Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 24, 2019	2018_556168_0011	028448-18, 029794-18, 029799-18, 030171-18, 031642-18	Critical Incident System

Licensee/Titulaire de permis

Park Lane Terrace Limited
284 Central Avenue LONDON ON N6B 2C8

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

Park Lane Terrace
295 Grand River Street North PARIS ON N3L 2N9

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

LISA VINK (168), YVONNE WALTON (169)

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): November 21, 22, 23, 26, 27, 28, 29 and 30, 2018.

This inspection was completed related to:
Log #028448-18, for Critical Incident Report #2779-000036-18, related to duty to protect and responsive behaviours.
Log #029794-18, for Critical Incident Report #2779-000037-18, related to pain management and falls prevention and management.
Log # 029799-18, for Critical Incident Report #2779-000038-18, related to falls prevention and management.
Log # 030171-18, for Critical Incident Report #2779-000042-18, related to duty to protect and responsive behaviours.
Log # 031642-18, for Critical Incident Report #2779-000045-18, related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, former and current Director of Care (DOC), former Assistant Director of Care (ADOC), the Physiotherapist (PT), the Physiotherapist Assistant (PTA), recreation staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Social Worker (SW), the Resident Assessment Instrument (RAI) Coordinator, family members and residents.

During the course of the inspection, the inspectors observed the provision of care and services, monitored residents, reviewed records including but not limited to policies and procedures, meeting minutes, incident reports and clinical health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

9 WN(s)
2 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (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 :

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

A. Resident #011 was previously identified at an identified risk for falls.
On a specified date in November 2018, the resident sustained a fall, at which time a Fall Risk Assessment was completed by RPN #118 which identified the resident at a different risk level.
A review of the plan of care with the RAI Coordinator confirmed that the plan identified the resident was at the initial risk for falls and not at the current risk as identified in the most recent assessment.
The plan of care was changed immediately by the RAI Coordinator to reflect the actual falls risk for the resident.

B. Resident #011 was at risk for falls and had a number of interventions in place to manage this need.
A review of the plan of care, in place on an identified date in November 2018, included the use of two devices.
A review of the incident report for a fall, in November 2018, did not include the use of the devices.
Observations of the resident, their mobility aids, their room and bed, on two dates in November 2018, did not include the presence of the devices.
Interviews conducted with RN #113 and PSW #106 verified that the devices were no longer used by the resident.

RN #113 reviewed the plan of care and verified that the identified interventions were still recorded in the plan; however, were no longer a care need of the resident. They identified that they would revise the plan of care to reflect the change in needs.

C. A review of the clinical record identified that resident #013 fell on an identified date in November 2018.
After the fall, the resident was assessed and transferred to the hospital, where they were diagnosed with an injury.
The resident returned the following day with an intervention.
A review of the plan of care, printed on an identified date in November 2018, did not include the intervention or any changes in the resident's care needs related to the injury or the use of the intervention.
The DOC confirmed that the plan of care was not updated following the fall.

Subsequent assessments of resident #013 identified a change in status.
The physician was contacted, informed of the change in status and ordered diagnostic tests. Later that shift, the resident was transferred and admitted to the hospital.
The resident returned from the hospital following treatment and with additional diagnosis.
A review of the plan of care, on return from hospital did not include the presence of the additional diagnosis nor the care required due to the diagnosis and changes in their care needs.
The S.A.L.T. (Safe Ambulating Lift and Transfer) logo posted in the resident's room identified a specific level of assistance for transfers, not reflective of current needs.
On an identified date in November 2018, RPN #114 and RPN #116, confirmed that they had cared for the resident since their return from hospital six days prior; however, had not made revisions to their plan of care.
On an identified date in November 2018, discussion with RPN #100, identified that they had made some changes to the resident's plan of care two days prior; however, due to technical issues, was not able to save the changes initially.
The plan of care, printed following the discussion with RPN #100, identified that the resident had changes to care needs which included: alteration in skin integrity and a change in transfer and falls risk status.
The plan of care did not include: the use of an intervention and provided conflicting statements regarding falls risk level, ability to complete a task, level of assistance for mobility, and identified a specific behaviour as a current care need.

The plan of care was not reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer

necessary. [s. 6. (10) (b)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that 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 policy was complied with.

In accordance with Ontario Regulation 79/10 s. 48(1)(1) every licensee of a long-term care home was to ensure that the following interdisciplinary program was developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the licensee's Post Fall Algorithm, 5.2, which was part of the licensee's Falls Prevention Policy.

The Post Fall Algorithm identified that when a resident sustained a fall staff were to: at the time of the fall, assess for vital signs and injury, for example bruising, laceration or fracture; complete a Fall Risk Assessment; refer to the physiotherapist for assessment and place a falling star logo at the bedside/wheelchair/walker.

A. Resident #011 sustained a fall on an identified date in November 2018.
A review of the clinical record did not include a referral to physiotherapy following the fall, nor an assessment by the physiotherapist related to the fall.
A review of the clinical record, by the PTA verified that a physiotherapist referral was not initiated following the fall.
A review of the clinical record, by the RAI Coordinator and RPN #118, who worked during the identified shift verified that a physiotherapist referral was not initiated for the fall.
Observation of the resident, on two dates in November 2018, verified that the resident did not have a falling star logo in place at the bedside or on their mobility aids.
Observation of the resident and their room, with RN #113, verified that the falling star logo was not in place for the resident.

B. Resident #014 was identified at a specified risk for falls.
According to the clinical record the resident had an identified ability for mobility with a device and sustained a fall in October 2018 and November 2018.
i. A review of the clinical record included a progress note regarding the incident of October 2018.
The note identified the incident, as reported and actions taken prior to the arrival of staff.
The resident denied injuries and continued with their plan for the day.
The progress note did not include documentation of vital signs, a physical assessment for injury or a Falls Risk Assessment.
A progress note, the following shift, identified that they had a symptom and an alteration in skin integrity.
RN #113, reviewed the clinical record and confirmed that it did not include vital signs following the incident, an assessment of injuries nor a Falls Risk Assessment for the fall.

ii. A review of the clinical record for the fall, in November 2018, did not include a Fall Risk Assessment nor a referral submitted to the physiotherapist for assessment for the fall.
A review of the clinical record, by RN #113 verified that the identified Fall Risk Assessment and referral to physiotherapy was not completed as required.

C. Resident #013 was identified at a specified risk for falls.
The resident sustained unwitnessed falls on two dates in October 2018.
i. A review of the clinical record, for one of the falls did not include a referral to the physiotherapist for assessment.
RPN #122, who worked during the identified fall, verified that a referral to physiotherapy was not initiated for the fall, following a review of the clinical record.

PSW #115, the PT and PTA each verified, following an observation of the resident's room and mobility aid that a falling star logo was not in place at the bedside or on the aid.

Staff did not comply with the policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee 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 policy was complied with.

In accordance with Ontario Regulation 79/10 s. 48(1)(1) every licensee of a long-term care home was to ensure that the following interdisciplinary program was developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the licensee's Head Injury Routine, 6.2, effective June 2017, which was part of the licensee's Falls Prevention Policy.

The policy identified that head injury routine (HIR) would be initiated for all resident falls that were not witnessed and for witnessed resident falls that included the possibility of a head injury. Exception when a competent resident or family member (who witnessed the fall incident) reported that the resident did not hit his/her head during the fall.

A. Resident #011, was identified in their plan of care with a focus statement for a level of ability of intellectual functioning.
The resident sustained an unwitnessed fall, on an identified date in November 2018.
Progress notes, earlier in the day indicated the resident was identified to be agitated.
The record included that the resident stated that they did not hit their head during the fall.

A review of the clinical record did not include any HIR for the resident following the fall.
Interview with RPN #118 who worked on the identified shift, confirmed that a HIR was not initiated following the fall, based on the statement of the resident that they did not hit their head.

B. Resident #013 was identified at a specified risk for falls.
The resident sustained two unwitnessed falls in October, 2018, and had a focus statement on their plan of care for a level of ability for intellectual functioning.
i. A review of the clinical record, for the first fall in October 2018, did not include the

completion of HIR as required. Documentation of HIR was completed on seven occasions over the span of two days.
RPN #122, following a review of the clinical record, verified that HIR was not documented as completed at the frequency required by the policy for the resident post fall.
ii. A review of the clinical record, for the second fall in October 2018, did not include an assessment of HIR as required post fall.
RPN #122, who worked during the identified fall, reviewed the clinical record and verified that the HIR was not initiated or completed for this fall.

The policy was not 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".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

According to clinical records and incident reports residents #010, #011 and #015 were involved in altercations and potentially harmful interactions.

A. Residents #010 and #011 were involved in altercations and potentially harmful

interactions on the following occasions:
i. On a specified date in October 2017, when resident #011 was agitated and resident #010 hit them;
ii. On a specified date in September 2018, when resident #010 was verbally aggressive towards resident #011; and
iii. On a specified date November 2018, when resident #010 hit resident #011, in response to an interaction resident #011 had with resident #012.

On an identified date in November 2018, interview with resident #010 identified that they have had negative interactions with resident #011 previously.
Recreation staff member #103, identified that residents #010 and #011 did not get along.
PSW #106, identified that staff monitor resident #010 when residents #011 and #015 were in close visual proximity.
RN #113, identified awareness that residents #010 and #011 did not get along.

B. Resident #011 demonstrated responsive behaviours as documented in their clinical record and communicated by staff during interviews which had the potential for altercations or potentially harmful situations between and among residents.
A review of the progress notes for resident #011 identified:
i. On a specified date in November 2018, the resident had undesired contact with co-residents. Interview with RN #113 confirmed the presence of the behaviour.
ii. On a specified date in November 2018, the resident had undesired contact with a co-resident.
iii. On a specified date in November 2018, the resident was verbally and physically responsive to care.

Interview with the RAI Coordinator confirmed the resident was resistive to care, as identified in the progress notes and following a review of the plan of care, verified that the plan did not include the identified behaviours or interventions for the additional behaviour identified.

C. Residents #010 and #015 were involved in altercations and potentially harmful interactions on the following occasions:
i. On a specified date in September 2018, when resident #010 hit resident #015; and
ii. On a specified date in October 2018, when resident #015 had undesired contact with resident #010 who responded with physical aggression to the co-resident.

On a specified date in November 2018, resident #010 identified that they did not like

resident #015.
The DOC, identified that resident #015 stated that co-residents had an opinion of their actions towards resident #010.
The SW, identified that resident #015 acknowledged that they responded to and that people had an opinion regarding their approach to resident #010.
The RAI Coordinator, identified awareness that resident #010 did not get along with resident #015 and the potential for a recurrence of an incident between the residents.
RN #113, identified that resident #015 had the potential for physical aggression and awareness that residents #010 and #015 did not get along.
RN #119, identified awareness that residents #010 and #015 did not get along.
Following a review of the plan of care, for resident #015, the RAI Coordinator confirmed that the plan did not include the behaviour of physical aggression, nor any interventions to manage the behaviour.

D. According to the clinical record and staff interviews resident #015 demonstrated another responsive behaviour which had the potential for an altercation or potentially harmful situation between and among residents.
i. On an identified date in August 2018, the resident was observed to enter an area of the resident home area which they did not have the authority to enter and demonstrated an action.

Interview with the DOC identified that the resident had a history of the action.
Interview with RN #113 identified that the resident had been located in similar areas previously and that a person of importance to the resident previously reported that the action had occurred.
Interview with the RAI Coordinator following a review of the plan of care, verified that the plan did not include the behaviour, nor any interventions to manage the behaviour.

Staff at the home and documentation supported that some interventions were put in place, on or before an identified date in November 2018, in an effort to discourage altercations and potentially harmful interactions between the residents including but not limited to: reinstruction on inappropriate behaviour, promotion of avoidance, change in routine and involvement of a third party.

At the time of this inspection the three residents continued to interact with each other daily due to their physical environment.

Steps were not taken to minimize the risk of altercations and potentially harmful

interactions between residents by identifying and implementing interventions. [s. 54. (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The licensee's policy Abuse Prevention Elimination and Reporting, A.2, effective May 2017, identified the protocol for reporting allegations of resident abuse and the protocol for investigating allegations of resident abuse by a resident.

This policy directed staff to "immediately report alleged, suspected or witnessed incident [of abuse] to the registered staff member" and "the registered staff member must immediately contact the Administrator, Director of Nursing or delegate".
When investigating an allegation "the person receiving the initial report shall obtain a detailed account of the incident from the person reporting the incident", "the staff member receiving the initial report shall ensure that all information is documented in both resident's charts in chronological order" and "as soon as possible the Administrator/DON/delegate will meet with all parties identified in the incident".

A. A review of the clinical record of resident #010 identified that they were involved in an incident with a co-resident on an identified date in October 2017.
On an identified date in November 2018, the co-resident was identified, by RN #113, to be resident #011, which was supported by their clinical record.

The documentation, at the time by RN #113, identified that the incident was not witnessed; however, resident #010 hit resident #011. Resident #011 responded to this action verbally.
Resident #010 admitted that they hit resident #011.
On an identified date in November 2018, interview with RN #113, identified that they were not able to recall if they reported the incident immediately; however, at the time of the incident, management would have been informed at minimum the next business day during morning meeting.
Interview with the former DOC, on an identified date in November 2018, identified that they had some recollection of the incident; however, could not comment on how they became aware of the incident, by whom, when or actions taken including reporting to the Director.
On an identified date in November 2018, a review of documents available in the home, by the Administrator, identified that they did not have any additional records related to the incident, only those in point click care, the electronic documentation system for clinical health records.
A review of the Critical Incident System, on an identified date in November 2018, did not include an incident report for the incident.

B. A review of the clinical record of resident #015 included a progress note, for a specified date in September 2018, where they reported an incident with resident #010 the day before.
The note included the reported actions of resident #010, a change in an identified area for resident #015 and the response of resident #015. RN #113 responded to the comments, provided reassurance, assessed the resident's reported injury and interviewed resident #010 who verified an incident with the co-resident.
RN #113 documented a progress note regarding their discussion with resident #010, related to the incident, in their clinical record.
Resident #015 was able to recount the incident when interviewed on a specified date in November 2018.
Resident #010 was able to discuss the incident when interviewed on a specified date in November 2018.
On a specified date in November 2018, RN #113, identified that they were notified of the incident, in September 2018, at shift report, which was supported by PSW #106, and for that reason approached resident #015. They indicated that they took no additional actions related to reporting the incident as believed that this was completed by the staff member who was initially informed of the incident.
A review of the Daily Assignment Sheet identified RN #119 as the staff member who

worked on the identified shift.
On a specified date in November 2018, interview with resident #015 identified, without hesitation, that they immediately reported the incident to RN #119.
On a specified date in November 2018, RN #119, identified that they recalled resident #015 reported an incident with resident #010, although could not confirm an exact date. They noted that to their recall there were no witnesses to the alleged incident nor evidence of injury to resident #015, who at times was not reliable. Following the allegation they spoke with both residents and provided direction in an effort to prevent future incidents. They had no recall of documenting the allegation; however, identified that they would have shared the information, which they were unable to support with facts, verbally at shift report.
On a specified date in November 2018, the DOC, identified that they were unaware of the incident until resident #015 told the story to a third party, the month before. The DOC verified that when they learned of the allegation they did not interview resident #010 regarding the allegation, nor did they report the information to the Director, as they were not aware if there was a specific incident.

The policy that promotes zero tolerance of abuse and neglect of residents was not complied with. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure that when the resident had fallen, the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A. Resident #014 was identified to be at a specific risk for falls.
According to the progress notes, on a specified date in October 2018, the resident sustained a fall.
A review of the electronic clinical record, including Risk Management, Active and Historical, did not include a post fall assessment.
Interview with RN #113 following a review of the record confirmed that a post fall assessment was not conducted using a clinically appropriate assessment instrument for the incident, in October 2018, and that this was the expectation for all falls.

B. According to the clinical records resident #013 was identified at specific risk for falls and sustained a fall on an identified date in October 2018.
The records, including a review of Risk Management, Active and Historical, did not include a post fall assessment using a clinically appropriate assessment instrument that was specifically designed for falls.
RPN #122, who worked at the time of the fall, verified, following a review of the clinical record that a post fall assessment was not conducted.

When the resident had fallen, the resident was not assessed and, if required, a post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident has fallen, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that the resident was protected from abuse by anyone.

Ontario Regulation 79/10 section 2(1) defines emotional abuse as any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

Ontario Regulation 79/10 section 2(1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

A. A review of the clinical record of resident #010 identified that they were involved in an incident with a co-resident on an identified date in October 2017.
The co-resident was identified, by RN #113, during an interview on an identified date in November 2018, to be resident #011, which was supported by their clinical record.
The documentation, at the time, by RN #113, identified that the incident was not witnessed; however, resident #010 hit resident #011. Resident #011 responded to this action verbally. On assessment resident #011 had an injury which resolved without

treatment or intervention.
Resident #010 admitted that they hit resident #011.
According to the progress notes resident #011 recalled the incident the following day and identified resident #010 by name.
On an identified date in November 2018, the Administrator verified that the incident, as reviewed in the clinical record would be considered abuse.

Resident #011 was not protected from abuse by resident #010.

B. A review of the clinical record of resident #015 included a progress note, for a specified date in September 2018, where they reported an incident with resident #010 the day before.
The incident included the actions of resident #010, a change in an identified area for resident #015 and the response of resident #015. RN #113 responded to the comments, provided reassurance, assessed the resident's reported injury and interviewed resident #010 who verified an incident with the co-resident.
Resident #015 was able to recount the incident when interviewed on a specified date in November 2018.
Resident #010 was able to discuss the incident when interviewed on a specified date in November 2018.

Resident #015 was not protected from abuse from resident #010.

C. A review of Critical Incident Report 2779-000026-18, intake 028448-18, identified an incident, on a specified date in October 2018, where resident #010 was physically aggressive towards resident #015.
A review of the incident demonstrated that resident #015 demonstrated an activity towards resident #010 prior to the aggression.
On an identified date in November 2018, RPN #100, who worked on the identified shift, indicated that they did not witness the entire incident. When they assessed resident #015, they were unable to observe an injury; however, the resident reported pain and they noted that this type of pain was not unusual for the resident; however, they did not complain of pain later in the shift.
Resident #015 was able to recount the incident when interviewed on a specified date in November 2018.
Resident #010 was able to discuss the incident when interviewed on a specified date in November 2018.

Resident #015 was not protected from abuse from resident #010.

This area of non compliance, LTCHA s. 19(1) was identified as Compliance Order #008, on Inspection Report 2018_695156_0006, Log Number 016725-18, with a Report Date of January 15, 2019, and a Compliance Due Date of March 18, 2019. [s. 19. (1)]

WN #7: 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 failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director, including abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

A. A review of the clinical record of resident #010 identified that they were involved in an incident with a co-resident on a specified date in October 2017.
On a specified date in November 2018, the co-resident was identified, by RN #113, to be resident #011, which was supported by their clinical record.
The documentation, at the time by RN #113, identified that the incident was not

witnessed; however, resident #010 hit resident #011. Resident #011 responded to this action verbally. On assessment resident #011 had an injury which resolved without treatment or intervention.
Resident #010 admitted that they hit resident #011.
On an identified date in November 2018, interview with RN #113, identified that they were not able to recall if they reported the incident immediately; however, at the time of the incident, management would have been informed at minimum the next business day during morning meeting.
On an identified date in November 2018, interview with the former DOC, identified that they had some recollection of the incident; however, could not comment on how they became aware of the incident, by whom, when or actions taken.
On an identified date in November 2018, a review of documents available in the home, by the Administrator, identified that they did not have any additional records related to the incident, only those in point click care, the electronic documentation system, for clinical health records.
A review of the Critical Incident System by the Administrator, did not include a report for the incident.

B. A review of the clinical record of resident #015 included a progress note, for a specified date in September 2018, where they reported an incident with resident #010 the day before.
The incident included the actions of resident #010, a change in an identified area for resident #015 and the response of resident #015. RN #113 responded to the comments, provided reassurance, assessed the resident's reported injury and interviewed resident #010 who verified an incident with the co-resident.
Resident #015 was able to recount the incident when interviewed on a specified date in November 2018.
Resident #010 was able to discuss the incident when interviewed on a specified date in November 2018.
RN #113, identified that they were notified of the incident at shift report, which was supported by PSW #106.
The RN identified that they took no actions related to reporting the incident as believed that this was completed by the staff member who was initially aware of the incident.
A review of the Daily Assignment Sheet identified RN #119 as the staff member who worked the identified shift.
On an identified date in November 2018, interview with resident #015, identified, without hesitation, that they immediately reported the incident to RN #119.
Interview with RN #119, on an specified date in November 2018, identified that they

recalled resident #015 reporting an incident with resident #010, although could not confirm an exact date. They noted that to their recall there were no witnesses to the alleged incident nor evidence of injury to resident #015, who at times was not reliable. Following the allegation the RN spoke with both residents and provided direction in an effort to prevent future incidents. They were not able to recall if they documented the allegation; however, identified that they would have shared the information, which in their opinion, they were unable to support with facts, verbally at shift report.
Interview, with the DOC verified that they were unaware of the incident until resident #015 told the story to a third party, the month before. The DOC verified that when they learned of the allegation they did not report the information to the Director, as they were not aware that there was a specific incident.

The person who had reasonable grounds to suspect that the following had occurred or may have occurred, failed to immediately reported the suspicion and the information upon which it was based to the Director, including abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. [s. 24. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours included assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

Resident #015 had known responsive behaviours.
A review of the clinical record included progress notes related to specific incidents of responsive behaviours.
A progress note on a specified date in October 2018, identified that the resident refused care; however, did not include any interventions to address the behaviour, nor the resident's response.
A progress note on an specified date in October 2018, identified that the resident was resistive during the shift, refused a meal, medication and care; however, did not include any interventions to address the behaviours, nor the resident's response.
A progress note on a specified date in October 2018, identified the resident to be verbally aggressive during care and not cooperative with routine; however, did not include any interventions to address the behaviours.
Progress notes on two specific dates in October identified the resident refused care; however, did not include any interventions to address the behaviour, nor the resident's response.
A progress note on a specific date in November 2018, identified the resident to be verbally aggressive; however, did not include any interventions to address the behaviour, nor the resident's response.

The RAI Coordinator, following a review of some of the progress notes identified above verified that the documentation did not include interventions nor the resident's response.

Actions taken to meet the needs of the resident with responsive behaviours did not consistently include: assessment, reassessments, interventions, and documentation of the resident's responses to the interventions. [s. 53. (4) (c)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

The licensee failed to ensure that all staff at the home received training as required by this section.

The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before they received training in the areas mentioned below: the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and policies of the licensee, that were relevant to the person's responsibilities.

An identified individual worked at the home, as arranged by their employer, a third party agency who provided onsite services to long-term care homes.
The employer held a contract with the home, to provide services, since a specific month in 2017, for a minimum number of hours per week.

The identified individual was identified as "staff" according to the interpretation of "staff" in the LTCHA, 2007, as a person who worked at the home, pursuant to a contract or agreement between the licensee and an employment agency or other third party.

The staff member was interviewed, on a specified date in November 2018, and verified that they worked in the home for a period of time greater than six months.
They shared their education and work experience related to their current responsibilities; however, identified that they had not received specific training in the home or by the licensee on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and policies of the licensee, on responsive behaviours, that were relevant to their responsibilities.
A request was made to provide the training records of the individual.
The home was not able to provide a record of the training required, as confirmed by the DOC.

Staff in the home did not receive training as required by this section and a person performed their responsibilities before they received training in the areas of the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and policies of the licensee, that were relevant to their responsibilities.

This area of non compliance, LTCHA s. 76 was identified as Compliance Order #001, on Inspection Report 2018_695156_0006, Log Number 016725-18, with a Report Date of January 15, 2019, and a Compliance Due Date of April 15, 2019. [s. 76. (1)]

Issued on this 29th day of January, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2018_556168_0011
Log No. / No de registre :	028448-18, 029794-18, 029799-18, 030171-18, 031642-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 24, 2019
Licensee / Titulaire de permis :	Park Lane Terrace Limited 284 Central Avenue, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	Park Lane Terrace 295 Grand River Street North, PARIS, ON, N3L-2N9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sandy Hall

To Park Lane Terrace Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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) of the LTCHA.

Specifically the licensee must:
1. Reassess resident #013 and any other resident, in relation to falls risk, interventions required related to the prevention and management of falls and changes in care needs related to an injury.
As a result of this reassessment the licensee shall review and revise the resident's plan of care as appropriate to ensure that it is reflective of current needs.
2. Develop and implement a tool to ensure that when a resident's care needs change, the changes are communicated to staff who are responsible for coordinating the reassessment of the resident and the review and revision of the plan of care.
3. Develop, implement and document an auditing mechanism, at times and frequencies to be determined by the licensee, to ensure that when a resident has a change in care needs, that they are reassessed and their plans of care revised to reflect those changes. Audit results are to be maintained and provided to Inspector(s) on request at the time of the Follow Up Inspection.

Grounds / Motifs :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when

the resident's care needs changed or care set out in the plan was no longer necessary.

A. Resident #011 was previously identified at an identified risk for falls.
On a specified date in November 2018, the resident sustained a fall, at which time a Fall Risk Assessment was completed by RPN #118 which identified the resident at a different risk level.
A review of the plan of care with the RAI Coordinator confirmed that the plan identified the resident was at the initial risk for falls and not at the current risk as identified in the most recent assessment.
The plan of care was changed immediately by the RAI Coordinator to reflect the actual falls risk for the resident.

B. Resident #011 was at risk for falls and had a number of interventions in place to manage this need.
A review of the plan of care, in place on an identified date in November 2018, included the use of two devices.
A review of the incident report for a fall, in November 2018, did not include the use of the devices.
Observations of the resident, their mobility aids, their room and bed, on two dates in November 2018, did not include the presence of the devices.
Interviews conducted with RN #113 and PSW #106 verified that the devices were no longer used by the resident.
RN #113 reviewed the plan of care and verified that the identified interventions were still recorded in the plan; however, were no longer a care need of the resident. They identified that they would revise the plan of care to reflect the change in needs.

C. A review of the clinical record identified that resident #013 fell on an identified date in November 2018.
After the fall, the resident was assessed and transferred to the hospital, where they were diagnosed with an injury.
The resident returned the following day with an intervention.
A review of the plan of care, printed on an identified date in November 2018, did not include the intervention or any changes in the resident's care needs related to the injury or the use of the intervention.
The DOC confirmed that the plan of care was not updated following the fall.

Subsequent assessments of resident #013 identified a change in status.
The physician was contacted, informed of the change in status and ordered diagnostic tests. Later that shift, the resident was transferred and admitted to the hospital.
The resident returned from the hospital following treatment and with additional diagnosis.
A review of the plan of care, on return from hospital did not include the presence of the additional diagnosis nor the care required due to the diagnosis and changes in their care needs.
The S.A.L.T. (Safe Ambulating Lift and Transfer) logo posted in the resident's room identified a specific level of assistance for transfers, not reflective of current needs.
On an identified date in November 2018, RPN #114 and RPN #116, confirmed that they had cared for the resident since their return from hospital six days prior; however, had not made revisions to their plan of care.
On an identified date in November 2018, discussion with RPN #100, identified that they had made some changes to the resident's plan of care two days prior; however, due to technical issues, was not able to save the changes initially.
The plan of care, printed following the discussion with RPN #100, identified that the resident had changes to care needs which included: alteration in skin integrity and a change in transfer and falls risk status.
The plan of care did not include: the use of an intervention and provided conflicting statements regarding falls risk level, ability to complete a task, level of assistance for mobility, and identified a specific behaviour as a current care need.

The plan of care was not reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

The severity of this issue was determined to be a level 2 as there was the potential for actual harm. The scope of the issue was a level 2 as it was a pattern.
The home had a level 5 compliance history as multiple non compliance with at least one related order to the current area of concern that included:
-voluntary plan of correction (VPC) issued April 22, 2016, (2016-275536-0007);

-VPC issued May 27, 2016, (2016-343585-0007);
-compliance order (CO) #003 issued May 25, 2017, (2017-556168-0006) with a compliance due date of December 28, 2017;
-written notification (WN) issued February 13, 2018, (2017-689586-0013); and
-VPC issued January 15, 2019, (2018-695156-0006).

(168)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 03, 2019

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) of O. Reg. 79/10.

Specifically the licensee must:
1. Ensure that, should residents #011 and #013, or any other resident, sustain a fall they are assessed and provided care as appropriate according to the licensee's policies in their falls prevention and management program to reduce the incidence of falls and the risk of injury, specifically the polices:
a. Post Fall Algorithm, 5.2, and
b. Head Injury Routine, 6.2, effective June 2017.
2. Create, implement and document an auditing process to ensure that all residents who sustain a fall are assessed as required based on the falls policies. Follow up action shall be taken when appropriate. The audits may be completed at times and frequencies as determined by the licensee.

Grounds / Motifs :

1. The licensee 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 policy was complied with.

In accordance with Ontario Regulation 79/10 s. 48(1)(1) every licensee of a long-term care home was to ensure that the following interdisciplinary program was developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the licensee's Post Fall Algorithm, 5.2, which was part of the licensee's Falls Prevention Policy.

The Post Fall Algorithm identified that when a resident sustained a fall staff were to: at the time of the fall, assess for vital signs and injury, for example bruising, laceration or fracture; complete a Fall Risk Assessment; refer to the physiotherapist for assessment and place a falling star logo at the bedside/wheelchair/walker.

A. Resident #011 sustained a fall on an identified date in November 2018.
A review of the clinical record did not include a referral to physiotherapy following the fall, nor an assessment by the physiotherapist related to the fall.
A review of the clinical record, by the PTA verified that a physiotherapist referral was not initiated following the fall.
A review of the clinical record, by the RAI Coordinator and RPN #118, who worked during the identified shift verified that a physiotherapist referral was not initiated for the fall.
Observation of the resident, on two dates in November 2018, verified that the resident did not have a falling star logo in place at the bedside or on their mobility aids.
Observation of the resident and their room, with RN #113, verified that the falling star logo was not in place for the resident.

B. Resident #014 was identified at a specified risk for falls.
According to the clinical record the resident had an identified ability for mobility with a device and sustained a fall in October 2018 and November 2018.
i. A review of the clinical record included a progress note regarding the incident of October 2018.
The note identified the incident, as reported and actions taken prior to the arrival of staff. The resident denied injuries and continued with their plan for the day.
The progress note did not include documentation of vital signs, a physical assessment for injury or a Falls Risk Assessment.
A progress note, the following shift, identified that they had a symptom and an alteration in skin integrity.
RN #113, reviewed the clinical record and confirmed that it did not include vital signs following the incident, an assessment of injuries nor a Falls Risk

Assessment for the fall.

ii. A review of the clinical record for the fall, in November 2018, did not include a Fall Risk Assessment nor a referral submitted to the physiotherapist for assessment for the fall.
A review of the clinical record, by RN #113 verified that the identified Fall Risk Assessment and referral to physiotherapy was not completed as required.

C. Resident #013 was identified at a specified risk for falls.
The resident sustained unwitnessed falls on two dates in October 2018.
i. A review of the clinical record, for one of the falls did not include a referral to the physiotherapist for assessment.
RPN #122, who worked during the identified fall, verified that a referral to physiotherapy was not initiated for the fall, following a review of the clinical record.

PSW #115, the PT and PTA each verified, following an observation of the resident's room and mobility aid that a falling star logo was not in place at the bedside or on the aid.

Staff did not comply with the policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee 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 policy was complied with.

In accordance with Ontario Regulation 79/10 s. 48(1)(1) every licensee of a long-term care home was to ensure that the following interdisciplinary program was developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the licensee's Head Injury Routine, 6.2, effective June 2017, which was part of the licensee's Falls Prevention Policy.

The policy identified that head injury routine (HIR) would be initiated for all resident falls that were not witnessed and for witnessed resident falls that included the possibility of a head injury. Exception when a competent resident

or family member (who witnessed the fall incident) reported that the resident did not hit his/her head during the fall.

A. Resident #011, was identified in their plan of care with a focus statement for a level of ability of intellectual functioning.
The resident sustained an unwitnessed fall, on an identified date in November 2018. Progress notes, earlier in the day indicated the resident was identified to be agitated. The record included that the resident stated that they did not hit their head during the fall.
A review of the clinical record did not include any HIR for the resident following the fall.
Interview with RPN #118 who worked on the identified shift, confirmed that a HIR was not initiated following the fall, based on the statement of the resident that they did not hit their head.

B. Resident #013 was identified at a specified risk for falls.
The resident sustained two unwitnessed falls in October, 2018, and had a focus statement on their plan of care for a level of ability for intellectual functioning.
i. A review of the clinical record, for the first fall in October 2018, did not include the completion of HIR as required. Documentation of HIR was completed on seven occasions over the span of two days.
RPN #122, following a review of the clinical record, verified that HIR was not documented as completed at the frequency required by the policy for the resident post fall.
ii. A review of the clinical record, for the second fall in October 2018, did not include an assessment of HIR as required post fall.
RPN #122, who worked during the identified fall, reviewed the clinical record and verified that the HIR was not initiated or completed for this fall.

The policy was not complied with. [s. 8. (1) (a),s. 8. (1) (b)] (168)

2. The severity of this issue was determined to be a level 2 as there was the potential for actual harm. The scope of the issue was a level 2 as it was a pattern.
The home had a level 5 compliance history as multiple non compliance with at least one related order to the current area of concern that included:
-voluntary plan of correction (VPC) issued May 27, 2016, (2016-343585-0007);

-written notification (WN) issued September 7, 2016, (2016-210169-0012);
-WN issued September 7, 2016, (2016-210169-0011);
-compliance order (CO) #003 (for LTCHA s. 6(10) related to plan of care with grounds identified related to falls prevention interventions) issued May 25, 2017, (2017-556168-0006) with a compliance due date of December 28, 2017;
-CO #002 (for O Reg 79/10 s. 49(2) related to falls prevention and management) issued May 25, 2017, (2017-556168-0006) with a compliance due date of December 28, 2017;
-VPC issued February 13, 2018, (2017-689596-0013); and
-VPC issued January 15, 2019, (2018-695156-0006). (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee must be compliant with s. 54 of O. Reg 79/10.

Specifically the licensee must:
1. Take steps to minimize the risk of altercations and potentially harmful interactions between and among residents including residents #011 and #015, and any other residents.
2. Minimize the risks by taking actions including, but not be limited to: identification of triggers for the risk for each resident and identification of interventions to manage the risk for each resident. Once these triggers and interventions are identified they are to be recorded in each resident's plan of care and communicated to all staff who provide care to the residents.
3. Develop, implement and document a process to ensure that when a risk of altercations or potentially harmful interactions between and among residents is identified that this information is communicated to staff who are responsible for the resident's care and the leadership team for immediate action to be implemented to minimize the risk.

Grounds / Motifs :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

According to clinical records and incident reports residents #010, #011 and #015 were involved in altercations and potentially harmful interactions.

A. Residents #010 and #011 were involved in altercations and potentially harmful interactions on the following occasions:
i. On a specified date in October 2017, when resident #011 was agitated and resident #010 hit them;
ii. On a specified date in September 2018, when resident #010 was verbally aggressive towards resident #011; and
iii. On a specified date November 2018, when resident #010 hit resident #011, in response to an interaction resident #011 had with resident #012.

On an identified date in November 2018, interview with resident #010 identified that they have had negative interactions with resident #011 previously.
Recreation staff member #103, identified that residents #010 and #011 did not get along.
PSW #106, identified that staff monitor resident #010 when residents #011 and #015 were in close visual proximity.
RN #113, identified awareness that residents #010 and #011 did not get along.

B. Resident #011 demonstrated responsive behaviours as documented in their clinical record and communicated by staff during interviews which had the potential for altercations or potentially harmful situations between and among residents.
A review of the progress notes for resident #011 identified:
i. On a specified date in November 2018, the resident had undesired contact with co-residents. Interview with RN #113 confirmed the presence of the behaviour.
ii. On a specified date in November 2018, the resident had undesired contact with a co-resident.
iii. On a specified date in November 2018, the resident was verbally and physically responsive to care.

Interview with the RAI Coordinator confirmed the resident was resistive to care, as identified in the progress notes and following a review of the plan of care, verified that the plan did not include the identified behaviours or interventions for the additional behaviour identified.

C. Residents #010 and #015 were involved in altercations and potentially harmful interactions on the following occasions:
i. On a specified date in September 2018, when resident #010 hit resident #015; and
ii. On a specified date in October 2018, when resident #015 had undesired contact with resident #010 who responded with physical aggression to the co-resident.

On a specified date in November 2018, resident #010 identified that they did not like resident #015.
The DOC, identified that resident #015 stated that co-residents had an opinion of their actions towards resident #010.
The SW, identified that resident #015 acknowledged that they responded to and that people had an opinion regarding their approach to resident #010.
The RAI Coordinator, identified awareness that resident #010 did not get along with resident #015 and the potential for a recurrence of an incident between the residents.
RN #113, identified that resident #015 had the potential for physical aggression and awareness that residents #010 and #015 did not get along.
RN #119, identified awareness that residents #010 and #015 did not get along.
Following a review of the plan of care, for resident #015, the RAI Coordinator confirmed that the plan did not include the behaviour of physical aggression, nor any interventions to manage the behaviour.

D. According to the clinical record and staff interviews resident #015 demonstrated another responsive behaviour which had the potential for an altercation or potentially harmful situation between and among residents.
i. On an identified date in August 2018, the resident was observed to enter an area of the resident home area which they did not have the authority to enter and demonstrated an action.

Interview with the DOC identified that the resident had a history of the action.
Interview with RN #113 identified that the resident had been located in similar areas previously and that a person of importance to the resident previously reported that the action had occurred.
Interview with the RAI Coordinator following a review of the plan of care, verified

that the plan did not include the behaviour, nor any interventions to manage the behaviour.

Staff at the home and documentation supported that some interventions were put in place, on or before an identified date in November 2018, in an effort to discourage altercations and potentially harmful interactions between the residents including but not limited to: reinstruction on inappropriate behaviour, promotion of avoidance, change in routine and involvement of a third party.

At the time of this inspection the three residents continued to interact with each other daily due to their physical environment.

Steps were not taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions. [s. 54. (b)]

The severity of this issue was determined to be a level 2 as there was the potential for actual harm. The scope of the issue was a level 3 as it was a widespread.
The home had a level 3 compliance history as there was one or more related non compliance in the past three years, that included:
-voluntary plan of correction (VPC) issued May 24, 2017, (2017_555506_0009);
-VPC issued May 24, 2017, (2017-556168-0006); and
-VPC issued January 15, 2019, (2018-695156-0006).

(168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 24th day of January, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

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