initial assessment for the use of the restraint was completed six months after the restraint was initiated.

In an interview, Director of Care #100 stated that resident #006 should have had an assessment for the use of the restraint when the restraint was initiated.

C. On a specified date, resident #009 was observed with a potential restraint applied.

Review of resident #009's clinical record in PCC noted resident #009 had an order for a restraint for safety.

Further review of resident #009's assessments in PCC noted the resident had an initial assessment for the use of the restraint on a specified date.

In an interview, Registered Nurse (RN) #109 stated that resident #009 used a restraint. RN #109 stated that restraint assessments were completed initially when a restraint was started and then the restraint was reassessed quarterly after that. RN #109 stated that restraint assessments were completed electronically under the

assessment tab in PCC.

RN #109 reviewed resident #009's electronic assessments in PCC with inspector. RN #109 stated resident #009 should have had a quarterly restraint assessment completed, and confirmed that resident #009 had not had a quarterly assessment completed.

In an interview, Director of Care #100 stated resident #009 should have had a quarterly restraint assessment completed.

The licensee has failed to ensure that the home's written policy to minimize the restraining of residents was complied with.

The severity of this issue was determined to be a level 2 as there was minimal risk to the resident. The scope of the issue was a level 3 as it was widespread, involving three out of three residents. The home had a level 2 history of noncompliance to a different subsection of Ontario Regulation 79/10. (522)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 16, 2019(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee must comply with s. 26 (3) 19 of Ontario Regulation 79/10.

Specifically, the licensee must ensure that resident #005's plan of care is based on an interdisciplinary assessment with respect to the resident's safety risks related to resident #012 removing resident #005's seat belt and table top restraint.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care for resident #005 was based on an interdisciplinary assessment with respect to the resident's safety risks.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term, related to the fall of resident #005.

A review of resident #005's clinical record in Point Click Care (PCC) noted resident #005 had an order for two restraints to be applied for safety.

On a specified date, the door to resident #005's room was observed to be closed and resident #005 could be heard yelling in their room. When inspector entered resident #005's room, resident #005 was observed to not to have one of their restraints in place and the other restraint was not applied appropriately.

Inspector called Personal Support Worker (PSW) #103, who was in the hallway, for assistance. PSW #103 applied both restraints to resident #005 appropriately.

PSW #103 stated that staff tried to keep a close eye on resident #005, but resident #012, would take resident #005 into their room and close the door. PSW #103 stated resident #005 would ask resident #012 to remove the restraints and due to resident #012's cognitive deficits they would do what resident #005 requested as they did not understand this put resident #005 at risk.

A review of resident #005's most recent care plan noted no interventions related to resident #012 removing resident #005's restraints.

In an interview, Registered Practical Nurse (RPN) #107 stated that staff had to watch resident #012 as they would remove resident #005's restraints. RPN #107 stated there was a note in resident #012's progress notes on a specified date, that resident

#012 removed resident #005's restraints. RPN #107 stated they had told the staff they needed to be extra vigilant about this and monitor resident #005.

RPN #107 reviewed resident 005's care plan with inspector. RPN #107 confirmed there were no interventions in resident #005's care plan related to resident #012 removing resident #005's restraints.

RPN #107 stated there should be interventions related to resident #012 removing resident #005's restraints due to the risk to resident #005. RPN #107 stated that they would speak with staff and put it in both resident #005 and #012's care plans.

In an interview, Registered Nurse (RN) #109 stated they had spoken to resident #012 about removing resident #005's restraints. RN #109 stated staff should be monitoring the residents closely to prevent resident #012 from removing the restraints from resident #005. RN #109 reviewed resident #005's care plan with inspector and noted there was nothing noted in resident #005's care plan related to resident #012 removing resident #005's restraints.

Seven days after the first observation, inspector observed the door to resident #005's room to be closed. Inspector knocked the door and went inside and found resident #005 seated without both their restraints in place. Inspector immediately pulled the call bell which was on the floor by the resident's bed.

Personal Support Worker (PSW) #110 entered the room and turned off the call bell. Inspector explained how resident was found when inspector entered the room. PSW #110 stated that resident #012 would often remove resident #005's restraints. PSW #110 applied both restraints to resident #005. PSW #110 stated the staff were completing report and they would take resident #005 with them so they could watch resident #005.

Inspector spoke with Director of Care (DOC) #100 regarding both incidents related to resident #005's restraints. DOC #100 stated there should be interventions in resident #005's care plan related to resident #012 removing resident #005's restraints and that staff should have updated resident #005's care plan when inspector identified with registered staff on two occasions, that there were no interventions documented related to this.

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

The licensee has failed to ensure that the plan of care for resident #005 was based on an interdisciplinary assessment with respect to the resident's safety risks related to resident #012 removing resident #005's restraints.

The severity of this issue was determined to be a level 3 as there was actual risk to the resident. The scope of the issue was a level 1 as it was isolated. The home had a level 3 history of previous noncompliance to the same subsection of Ontario Regulation 79/10, that included a Voluntary Plan of Correction (VPC) issued April 4, 2019 (2019_587129_0004) and a VPC issued March 8, 2018 (2018_555506_0007). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 15, 2019

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 49 (2) of Ontario Regulation 79/10.

Specifically, the licensee must ensure that when the resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Grounds / Motifs :

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

A. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care on a specified date, related to the fall of resident #004.

In an interview Registered Practical Nurse #107 stated that Post Falls Assessments were completed on a Post Fall No Head Injury or Post Fall with Head Injury Assessment form and filed in the resident's hard copy chart.

Review of resident #004's hard copy clinical record noted a Post Fall With Head Injury Assessment, the head injury routine was noted as initiated at a specified date

and time. The post fall assessment was not completed.

In an interview, Registered Nurse #109, noted a post fall assessment was not completed for resident #004.

B. A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term on a specified date, related to the fall of resident #005.

Review of resident #005's hard copy clinical record noted a post fall assessment was not completed for resident #005's fall.

Further review of resident #005's electronic record and risk management in Point Click Care noted resident #005 had a total of 19 falls in the past year and a half. Review of resident #005's hard copy clinical record noted no documented post fall assessments for three of those falls.

In an interview, Registered Nurse #109 acknowledged that the post fall assessments were not completed for resident #005 for the three falls.

In an interview, Director of Care #100 stated that a post fall assessment should be completed after every fall.

The licensee has failed to ensure that when resident #005 and resident #004 had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The severity of this issue was determined to be a level 2 as there was minimal risk to the resident. The scope of the issue was a level 2 as it was a pattern. The home had a level 3 history of previous noncompliance to this subsection of Ontario Regulation 79/10, which included a Voluntary Plan of Correction (VPC) issued on April 4, 2019 (2019_587129_0004). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 16, 2019(A1)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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 20th day of August, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by JULIE LAMPMAN (522) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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