Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 30, 2019	2019_800532_0012	009991-19, 009992-19, 015574-19, 017259-19	Critical Incident System

Licensee/Titulaire de permis

Sharon Farms & Enterprises Limited
108 Jensen Road LONDON ON N5V 5A4

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

Strathcona Long Term Care
720 Princess Street MOUNT FOREST ON N0G 2L3

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

NUZHAT UDDIN (532)

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): September 16-20, 22-24, 29, 30, and October 1, 2019.

The following intakes were completed in this Critical Incident (CI) inspection:

Log #015574-19, CI #1002-000017-19, related to falls prevention.

Log #009991-19, Follow-up to CO #001 from inspection #2019_755728_0006, related to abuse policy;

Log #009992-19-Follow-up to CO#002 from inspection #2019_755728_0006, related to training.

During the course of the inspection, the inspector(s) spoke with the Administrator, Co-Director of Cares (DOCs), Administrative Assistants, Clinical Nurse, Resident Assessment Instrument (RAI) Coordinator, Behavioural Support Ontario (BSO) Lead, Registered Nurses (RN), Registered Practical Nurses, (RPN), Personal Support Workers (PSW), residents and family members.

The inspectors also toured resident home areas, observed resident care provision, resident staff interaction, reviewed relevant residents' clinical records, relevant policies and procedures pertaining to the inspection.

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

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **5 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #001	2019_755728_0006	532
LTCHA, 2007 S.O. 2007, c.8 s. 76. (1)	CO #002	2019_755728_0006	532

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. 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 has failed to ensure that when the identified 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) An identified resident was observed complaining of pain.

Progress notes for the resident documented that the resident's pain was not relieved by initial interventions and they continued to complain of pain for an identified period of time.

A PSW indicated that the resident's pain had worsened over the past several weeks.

An identified RPN shared that the resident was experiencing pain on a regular basis for the past several weeks. They indicated that the resident was receiving analgesics as needed for pain. The RPN acknowledged that there was no pain assessment completed since the resident's admission, despite signs the resident was in pain.

The RAI Coordinator and DOC both acknowledged that a pain assessment and a pain screening was not done for the resident even though they had high pain scores and pain was not relieved by initial interventions.

b) Record review indicated that an identified resident sustained a number of falls.

Progress notes indicated that the resident complained of pain after one of the falls and increased behaviours were noted.

A clinical note stated that the resident was assessed by the BSO PSW concerning a recent increase in responsive behaviours and it was noted that this behaviour worsened after the resident's fall. The resident admitted to having pain.

The clinical record showed that the last pain assessment was done on admission and there was no pain assessment completed since.

During an interview with resident they nodded "yes" when asked about pain.

A PSW reported that the resident verbalized pain and expressed facial grimacing.

The Resident Assessment Coordinator stated that there was no pain assessment done

for the resident.

The licensee has failed to ensure that when the identified resident's pain was not relieved by initial interventions; the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not charged for falls prevention equipment that the licensee was required to provide to residents using funding that the licensee received from the local health integration network and or the Minister, for falls prevention.

A Critical incident was submitted to the MLTC, which reported that an identified resident sustained a fall with injury. The CI stated that the resident was to be assessed for falls prevention equipment if the substitute decision maker (SDM) agreed.

The DOC stated that the family purchased the falls prevention equipment and the home ordered them.

The Falls Lead / RN provided a list of four other residents in the home that had falls prevention equipment that was purchased by their respective SDMs.

The Falls Lead / RN reviewed the falls intervention risk management policy and the protocol for the falls prevention equipment and stated that the identified resident was a candidate for falls prevention equipment but since the equipment was not available in the home, a referral would be made for the resident to be assessed. They shared that the falls prevention equipment were part of the falls program, but they asked family to cover the cost.

The DOC confirmed that the list of four residents was accurate and that their current practice was to charge residents for this particular equipment, acknowledging they were part of the fall prevention program.

The licensee has failed to ensure that a resident was not charged for goods and services that the licensee was required to provide to a resident using funding that the licensee received from the local health integration network and or the Minister, for falls prevention. [s. 245. 1.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 has failed to ensure that when the identified residents were being reassessed and the plan of care revised when care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care in relation to falls.

a) A CI was submitted to the Ministry of Long Term Care (MLTC), which reported that an identified resident sustained a fall with injury.

The post fall assessment documented that the resident had sustained an identified number of falls with injury prior to this reported fall. The fall risk assessment indicated that the resident was at risk of falls.

The Falls Interventions Risk Management (FIRM) Implementation policy stated that the prevention strategies should be in place to meet the needs as per Resident Plan of Care. These strategies, critical for preventing fall incidents, would include, but were not limited to, the fall interventions Risk Management Strategies. Under Plan of Care the policy stated that the plan of care must reflect the resident focused goals for the prevention and or minimization of falls, intervention descriptions would include strategies in place to prevent falls.

The plan of care for the resident indicated that the plan had not been revised, and different approaches were not considered in the revision of the plan of care after the falls.

The CO-DOC acknowledged that the plan of care was only reviewed and revised after the identified fall that resulted in an injury and acknowledged that different approaches were not considered after the previous falls to prevent further falls and or injuries.

b) Post fall assessment reports documented that an identified resident had a specified number of falls in a particular month.

The fall risk assessment stated that the resident was at risk of falls.

A review of the plan of care outlined specified interventions for falls prevention.

An identified RPN indicated that these recent falls for the resident were related to the resident's diagnosis and pain. The RPN said that the plan of care had not been reviewed and revised to include new strategies after a number of identified falls. The RPN acknowledged that different approaches were not discussed or trialed for this resident.

The DOC was made aware of the strategies that were discussed with the identified RPN, but they were not implemented. The DOC acknowledged that the plan of care had not been updated with new approaches to care.

The licensee has failed to ensure that the identified residents were reassessed and the plan of care revised when care set out in the plan had not been effective, and that different approaches were considered in the revision of the plan of care. [s. 6. (11) (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 residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: 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 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 the policy was complied with.

In accordance with O. Reg. 79/10, s. 48(1) and in reference to s. 52 (2) the licensee was required to have a pain management program that provided for 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.

Specifically, the licensee's "Pain Management" policy (PM-N-20), effective date January 2018, stated under pain assessment:
Collaborate with resident/SDM family and interdisciplinary team to conduct a full pain assessment utilizing a clinically appropriate instrument, following a three-day pain screening where pain was identified.

The policy directed registered staff to conduct a full pain assessment utilizing a clinically appropriate instrument following a three-day pain screening where pain was identified.

Record review indicated that an identified resident complained of pain and an increase in the resident's behaviours was noted.

The clinical record showed that a pain screening was initiated on an identified date for 14 days rather than three days and no pain assessment was done following a three-day pain screening as stated in the policy.

The RAI Coordinator and the DOC acknowledged that a pain screening was completed for 14 days and a pain assessment was done following the 14 day pain screening.

The licensee failed to ensure that the pain policy PM-N-20, was complied with when the licensee completed a pain screening for 14 days rather than three days and no pain assessment was done following a three-day pain screening as stated in the policy. [s. 8. (1) (a),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 pain policy, is in compliance with and is implemented in accordance with applicable requirements under the Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that an identified resident was protected from abuse by another identified resident.

As per O. Reg 79/10 s.5 "physical abuse" means subject to subsection (2), the use of physical force by a resident that causes physical injury to another resident.

This inspection was completed as a follow up to Compliance Order (CO) #001 from inspection #2019_755728_0006 issued on April 16, 2019, related to policy to promote zero tolerance of abuse.

Progress notes indicated that an identified resident had a specified diagnosis and a history of responsive behaviours.

The Behavioural Support Ontario (BSO) PSW indicated that they reviewed the resident's clinical notes and noted that the resident had BSO interventions already in place.

A critical incident (CI) was submitted to the Ministry of Long-Term Care (MLTC) which stated that there was a resident to resident altercation that resulted in an injury to another identified resident.

The RPN acknowledged that the identified resident was injured by another identified resident.

The licensee has failed to ensure that an identified resident was protected from abuse by another identified resident. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that licensee shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The DOC provided the pain program evaluation and the falls program evaluation dated December 2018.

The evaluation was based on a pain and a fall inspection protocol; however, it did not include a summary of the changes made and the dates that those changes were implemented. This was confirmed with the DOC.

The licensee has failed to ensure that a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

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 a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when an identified resident has fallen, the resident was assessed and, if required, a post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The clinical record indicated that an identified resident was at risk of falls. The risk management report indicated that the resident had a fall on a specified date. A review of the post fall assessment showed that only the vitals signs were completed in the post fall assessment and the rest of the assessment was incomplete.

In an interview, the SDM stated that the resident sustained a fall and the resident had identified pain post fall.

The DOC acknowledged that the post fall assessment was incomplete and reassured that they had asked the registered staff to complete it.

The licensee has failed to ensure that when the identified resident has fallen, the resident was assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were provided training in pain management, including recognition of specific and non-specific signs of pain.

LTCHA, C.8, s. 76. (7) states that every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 1. Abuse recognition and prevention. 2. Mental health issues, including caring for persons with dementia. 3. Behaviour management. 4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 5. Palliative care. 6. Any other areas provided for in the regulations.

The ED provided Surge learning training records in relation to the pain program for 2018, and the following was noted:

-57 percent of registered staff did not complete the training on pain assessment and management.

- 20 percent of direct care staff did not complete the training.

The DOC acknowledged that the training on pain management was not completed by all staff for the year 2018.

The licensee has failed to ensure that direct care staff were provided training in pain management, including recognition of specific and non-specific signs of pain. [s. 221. (1) 4.]

Issued on this 12th day of November, 2019

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2019_800532_0012
Log No. / No de registre :	009991-19, 009992-19, 015574-19, 017259-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 30, 2019
Licensee / Titulaire de permis :	Sharon Farms & Enterprises Limited 108 Jensen Road, LONDON, ON, N5V-5A4
LTC Home / Foyer de SLD :	Strathcona Long Term Care 720 Princess Street, MOUNT FOREST, ON, N0G-2L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cate MacLean

To Sharon Farms & Enterprises Limited, 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 :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 52 (2).

Specifically the licensee must ensure that:

a) 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.
b) There is a communication tool developed and implemented between the PSWs and the registered staff when verbal and non-verbal residents exhibit pain and responsive behaviours.
c) The physician-nurse communication tool that is currently in place is used by the registered staff to communicate to the physician, residents' verbal and non-verbal signs and symptoms of pain.
d) Training is provided to the registered staff of the home related to the home's pain policy, specifically recognizing, assessing, documenting and evaluating pain.
e) All staff sign off on the completed training and records are kept in the home.

Grounds / Motifs :

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

An identified resident was observed complaining of pain.

Progress notes for the resident documented that the resident's pain was not

relieved by initial interventions and they continued to complain of pain for an identified period of time.

A PSW indicated that the resident's pain had worsened over the past several weeks.

An identified RPN shared that the resident was experiencing pain on a regular basis for the past several weeks. They indicated that the resident was receiving analgesics as needed for pain. The RPN acknowledged that there was no pain assessment completed since the resident's admission, despite signs the resident was in pain.

The RAI Coordinator and DOC both acknowledged that a pain assessment and a pain screening was not done for the resident even though they had high pain scores and pain was not relieved by initial interventions.

(532)

2. Record review indicated that an identified resident sustained a number of falls.

Progress notes indicated that the resident complained of pain after one of the falls and increased behaviours were noted.

A clinical note stated that the resident was assessed by the BSO PSW concerning a recent increase in responsive behaviours and it was noted that this behaviour worsened after the resident's fall. The resident admitted to having pain.

The clinical record showed that the last pain assessment was done on admission and there was no pain assessment completed since.

During an interview with resident they nodded "yes" when asked about pain.

A PSW reported that the resident verbalized pain and expressed facial grimacing.

The Resident Assessment Coordinator stated that there was no pain assessment done for the resident.

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

The scope of this issue was a level 2 pattern. The severity of the issue was determined to be a level 2, minimal harm or minimal risk. The home has a level 2 history previous non-compliance to a different subsection. (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 06, 2020

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 245. The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act.
O. Reg. 79/10, s. 245.

Order / Ordre :

The licensee must be compliant with s. 245. of the Ontario Regulations 79/10.

Specifically, the licensee must ensure that residents are not charged for falls prevention equipment that the licensee was required to provide to the residents using funding that the licensee received from the Local Health Integration Network (LHIN) or accommodation charges received under the LTCHA.

The licensee must ensure:
a) The Long Term Care Home stops charging the identified residents and any other resident requiring falls prevention equipment;
b) Residents/Substitute Decision Makers (SDM) are made aware of the fall's prevention equipment available to them at no cost; and
c) An audit is conducted of all residents who lived in the home during 2019 to determine if they had used or are using falls prevention equipment that was provided by the resident/representative. The licensee shall reimburse all expenses incurred by the resident/representative in 2019, for the full cost of the equipment used.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was not charged for the hip protectors that the licensee was required to provide to a resident using funding

that the licensee received from the local health integration network and or the Minister, for falls prevention.

A Critical incident was submitted to the MLTC, which reported that an identified resident sustained a fall with injury. The CI stated that the resident was to be assessed for falls prevention equipment if the substitute decision maker (SDM) agreed.

The DOC stated that the family purchased the falls prevention equipment and the home ordered them.

The Falls Lead / RN provided a list of four other residents in the home that had falls prevention equipment that was purchased by their respective SDMs.

The Falls Lead / RN reviewed the falls intervention risk management policy and the protocol for the falls prevention equipment and stated that the identified resident was a candidate for falls prevention equipment but since the equipment was not available in the home, a referral would be made for the resident to be assessed. They shared that the falls prevention equipment were part of the falls program, but they asked family to cover the cost.

The DOC confirmed that the list of four residents was accurate and that their current practice was to charge residents for this particular equipment, acknowledging they were part of the fall prevention program.

The licensee has failed to ensure that a resident was not charged for goods and services that the licensee was required to provide to a resident using funding that the licensee received from the local health integration network and or the Minister, for falls prevention.

The scope of this issue was a level 3 widespread. The severity of the issue was determined to be a level 2, minimal harm or minimal risk. The home has a level 2 history previous non-compliance to a different subsection. (532)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 06, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 30th day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

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