Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 08, 2019	2019_787640_0004 (A1) (Appeal\Dir#: DR# 114)	025945-17	Complaint

Licensee/Titulaire de permis

Parkwood Mennonite Home Inc.
726 New Hampshire Street WATERLOO ON N2K 4M1

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

Parkwood Mennonite Home
726 New Hampshire Street WATERLOO ON N2K 4M1

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

Amended by Lynne Haves (Director) - (A1)(Appeal\Dir#: DR# 114)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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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*

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#001,CO#002.
The Director's review was completed on April 08, 2019.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 114.
A copy of the Director Order is attached.

Issued on this 8 th day of April, 2019 (A1)(Appeal\Dir#: DR# 114)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

Amended by Lynne Haves (Director) - (A1)(Appeal/Dir# DR# 114)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 21, 22, 23, 24 and 28, 2019.

This inspection was conducted concurrently with a Critical Incident Inspection #2019_787640_0003.

The following Complaint report was included in the inspection:

Log #025945-17 related to fall with fracture

The following Critical Incident Reports (CI) were included in the inspection:

Log #027701-17 related to fall with fracture

Log #001328-18 related to fall with fracture

PLEASE NOTE: Written notification and Compliance Orders related to LTCHA, 2007, s. 6 (7) and s. 33 (4) and O. Reg. 79/10, s. 8 (1) were identified in a concurrent inspection #2019_787640_0003, (Log #003499-18 and Log #028076-18).

During the course of the inspection, the inspector(s) spoke with residents, residents families, personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), Restorative Care Program Lead/Falls Prevention Program Lead, Restorative Care staff, Resident Assessment Instrument/Minimum Data Set (RAI/MDS) Coordinator, Clinical Coordinator, Director of Care and the Administrator.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Minimizing of Restraining

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

4 WN(s)
0 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. (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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

a) Resident #001 had sustained multiple falls since their admission in January 2017. As a result, two safety devices were implemented on an identified date in November 2017.

PSW #102 told the LTCH Inspector the resident had multiple interventions including the two safety devices that were to be in place at all times.

The plan of care directed staff to apply both of the safety devices to the resident at all times.

The Long Term Care Homes (LTCH) Inspector reviewed the home's required Personal Support Worker (PSW) documentation for the months in 2018 wherein the resident had a fall.

Specifically:

- on an identified date in February 2018, the resident fell. The incident report stated that both safety devices were not in place at the time of the fall.
- on an identified date in July and August 2018, the resident was found on their bedroom floor and one of the safety devices were not documented as being applied.

In February 2018, there were eight occurrences where one of the safety devices was not documented as being in place and eight occurrences where the second safety device was not documented as being applied. In July 2018, one of the safety devices was not in place for five shifts and the second safety device was not applied on 11 shifts. In August 2018, one of the safety devices was not in place on six shifts and the second safety device was not applied on 13 shifts. In November 2018, one of the safety devices was not in place on seven shifts and the second safety device was not applied on 10 shifts. In December 2018, one of the safety devices was not in place on five shifts and the second safety device was not applied on five shifts.

b) Resident #002 sustained unwitnessed falls on an identified date in September 2018, October 2018, that resulted in a significant injury, and December 2018. The resident was receiving daily anticoagulant therapy.

The resident's plan of care directed that two safety devices be applied at all times and they were implemented in October 2018.

The LTCH Inspector reviewed the clinical record for the months of October, November and December 2018, which identified several shifts where the two safety devices had not been applied.

During the three months reviewed there were 19 shifts where one of the safety devices was not documented as being in place and 19 shifts where the second safety device was not documented as being applied.

PSWs #110 and #111 told the LTCH Inspector that the resident was to have the two safety devices in place at all times. They were required to document when they were applied in their documentation tool in POC.

c) Resident #006 sustained an unwitnessed fall on an identified date in November 2018.

The resident's plan of care directed that a safety device was to be applied at all times and was initiated on an identified date June 2017.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record for the months of November and December 2018, which identified several shifts where

the safety device had not been applied.

During the month of November 2018, the safety device was not documented as being applied on 24 occasions. For the month of December 2018, the safety device was not documented as being applied on 31 occasions.

PSWs #110 and #111 told the LTCH Inspector that the resident was to have the two safety devices in place at all times. They were required to document when they were applied in their documentation tool in POC.

d) Resident #005 sustained falls on two identified dates in October 2018, two in November 2018 and three in December 2018.

The resident's plan of care directed that a specific safety device was to be applied at all times and was initiated on an identified date in January 2019.

The LTCH Inspector reviewed the clinical record for the month of January 2019, which identified several shifts where the safety device had not been applied.

In the month reviewed of January 2019, there were six shifts where the safety device was not documented as being in place and one shift where the safety device was documented as not functioning.

PSWs #108 told the LTCH Inspector that the resident was to have the safety device in place at all times. They were required to document when they were applied in their documentation tool in POC.

The DOC reviewed the documentation as above and acknowledged that staff had not provided the specified care as set out in the plan of care regarding the two specific safety devices for resident #001, #002, #005 and #006.

The licensee failed to ensure that care was provided as directed in the plan of care. [s. 6. (7)]

2. The licensee failed to ensure that when the plan of care was being revised because care set out in the plan was not effective, that different approaches were considered in the revision of the plan of care.

Resident #001 was admitted to the home in January 2017. From admission to the

end of 2018, they sustained a total of 20 falls of which 14 falls they were found on the floor in their bedroom, five times the safety device did not activate and on one occurrence, the safety device was not in place.

According to resident #001's plan of care, the safety device had been implemented in November 2017.

The Restorative Care Lead told the LTCH Inspector that the safety device may not activate if it was placed in the wrong position on the resident or if the cord was too long. They acknowledged the home had not tried an alternative to the specific safety device for this resident.

The licensee failed to try different approaches when the care set out in the plan was not effective [s. 6. (11) (b)]

Additional Required Actions:

(A1)(Appeal/Dir# DR# 114)
The following order(s) have been rescinded: CO# 001

WN #2: 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 :

1. The licensee failed to ensure that the use of a Personal Assistance Services Device (PASD) had been approved by a regulated healthcare professional.

a) Resident #001 sustained an unwitnessed fall on an identified date in November 2017, following which they had complained of pain in a specific area. On a second date in November 2017, the resident sustained an unwitnessed fall following which they demonstrated signs of pain in the same area.

On a identified date in November 2017, resident #001 was transferred for assessment. The resident returned to the home the same day with a diagnosis of a significant injury.

On an identified date in November 2017, the Restorative Care Lead documented they observed the resident to be currently using a specific PASD.

PSW #108 told the LTCH Inspector the resident was not able to get up from the PASD and it was in use for safety and comfort.

RPN #100 told the LTCH Inspector that prior to implementation, when a specific PASD was believed to be of benefit to a resident, they would inform the Restorative Care Lead who then would inform the Occupational Therapist (OT) to assess the resident for the appropriateness of the PASD and sizing of the device.

The clinical record was reviewed and there were no notes regarding approval for the use of the PASD by a regulated healthcare professional prior to its implementation. There was no clear date and time of implementation of the PASD until the note on an identified date in November 2017, written by the Restorative Care Lead, when the PASD was already in use.

b) Resident #005 sustained two falls in October, two falls in November and three falls in December 2018.

A PASD was implemented on an identified date in December 2018, for safety and comfort. Resident #005 was unable to independently exit the PASD.

RPN #100 told the LTCH Inspector that prior to implementation, when a PASD was believed to be of benefit to a resident, they would inform the Restorative Care Lead who then would inform the OT to assess the resident for the appropriateness of the PASD and sizing of the device.

The clinical record was reviewed and there were no notes regarding approval to use the PASD by a regulated healthcare professional prior to its implementation.

The Restorative Care Lead acknowledged the PASDs for residents #001 and #005 had been implemented without approval by a regulated healthcare professional. [s. 33. (4) 3.]

2. The licensee failed to ensure that the use of a PASD was consented to by the resident or, if the resident was incapable, a substitute decision maker (SDM) of the resident.

a) Resident #001 had a PASD implemented following falls in November 2017, and another safety device implemented in May 2018.

PSWs #102 told the LTCH Inspector the PASD was implemented for comfort and safety. The resident was not able to independently exit the device.

The LTCH Inspector reviewed the clinical record which did not include consent for the implementation of either PASD.

b) Resident #002 had a PASD implemented following fall in October 2018.

PSWs #110 and #111 told the LTCH Inspector the PASD was implemented for comfort and safety. The resident was not able to independently exit the PASD.

The LTCH Inspector reviewed the clinical record which did not include consent for the implementation of the PASDs.

c) Resident #005 had a PASD implemented in December 2018.

PSWs #110 and #111 told the LTCH Inspector the PASD was implemented for comfort and safety. The resident was not able to independently exit the PASD.

The LTCH Inspector reviewed the clinical record which did not include consent for the implementation of the PASD.

The Restorative Care Lead and the DOC told the LTCH Inspector that the implementation of a PASD did not require staff to obtain consent.

The licensee failed to obtain consent for the use of PASDs for residents #001, #002 and #005. [s. 33. (4) 4.]

Additional Required Actions:

(A1)(Appeal/Dir# DR# 114)
The following order(s) have been rescinded: CO# 002

WN #3: 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, procedure or protocol, that the policy, procedure or protocol was complied with.

In accordance with O. Reg. 79/10, s.48, that required the licensee to ensure that the interdisciplinary programs including fall prevention, were developed and implemented in the home to include relevant policies, procedures and protocols to meet the requirements as set out in section 30.

Specifically, staff did not comply with the licensee's policy "Falls Prevention and Management Program", that directed staff to initiate head injury routine (HIR) for all un-witnessed falls and witnessed falls that had resulted in a possible head injury or if the resident was on anticoagulant therapy according to the PMH Head Injury Routine.

Head Injury Routine template with no policy number or date of revision, directed staff to complete the BP, pulse, pupils and level of consciousness every half hour for four times, then every hour for four occurrences, every two hours for four

occurrences, on Day 2 once and day 3 once for a total of 14 assessments.

Head Injury Routine template stating "Resource: adapted from Sunnybrook Post Falls Assessment Algorithm", with no date of implementation, directed staff to complete BP, pulse, pupils and level of consciousness every hour for four hours then every eight hours for the next 24 hours for a total of seven assessments.

a) Resident #001 was prescribed an anticoagulant twice daily with an initiated date in January 2017.

On an identified date in November 2017, resident #001 sustained an unwitnessed fall.

HIR form dated the same day as the fall in November 2017, was incomplete and did not include the required assessments on two occasions. HIR form dated an identified date in November 2017, was incomplete on one occasion and three occasions there were other notes in the boxes but no HIR assessments.

Resident #001 sustained an unwitness fall on an identified date in July 2018. The HIR was incomplete on three occasions.

The resident incurred 16 unwitnessed falls since their admission to the home in January 2017 to the end of December 2018.

The clinical record included HIR documentation for four of the 16 unwitnessed falls.

The DOC acknowledged that all unwitnessed falls for resident #001 required HIR based on the administration of anticoagulant therapy. They acknowledged that staff did not comply with the home's policy for 12 of 16 unwitnessed falls for this resident.

b) Resident #002 sustained unwitnessed falls on identified dates in September and October 2018 and one on an identified date in January 2019. The resident was found on the floor in various locations for all three falls. The fall that occurred in January 2019, the resident's head was resting in the foot rests of their wheelchair.

Resident #002 had been prescribed an anticoagulant on a daily basis since

September 2018.

HIR form with an identified date in September 2018, was incomplete. The fifth required HIR assessment was not completed.

HIR was not initiated or completed for the falls n October and December 2018.

RPN #100 and RN #109 told the LTCH Inspector that HIR was initiated if a resident had hit their head. If the fall was unwitnessed then they do not implement HIR unless the resident stated they had hit their head or with obvious head trauma and at no other time were they required to implement HIR.

The DOC acknowledged that all unwitnessed falls for resident #002 required HIR based on the administration of anticoagulants and the home's policy had not been complied with in two of three unwitnessed falls for this resident.

c) Resident #005 sustained one unwitnessed fall in October and two in December 2018, that resulted in head injury.

HIR form dated October 2018, was incomplete. The fifth required HIR assessment was not completed.

HIR form dated December 2018, was incomplete. The sixth required assessment was not completed and the documentation space was empty, save and except for the date and time the assessment was required.

RN #108 acknowledged that two of the unwitnessed falls for resident #005 that required HIR had not been completed as per the home's policy.

The licensee failed to ensure that the home's Fall Prevention and Management policy was complied with. [s. 8. (1) (a),s. 8. (1) (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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition was reported to the Director within one business day after the occurrence of the incident.

Resident #002 fell on an identified date in September 2018, and had an assessment on an identified date three days later that identified a significant injury. On an identified date in October 2018, as a result of continued pain and a decline in condition, an assessment was performed of two areas. The results were known on the same day the assessment occurred which identified a worsening of the significant injury.

On the following day in October, 2018, resident #002 was transferred to a higher level of care for treatment. The incident was reported to the Director on an identified date which was two days later than required.

The DOC acknowledged that the incident resulting in injury, transfer to higher level of care and significant change in condition for resident #002 was submitted late to the Director.

The licensee failed to ensure that the incident that resulted in a change in resident #002's condition, was not reported to the Director within one business day. [s. 107. (3)]

Issued on this 8 th day of April, 2019 (A1)(Appeal/Dir# DR# 114)

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by Lynne Haves (Director) - (A1) (Appeal/Dir# DR# 114)
Inspection No. / No de l'inspection :	2019_787640_0004 (A1)(Appeal/Dir# DR# 114)
Appeal/Dir# / Appel/Dir#:	DR# 114 (A1)
Log No. / No de registre :	025945-17 (A1)(Appeal/Dir# DR# 114)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 08, 2019(A1)(Appeal/Dir# DR# 114)
Licensee / Titulaire de permis :	Parkwood Mennonite Home Inc. 726 New Hampshire Street, WATERLOO, ON, N2K-4M1
LTC Home / Foyer de SLD :	Parkwood Mennonite Home 726 New Hampshire Street, WATERLOO, ON, N2K-4M1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Elisabeth Piccinin

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 Parkwood Mennonite Home Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

(A1)(Appeal/Dir# DR# 114)
The following Order(s) have been rescinded:

Order # / Ordre no :	001	**Order Type / Genre d'ordre :**	Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

(A1)(Appeal/Dir# DR# 114)
The following Order(s) have been rescinded:

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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.
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.
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.
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.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

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 :

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 O. Reg. 79/10.

Specifically, the licensee must ensure that;

The home's policy "Falls Prevention and Management Program" and the procedures identified within the policy related to the initiation of head injury routine are complied with.

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, procedure or protocol, that the policy, procedure or protocol was complied with.

In accordance with O. Reg. 79/10, s.48, that required the licensee to ensure that the interdisciplinary programs including fall prevention, were developed and implemented in the home to include relevant policies, procedures and protocols to meet the requirements as set out in section 30.

Specifically, staff did not comply with the licensee's policy "Falls Prevention and Management Program", that directed staff to initiate head injury routine (HIR) for all

un-witnessed falls and witnessed falls that had resulted in a possible head injury or if the resident was on anticoagulant therapy according to the PMH Head Injury Routine.

Head Injury Routine template with no policy number or date of revision, directed staff to complete the BP, pulse, pupils and level of consciousness every half hour for four times, then every hour for four occurrences, every two hours for four occurrences, on Day 2 once and day 3 once for a total of 14 assessments.

Head Injury Routine template stating "Resource: adapted from Sunnybrook Post Falls Assessment Algorithm", with no date of implementation, directed staff to complete BP, pulse, pupils and level of consciousness every hour for four hours then every eight hours for the next 24 hours for a total of seven assessments.

a) Resident #001 was prescribed an anticoagulant twice daily with an initiated date in January 2017.

On an identified date in November 2017, resident #001 sustained an unwitnessed fall.

HIR form dated the same day as the fall in November 2017, was incomplete and did not include the required assessments on two occasions. HIR form dated an identified date in November 2017, was incomplete on one occasion and three occasions there were other notes in the boxes but no HIR assessments.

Resident #001 sustained an unwitness fall on an identified date in July 2018. The HIR was incomplete on three occasions.

The resident incurred 16 unwitnessed falls since their admission to the home in January 2017 to the end of December 2018.

The clinical record included HIR documentation for four of the 16 unwitnessed falls.

The DOC acknowledged that all unwitnessed falls for resident #001 required HIR based on the administration of anticoagulant therapy. They acknowledged that staff did not comply with the home's policy for 12 of 16 unwitnessed falls for this resident.

b) Resident #002 sustained unwitnessed falls on identified dates in September and October 2018 and one on an identified date in January 2019. The resident was found on the floor in various locations for all three falls. The fall that occurred in January 2019, the resident's head was resting in the foot rests of their wheelchair.

Resident #002 had been prescribed an anticoagulant on a daily basis since September 2018.

HIR form with an identified date in September 2018, was incomplete. The fifth required HIR assessment was not completed.

HIR was not initiated or completed for the falls n October and December 2018.

RPN #100 and RN #109 told the LTCH Inspector that HIR was initiated if a resident had hit their head. If the fall was unwitnessed then they do not implement HIR unless the resident stated they had hit their head or with obvious head trauma and at no other time were they required to implement HIR.

The DOC acknowledged that all unwitnessed falls for resident #002 required HIR based on the administration of anticoagulants and the home's policy had not been complied with in two of three unwitnessed falls for this resident.

c) Resident #005 sustained one unwitnessed fall in October and two in December 2018, that resulted in head injury.

HIR form dated October 2018, was incomplete. The fifth required HIR assessment was not completed.

HIR form dated December 2018, was incomplete. The sixth required assessment was not completed and the documentation space was empty, save and except for the date and time the assessment was required.

RN #108 acknowledged that two of the unwitnessed falls for resident #005 that required HIR had not been completed as per the home's policy.

The licensee failed to ensure that the home's Fall Prevention and Management policy was complied with.

The severity of this issue was determined to be level 2, minimal harm or potential for actual harm. The scope of the issue was 3, widespread. The home had a level 3 compliance history of
one or more related non-compliance in the last three full years with this section of O. Reg. 79/10 that included;
- voluntary plan of correction (VPC) issued November 8, 2017 (2017_601532_0013) (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 22, 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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 8 th day of April, 2019 (A1)(Appeal/Dir# DR# 114)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by Lynne Haves (Director) - (A1)
(Appeal/Dir# DR# 114)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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