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 le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

Bureau régional de services de Hamilton
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Téléphone: (905) 546-8294
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jun 19, 2015;	2015_240506_0004 (A2)	H-001041-14	Critical Incident System

Licensee/Titulaire de permis

THE THOMAS HEALTH CARE CORPORATION
490 Highway #8 STONEY CREEK ON L8G 1G6

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

PINE VILLA NURSING HOME
490 HIGHWAY #8 STONEY CREEK ON L8G 1G6

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

LESLEY EDWARDS (506) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

When the first amendment was completed because of the compliance date, it put the report out of order. IT has fixed this and the report needed to be amended to ensure the report is in order.

Issued on this 19 day of June 2015 (A2)

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

Original report signed by the inspector.

Ontario

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

LESLEY EDWARDS (506) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): February 24, 25 and March 3, 2015.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Resident Care, registered staff, Personal Support Workers(PSWs)and residents.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Pain

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

- **5 WN(s)**
- **2 VPC(s)**
- **1 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	Legendé 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #001 provided clear direction to staff and others who provide direct care to the resident.

A review of resident #001's plan of care indicated that the resident was to use one side rail up while in bed for safety. In another area of the plan of care it indicated that the resident was to use two side rails up while in bed. Interview with the registered staff on an identified date in February, 2015, confirmed that the resident was to use two side rails up while in bed and confirmed that the resident's plan of care did not provide clear direction to the staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in their plan.

Resident #001's plan of care directed staff to apply a chair alarm to the resident's wheelchair while up in their wheelchair. An observation of the resident on an identified date in February, 2015, confirmed that the resident did not have the chair alarm applied to their wheelchair. Interview conducted with the registered staff on an identified date in February, 2015, indicated that the resident's chair alarm was broken

and had not been replaced. During an interview with the PSW they were able to find the resident's chair alarm in working condition in a storage room and applied the chair alarm to the resident's wheelchair. The registered staff confirmed that they did not follow the resident's plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that the resident's plan of care was reviewed and revised when the resident's care needs changed.

A) Resident #001 fell on an identified date in July, 2014. The resident had an x-ray done at the home three days post fall on identified areas on resident #001's body. The same day the x-ray was completed, on the evening shift the diagnostic lab called to confirm the resident had a fracture. The physician was not informed that the resident sustained a fracture until the next day. The physician spoke with the resident's family member during morning rounds and agreed to send the resident to the hospital for assessment. The plan of care related to pain management and mobility were not reviewed and revised when the resident was diagnosed with a fracture and the resident's care needs changed.
B) Resident #001's plan of care indicated that the resident was to use a bed alarm while in bed to help mitigate the risk for falls. An observation of the resident on an identified date in February, 2014, confirmed that the resident was not using a bed alarm while in bed. Interview with the registered staff on an identified date in February, 2015, confirmed that the resident was no longer using the bed alarm for the past five or six months. The registered staff confirmed that the plan of care should have been reviewed and revised as the care set out in the resident's plan changed. [s. 6. (10) (b)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 was cared for in a manner consistent with their needs.

Resident #001 sustained a fall on an identified date in July, 2014.

i.The Resident's family was notified of the fall on an identified date in July, 2014 and the family member requested to send the resident to the hospital if needed. The family member was reminded by the nurse that the resident was now palliative and sending the resident to the hospital was not an option. The family member stated that they did not understand the meaning of palliative care and they thought it meant only for chronic condition, but not for injuries. The nurse documented that the resident was complaining of pain, however there were no typical signs of fracture as assessed. The nurse stated that they would ask the physician for an order for an x-ray and continue to monitor the resident.
ii. There was no further documentation in the resident's health record about the resident's status for 15 hours.
iii. On an identified date in July, 2014, the resident complained of pain to their family member who informed the staff of the resident's pain. The family member again approached staff about what happens when a palliative resident has an injury and if a palliative resident can be sent to the hospital for a potential fracture. The nurse told the family member that they would speak with the other nurses and clarify what was to be done when a resident is on palliative care.
iv. On an identified date in July, 2014, the physician was called to get an order for an x-ray of the identified areas of concern and was informed that the resident was complaining pain.
v. On an identified date in July, 2014, the physician was in and assessed the resident and ordered an x-ray.
vi. On an identified date in July, 2014, in the evening the lab called to confirm the resident had a fracture. vii. On an identified date in July, 2014, the resident was experiencing more pain. The physician was contacted regarding the x-ray results. The physician spoke with the family and decided to send the resident to the hospital for assessment.
viii. The physician and the family were not informed that the resident sustained a fracture until the next day, 14 hours after the home was notified of the fracture from the lab. The Administrator/Director of Resident Care confirmed that the resident was not cared for in a manner that was consistent with their needs and the physician and the family should have been notified immediately when the x-rays results were sent to the home. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are cared for in a manner consistent with their needs, to be implemented voluntarily.

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 has failed to ensure that the policy and procedure for fall prevention was complied with.

The home's policy "Resident Client Care Manual, Fall Prevention Program" (policy number RC-04-09-13B, last revised November 2011) indicated that when a resident falls the registered staff shall:
i. Complete a post fall risk assessment.
ii.Complete a post assessment tool(SPLATT).
A. During a review of resident # 001's clinical record it was noted that the resident sustained a fall on an identified date in July, 2014. It was noted that the above tasks were not completed for resident #001. The registered staff confirmed that the home's Fall Prevention Program policy was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The home's policy "Resident Client Care Manual, Activities of Daily Living: Sleep, Rest and Comfort" (policy number RC-05-01-04A, last revised December 2010) indicated that when a resident has presence of pain to complete an appropriate comprehensive pain assessment and the frequency when to complete a pain assessment is when there is a change in condition with onset of pain or when the resident/family indicate pain is present.
A. During a review of resident #001's clinical record it was noted that the resident did not receive a comprehensive pain assessment after the resident fell on an identified date in July, 2014, and had complaints of pain that were both expressed by the resident and the resident's family member. This was confirmed through record review and the Administrator/Director of Resident Care also confirmed that pain assessments were not completed at this time. [s. 8. (1) (b)]

3. The home's policy "Resident Client Care Manual, Philosophy of Care" (policy number RC-02-04-02, last revised January 2011) indicated that the resident's wishes will always take the precedence and will be reversed immediately by the Registered Nurse on request of the resident or family.
i. During a review of resident #001's clinical record the resident sustained a fall on an identified date in July, 2014, the family requested that if needed the resident be sent to the hospital for assessment. The registered staff member responded by telling the family member that the resident is palliative and sending to the hospital is not an option.
ii. On an identified dare in July, 2014, the family member then approached the nursing staff once again to clarify what happens when a palliative resident sustains a potential fracture and if the resident can be sent to the hospital for assessment. The registered staff member responded by telling the family member that they would speak to other nurses to clarify what is done under palliative care for a resident. The home was not following their policy regarding philosophy of care and this was confirmed through clinical record review. [s. 8. (1) (b)]

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 home's fall, pain and philosophy of care policy are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) According to the clinical record, resident #001 made verbal expressions of pain on identified dates in July, 2014, related to a fall. The registered staff confirmed the resident's pain was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose, when the resident's pain was not relieved. [s. 52. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's written records were kept up to date at all times.

A) Resident #001 sustained a fall on an identified date in July, 2014. During a review of the resident's clinical record it was noted that there was no documentation in the resident's clinical file to indicate that the resident was assessed post fall.[s. 231. (b)]

Issued on this 19 day of June 2015 (A2)

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : LESLEY EDWARDS (506) - (A2)

Inspection No. / No de l'inspection : 2015_240506_0004 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-001041-14 (A2)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Jun 19, 2015;(A2)

Licensee / Titulaire de permis : THE THOMAS HEALTH CARE CORPORATION
490 Highway #8, STONEY CREEK, ON, L8G-1G6

LTC Home / Foyer de SLD : PINE VILLA NURSING HOME
490 HIGHWAY #8, STONEY CREEK, ON, L8G-1G6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : LISA PALADINO

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

To THE THOMAS HEALTH CARE CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 shall ensure that when resident care needs change, including resident # 001, the residents are reassessed and the plan of care is reviewed and revised.
1. The home is to educate registered staff on the requirement of reviewing and revising all residents plans of care when the residents care needs change.
2. The home is to develop and implement an audit system to ensure that all residents plans of care are reviewed and revised for accuracy.

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

Grounds / Motifs :

(A1)
1. S. 6 (10) b was previously issued as a VPC on June 17, 2014.

The licensee has failed to ensure that the resident s plan of care was reviewed and revised when the resident s care needs changed.

Aug 24/15 A) Resident #001 fell on July [redacted] 2014, at 1840 hours. The resident had an x-ray done at the home on July [redacted] 2014, to their right hip and right knee. On July [redacted] 2014, at 2221 hours the diagnostic lab called to confirm the resident had a fracture of their right hip. The physician was not informed that the resident sustained a fracture of their right hip until July [redacted] 2014, at 1205 hours. The physician spoke with the resident's daughter on July [redacted] 2014, during morning rounds and agreed to send the resident to the hospital for assessment. The plan of care related to pain management and mobility were not reviewed and revised when the resident was diagnosed with a fractured hip and the resident s care needs changed.
B) Resident #001's plan of care indicated that the resident was to use a bed alarm while in bed to help mitigate the risk for falls. An observation of the resident on February 24, 2014, confirmed that the resident was not using a bed alarm while in bed. Interview with the registered staff on February 24, 2015, confirmed that the resident was no longer using the bed alarm for the past five or six months. The registered staff confirmed that the plan of care should have been reviewed and revised as the care set out in the resident's plan changed. (506)

Aug 24/15

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

Apr 24, 2015(A1)

dates removed for the purpose of publication
Aug 24/15

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l’envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l’envoi. Si le titulaire de permis ne reçoit pas d’avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l’ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l’expiration du délai de 28 jours.

En vertu de l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d’interjeter appel, auprès de la Commission d’appel et de révision des services de santé, de la décision rendue par le directeur au sujet d’une demande de réexamen d’un ordre ou d’ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l’avis de décision du directeur, faire parvenir un avis d’appel écrit aux deux endroits suivants :

À l’attention du registraire
Commission d’appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l’amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d’appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d’appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 19 day of June 2015 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : LESLEY EDWARDS - (A2)

Service Area Office /
Bureau régional de services : Hamilton