Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Aug 19, 2020	2020_633577_0016 (A1)	005134-20	Critical Incident System

Licensee/Titulaire de permis

Board of Management of the District of Kenora
1220 Valley Drive KENORA ON P9N 2W7

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

Princess Court
Princess Street Box 725 DRYDEN ON P8N 2Z4

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

Amended by DEBBIE WARPULA (577) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Compliance date changed to September 29, 2020

Issued on this 19th day of August, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Aug 19, 2020	2020_633577_0016 (A1)	005134-20	Critical Incident System

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Board of Management of the District of Kenora
1220 Valley Drive KENORA ON P9N 2W7

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

Princess Court
Princess Street Box 725 DRYDEN ON P8N 2Z4

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

Amended by DEBBIE WARPULA (577) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 10-13, 2020

The following intake was inspected during this Critical Incident System (CIS) Inspection:

- One Log related to a resident fall.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Medical Director, Resident Assessment Instrument (RAI) Coordinator, Registered Nurse (RN), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs).

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and one policy and procedure.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) A Critical Incident System (CIS) report was received by the Director on an identified date, related to resident #001 who had an unwitnessed fall and suffered an injury.

A review of the home's policy, "Fall's Prevention Procedure - NUR -PR -145" revised July 2018, indicated that post fall, staff were required to document a 'Falls Investigation report', which included a 'Fall's Risk Assessment'; document a progress note incident of falls (PN-IF) which described the fall; a neurological vital sign record was to be initiated for all unwitnessed falls and witnessed falls that resulted in a possible head injury or if the resident was on anticoagulant therapy; neuro checks and vitals were required every hour for four hours, then every four hours for 24 hours (hrs); the resident was to be assessed and a progress note with a focus of falls was to be documented for the following four shifts.

During a record review, Inspector #577 found that resident #001 had four subsequent falls, as follows:

on an identified date -an unwitnessed fall occurred; a particular assessment was not documented; a progress note with a specific focus was not documented for the following number of shifts;
on the following day -an unwitnessed fall occurred; a particular assessment was not documented; a progress note with a specific focus was not documented for the following number of shifts;
two days later -two witnessed falls occurred; a specific report was not documented for the second fall; a progress note with a specific focus was not documented for the following number of shifts; and
on another identified date -an unwitnessed fall with a specific injury occurred; a particular assessment was initiated but not completed over a specified time period; a progress note with a specific focus was not documented for the following number of shifts.

b) During a record review, Inspector #577 found that resident #002 had two unwitnessed falls on two identified dates. A particular assessment was not documented and a progress note with a specific focus was not documented for the following number of shifts for both falls.

c) During a record review, Inspector #577 found that resident #003 had a witnessed fall on an identified date. A progress note with a specific focus was not documented for the following number of shifts.

During an interview with RN #100, they advised that a specific report was initiated after a resident fall; a progress note and a PN-IF was documented and a particular assessment was initiated if the resident suffered a specified injury or for suspicion of a specified injury; they further advised that they would document follow up notes if there was an injury.

During an interview with RPN #101, they advised that they would initiate a specific report and a progress note after a fall. Additionally, they would initiate a particular assessment if the resident suffered a specified injury or for suspicion of a specified injury. They further advised that they were required to document the fall in the 24hr report book as a reminder for staff to monitor the resident for the following number of days.

The Resident Assessment Instrument (RAI) Coordinator and Inspector #577 together reviewed the progress notes for resident #001, #002 and #003. They confirmed that there were no follow up falls notes for resident #001, #002 and

#003. They confirmed that staff were required to have documented a series of falls follow up progress notes, and was unclear on the required frequency.

The Assistant Director of Care (ADOC) and Inspector #577 together reviewed the progress notes for resident #001, #002 and #003. They confirmed that staff had not implemented the home's Fall's program as there were no falls notes for any of the subsequent number of shifts after the resident falls; they confirmed that there should have been a second specified report for resident #001 and a particular assessment was not completed as required when they had a specified injury. The inspector and the ADOC discussed the Fall's policy which indicated that a particular assessment record was to be initiated for all unwitnessed falls and witnessed falls that resulted in a possible specified injury. They advised that a particular assessment was to be completed only for possible specified injuries, not for all unwitnessed falls, and it was not their practice and they had never done the particular assessments for unwitnessed falls. Additionally, they advised that they allowed the registered staff to decide whether there was a possible specified injury that would have required a particular routine and stated that there was more risk in waking a resident up during the night to continue a particular routine. [s. 48. (1) 1.]

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 / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

Issued on this 19th day of August, 2020 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DEBBIE WARPULA (577) - (A1)
Inspection No. / No de l'inspection :	2020_633577_0016 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	005134-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 19, 2020(A1)
Licensee / Titulaire de permis :	Board of Management of the District of Kenora 1220 Valley Drive, KENORA, ON, P9N-2W7
LTC Home / Foyer de SLD :	Princess Court Princess Street, Box 725, DRYDEN, ON, P8N-2Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Patrick Berrey

To Board of Management of the District of Kenora, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

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

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

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

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee must be in compliance with Ontario Regulation (O. Reg.) 79/10,

r. 48(1)1
Specifically the licensee must:

a) Re-train all registered staff member's on the home's policy, “"Fall's Prevention Procedure - NUR -PR -145”, ensuring that post fall, a progress note is documented for the next four shifts, and the “Neurological Vital Sign Record”, is included.
b) The home will maintain a record of the retraining, what the training entailed, who completed the training and when the training was completed.
c) Conduct a knowledge audit of their staff's understanding of falls management best practices and policy/program.
d) Revise the home's Fall's Program/procedure, to ensure that it is congruent with Best Practices related to falls and post fall assessments, specifically related to unwitnessed falls and neurological assessments.

Grounds / Motifs :

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

a) A Critical Incident System (CIS) report was received by the Director on an identified date, related to resident #001 who had an unwitnessed fall and suffered an injury.

A review of the home's policy, "Fall's Prevention Procedure - NUR -PR -145" revised July 2018, indicated that post fall, staff were required to document a 'Falls Investigation report', which included a 'Fall's Risk Assessment'; document a progress note incident of falls (PN-IF) which described the fall; a neurological vital sign record was to be initiated for all unwitnessed falls and witnessed falls that resulted in a possible head injury or if the resident was on anticoagulant therapy; neuro checks and vitals were required every hour for four hours, then every four hours for 24 hours (hrs); the resident was to be assessed and a progress note with a focus of falls was to be documented for the following four shifts.

During a record review, Inspector #577 found that resident #001 had four

subsequent falls, as follows:

on an identified date -an unwitnessed fall occurred; a particular assessment was not documented; a progress note with a specific focus was not documented for the following number of shifts;
on the following day -an unwitnessed fall occurred; a particular assessment was not documented; a progress note with a specific focus was not documented for the following number of shifts;
two days later -two witnessed falls occurred; a specific report was not documented for the second fall; a progress note with a specific focus was not documented for the following number of shifts; and
on another identified date -an unwitnessed fall with a specific injury occurred; a particular assessment was initiated but not completed over a specified time period; a progress note with a specific focus was not documented for the following number of shifts.

b) During a record review, Inspector #577 found that resident #002 had two unwitnessed falls on two identified dates. A particular assessment was not documented and a progress note with a specific focus was not documented for the following number of shifts for both falls.

c) During a record review, Inspector #577 found that resident #003 had a witnessed fall on an identified date. A progress note with a specific focus was not documented for the following number of shifts.

During an interview with RN #100, they advised that a specific report was initiated after a resident fall; a progress note and a PN-IF was documented and a particular assessment was initiated if the resident suffered a specified injury or for suspicion of a specified injury; they further advised that they would document follow up notes if there was an injury.

During an interview with RPN #101, they advised that they would initiate a specific report and a progress note after a fall. Additionally, they would initiate a particular assessment if the resident suffered a specified injury or for suspicion of a specified injury. They further advised that they were required to document the fall in the 24hr report book as a reminder for staff to monitor the resident for the following number of days.

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

The Resident Assessment Instrument (RAI) Coordinator and Inspector #577 together reviewed the progress notes for resident #001, #002 and #003. They confirmed that there were no follow up falls notes for resident #001, #002 and #003. They confirmed that staff were required to have documented a series of falls follow up progress notes, and was unclear on the required frequency.

The Assistant Director of Care (ADOC) and Inspector #577 together reviewed the progress notes for resident #001, #002 and #003. They confirmed that staff had not implemented the home’s Fall’s program as there were no falls notes for any of the subsequent number of shifts after the resident falls; they confirmed that there should have been a second specified report for resident #001 and a particular assessment was not completed as required when they had a specified injury. The inspector and the ADOC discussed the Fall’s policy which indicated that a particular assessment record was to be initiated for all unwitnessed falls and witnessed falls that resulted in a possible specified injury. They advised that a particular assessment was to be completed only for possible specified injuries, not for all unwitnessed falls, and it was not their practice and they had never done the particular assessments for unwitnessed falls. Additionally, they advised that they allowed the registered staff to decide whether there was a possible specified injury that would have required a particular routine and stated that there was more risk in waking a resident up during the night to continue a particular routine. [s. 48. (1) 1.]

The decision to issue a Compliance Order (CO) was based on the severity which indicated minimal harm or risk, and the scope which was widespread. The home's compliance history identified a history of unrelated non-compliance. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 29, 2020(A1)

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 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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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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 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 19th day of August, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by DEBBIE WARPULA (577) - (A1)

Ontario

Ministry of Long-Term Care

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

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