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

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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
Jun 02, 2020	2020_626501_0003 (A2)	022698-19, 000218-20, 001836-20	Critical Incident System

Licensee/Titulaire de permis

Shepherd Village Inc.
3758/3760 Sheppard Avenue East TORONTO ON M1T 3K9

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

Shepherd Lodge
3760 Sheppard Avenue East TORONTO ON M1T 3K9

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

Amended by SUSAN SEMEREDY (501) - (A2)

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

Extension of compliance due date related to COVID-19.

Issued on this 2 nd day of June, 2020 (A2)

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

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

Amended by SUSAN SEMEREDY (501) - (A2)

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): January 31, 2019, February 3, 4, 5, 6, 7, 10, 11, 12, 2020. An off-site interview was conducted February 14, 2020.

The following intakes were inspected during this inspection, both related to falls prevention and management:

Log #022698-19

Log #000218-20

PLEASE NOTE: A Written Notification and Compliance Order related to O.Reg. 79/10 s.8(1)(b), identified in a concurrent inspection #2020_838760_0004 (Log # 022454-19 and #001518-20) were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Quality Compliance Manager (QCM), Associate Director of Care (ADOC), nurse managers (NM), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), registered dietitian (RD), physiotherapist (PT), physiotherapy assistant (PTA), nursing rehabilitation coordinator (NRC), residents, and substitute decision-makers (SDM).

During the course of inspection, the inspectors(s) conducted observations of staff and resident interactions and the provision of care, reviewed health records, investigation notes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Pain
Responsive Behaviours

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

6 WN(s)
5 VPC(s)
2 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. 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 system, the system was complied with.

In accordance with O.Reg. 79/10, s. 48(1), the licensee was required to ensure that that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented.

Specifically, staff did not comply with the licensee's policy titled "Falls Prevention and Management", #NURS-13-7, effective July 1, 2019, which was part of the licensee's fall prevention and management program. The policy indicates that a registered staff (registered nurse or registered practical nurse) will ensure the resident is not moved prior to completing a preliminary assessment.

The home submitted a CIS report regarding resident #002 having a fall and sustaining injuries. According to the CIS report, resident #002 had a prior fall 10 days previously and also sustained an injury.

A review of resident #002's progress notes indicated that PSW #110 reported resident #002 had a fall and the RPN was notified approximately 50 minutes after the fall. The note indicated two staff helped the resident get up a walk to their room. RPN #114 assessed the resident and sent the resident to the hospital.

An interview with PSW #110 indicated that after resident #002 fell they went to get RPN #114 but they were on break and when they tried to call the nurse manager, they could not get through. According to PSW #110, they and PSW #111 got resident #002 up, took them across to their room by holding the resident on each

side. PSW #110 stated they noticed an injury. As well, the PSW indicated they did not want to leave resident #002 on the floor because they did not know when the RPN would be back.

An interview with RPN #114 indicated they were informed by PSW #110 that resident #002 had a fall after returning to the unit. RPN #114 stated they assessed the resident in bed and noted that the resident had an injury. The RPN indicated that it was not normal practice for PSWs to move residents before they were assessed by registered staff.

In separate interviews, NM #105 and QCM #106 indicated that in the above situation, the PSWs should not have moved resident #002 before they were assessed by registered staff and confirmed that the PSWs did not follow the home's falls prevention and management policy. [s. 8. (1) (b)]

2. A complaint was made to the MLTC related to the length of time that it took registered staff members to assess resident #010 after they had a fall.

A review of resident #010's progress notes indicated RPN #112 came back from their break and was informed by PSW staff that the resident had a fall. According to this documentation the RPN assessed the resident approximately 25 minutes after the fall.

An interview with a family member of resident #010 who was there at the time of the fall, indicated PSW staff told them a registered nurse was unavailable to assess the resident as they were on break. Resident #010 got themselves up without waiting and the unit nurse assessed the resident in bed after returning from their break.

An interview with RPN #112 indicated they were not contacted immediately by the PSW's who first attended to resident #010 after their fall but were made aware of the fall after they came back from break. RN Float #119 and NM #118 both indicated during separate interviews that they had not been informed of resident #010's fall that shift and could not recall assessing the resident.

An interview with ADOC #107 indicated the home's expectation is for registered staff to be informed immediately after a resident has fallen and if the unit nurse is unavailable, the staff are to contact the float RN or NM. The ADOC confirmed staff failed to follow the home's falls prevention and management policy related to this

incident. [s. 8. (1) (b)]

3. 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 system, the system was complied with.

In accordance with O.Reg. 79/10, s. 48(1), the licensee was required to ensure that that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented.

Specifically, staff did not comply with the licensee's policy titled "Falls Prevention and Management", #NURS-13-7, effective July 1, 2019, which indicates that interventions/strategies to reduce risks of falls include the implementation of monitoring devices such as alarms

The MLTC received a CIS report related to resident #004, who sustained a fall with injury that resulted in the resident being hospitalized.

A record review of progress notes for resident #004 indicated they were found by staff in their room and sustained a fall with injury. Staff members responded to the situation and emergency services transferred to resident to the hospital. The resident received treatment at the hospital and was readmitted to the home.

A record review of the home's investigation notes indicated a family member of another co-resident first noticed resident #004 sustained a fall and immediately got assistance from the staff. The family member stated in their interview during the home's investigation that they believed resident #004 required a fall prevention monitoring device as they had seen resident #004 fall in the past.

A record review of PT #120's assessment completed prior to resident #004's fall indicated the resident had a risk for falls and required greater assistance with activities of daily living. During this assessment, the resident and staff members indicated the resident was having a decline in their abilities and required the use of a mobility device.

An interview with PT #120 indicated resident #004 was known to attempt to be independent with activities of daily living and had a fall prevention monitoring device while recumbent however, such a device would have been beneficial for their mobility device as well.

An interview with resident #004's SDM indicated that the resident required assistance with their mobility due to their physical condition. The SDM indicated that resident #004 does not always call for assistance, when needed.

RPN #102 and RPN #124 both stated in their interview resident #004 had a history of not asking for assistance along with identified responsive behaviours. RPN #102 and PSW #109 stated resident #004 would have benefitted from an additional a fall prevention monitoring device prior to their fall.

An interview with ADOC #107 indicated that given resident #004's history, it would have been beneficial for resident #004, to have received an additional fall prevention monitoring device prior to their fall. [s. 8. (1) (b)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care.

The home submitted a CIS report regarding resident #002 having two falls with injury within a two-week time frame requiring hospitalization.

A review of resident #002's progress reports indicated that after the resident's return from the hospital after their first fall, a registered nurse (RN) received a call from the physiotherapist stating the resident was exhibiting pain. The RN called physician #122 and received an order for a pain medication to be administered as needed. Review of the order written on the prescriber order sheet indicated that if the above-mentioned pain medication was not working to call the physician.

A review of resident #002's progress notes for two weeks after the resident returned from the hospital, they were exhibiting signs and symptoms of pain. Registered staff were administering as needed pain and anti-psychotic medication regularly.

During an interview with RPN #127 who is the lead for the pain and palliative program in the home, they reviewed resident #002's progress notes during the above-mentioned time period and indicated that the resident's pain was not well managed. The RPN indicated that a routine pain medication, as well as, an as needed one could have been considered. According to RPN #127, registered staff

should have called the physician.

An interview with the day shift full time RPN #102 indicated they did not go on rounds with the physician during the above mentioned time period. An interview with part time RPN #125 indicated they did go on rounds with the physician during this time period and did not recall informing the physician about resident #002's signs and symptoms of pain mostly due to the fact they were unaware of the resident's condition.

An interview with physician #122 indicated that they were not informed of resident #002's signs and symptoms of pain and stated that it was important for staff to watch for these as resident #002 often was unable to verbally express their pain. The physician stated that if they had been aware of the situation, they could have made the pain medication a regular order.

An interview with quality compliance manager #106 confirmed resident #002's pain was not well managed during the above-mentioned time period and would have expected the registered staff to inform the physician of this. [s. 6. (4) (b)]

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

A review of resident #007's plan of care identified the resident had cognitive impairment and responsive behaviours. Interventions to respond to the resident's responsive behaviours included using specified techniques.

According to progress notes and interviews with PSWs #110 and #111, resident #007 followed the PSWs and a co-resident to a room and tried to enter forcefully. A PSW attempted to prevent the resident from entering by physical means which is when the resident fell. The PSWs admitted they should have used other techniques to deter resident #007 from following them and entering the room.

In separate interviews nurse manager (NM) #105 and QCM #106 indicated that in the above situation, the PSWs did not respond appropriately and confirmed that they did not provide the care as specified in the resident's plan of care.
[s. 6. (7)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care included an interdisciplinary assessment with respect to the resident's mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

The home submitted a CIS report regarding resident #002 having two falls with injury within a two-week time frame.

A review of resident #002's plan of care indicated the resident had cognitive impairment and responsive behaviours. Some interventions to address these behaviours were included.

A review of progress notes for several months previous to resident #002's falls with injuries indicated resident #002 was documented having a specified responsive behaviour after being triggered at an identified time during the day.

An interview with full-time RPN #124 indicated resident #002 often goes looking for their family member after they visit and then has responsive behaviours. An interview with BSO RPN #125 indicated resident #002 was known to have responsive behaviours mostly all day but especially at an identified time of the day when the family member would leave. RPN #124 stated they thought the family member was a trigger for resident #002's responsive behaviours.

An interview with QCM #106 who is also the lead for the responsive behaviour program in the home, indicated they were aware resident #002 had previous incidents of responsive behaviours which involved their family member but was unaware the family member was a trigger and that the responsive behaviours were becoming a problem again.

The QCM confirmed that the plan of care did not indicate there was an interdisciplinary assessment with respect to resident #002's mood and behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day. [s. 26. (3) 5.]

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 plan of care includes an interdisciplinary assessment with respect to the resident's mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #002.

The home submitted a CIS report regarding resident #002 having two falls with injury within a two-week time frame.

Review of resident #002's progress notes indicated that an incident occurred between the above-mentioned falls when the resident was found on the floor having placed themselves there in order to get to the toilet. Progress notes indicated RPN #128, PSW #128 and #129 pulled the resident across the floor with a pad and attempted to use a device to transfer the resident back to bed. The device was not functioning properly, so the staff members raised the bed and lowered the resident.

Interviews were conducted with the above-mentioned staff members each of whom had different versions of the incident. RPN #128 indicated PSWs at first used an improper device to assist the resident and when they were the using the appropriate device it was not working properly. PSW #129 indicated they only used the appropriate device, but it was not working properly. PSW #130 indicated they could not recall if any device was used to assist resident #002.

An interview with QCM #106 stated they were unaware of the circumstances of the above incident but would look into it. An off-site follow up interview with the manager indicated an investigation into the incident was conducted and they confirmed the above mentioned staff members did not use safe transferring techniques and devices to assist resident #002. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

The home submitted a CIS report regarding resident #002 having two falls with injury within a two-week time frame.

A review of resident #002's progress notes indicated PT #120 was going to email the nursing rehabilitation coordinator (NRC) regarding a schedule to maintain continence. A review of resident #002's most current plan of care indicated this schedule was not implemented until approximately two weeks after resident #002's second fall.

A further review of resident #002's progress notes indicated the resident was attempting to get out of bed and self-toilet on most days before their second fall. The resident sustained an additional fall with no injuries during this time in an attempt to self-toilet.

An interview with PT #120 indicated the home often considers implementing a schedule to maintain continence as a fall prevention measure. According to the PT, resident #002 would have benefitted from being toileted regularly to prevent them from falling.

An interview with NRC #127 indicated that they received an email from PT #120 regarding initiating a continence schedule for resident #002 after sustaining their first fall. According to the NRC, a three-day record was initiated the same day however, when reviewed a few days later it was incomplete. The NRC also stated they were not working for a period of time afterwards and when they returned spoke with direct care staff and implemented a schedule after resident #002's second fall.

In separate interviews, NM #105 and QCM #106 indicated a schedule to maintain continence should have been completed when resident #002 returned from the hospital after their first fall when they needed assistance from staff to manage and maintain continence. [s. 51. (2) (c)]

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 each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital that resulted in a significant change in the resident's health condition no later than three business days after the occurrence of the incident.

The home submitted a critical incident system (CIS) report regarding resident #002 having a fall and sustaining injury. According to the CIS report, resident #002 had a fall two weeks prior and also sustained an injury. There was no CIS report submitted to MLTC regarding the previous fall.

A review of resident #002's progress notes indicated the resident was sent to the hospital after their first fall and according to the hospital, initial results indicated there was no injury. However, upon return to the home a day later, a readmission note indicated there was an injury.

An interview with QCM #106 confirmed the home should have submitted a CIS report once they were aware of the injury for the first fall. [s. 107. (3.1) (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 Director is informed of an incident that causes an injury to a resident for which the resident was taken to a hospital that resulted in a significant change in the resident's health condition no no later than three business days after the occurrence of the incident, to be implemented voluntarily.

Issued on this 2 nd day of June, 2020 (A2)

[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 SUSAN SEMEREDY (501) - (A2)
Inspection No. / No de l'inspection :	2020_626501_0003 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	022698-19, 000218-20, 001836-20 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 02, 2020(A2)
Licensee / Titulaire de permis :	Shepherd Village Inc. 3758/3760 Sheppard Avenue East, TORONTO, ON, M1T-3K9
LTC Home / Foyer de SLD :	Shepherd Lodge 3760 Sheppard Avenue East, TORONTO, ON, M1T-3K9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cathy Fiore

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

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

Order / Ordre :

The licensee must be compliant with s.8(1) of O.Reg. 79/10.

Specifically, the licensee must:
(a) Develop and provide in-service education to all direct care staff related to the home's fall prevention and management policy. Keep a documented record of what this education included, when it was provided and by whom.
(b) Ensure that all fall prevention measures are considered when developing interventions to prevent further falls and injuries for resident #004 and all residents at risk for falls.
(c) Develop and implement an auditing process to ensure that registered staff attend to all residents that have fallen in a timely manner in keeping with the home's policy. Keep a documented record of these audits.

Grounds / Motifs :

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 system, the system was complied with.

In accordance with O.Reg. 79/10, s. 48(1), the licensee was required to ensure that that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented.

Specifically, staff did not comply with the licensee's policy titled "Falls Prevention and Management", #NURS-13-7, effective July 1, 2019, which was part of the licensee's fall prevention and management program. The policy indicates that a registered staff (registered nurse or registered practical nurse) will ensure the resident is not moved prior to completing a preliminary assessment.

The home submitted a CIS report regarding resident #002 having a fall and sustaining injuries. According to the CIS report, resident #002 had a prior fall 10 days previously and also sustained an injury.

A review of resident #002's progress notes indicated that PSW #110 reported resident #002 had a fall and the RPN was notified approximately 50 minutes after the fall. The note indicated two staff helped the resident get up a walk to their room. RPN #114 assessed the resident and sent the resident to the hospital.

An interview with PSW #110 indicated that after resident #002 fell they went to get RPN #114 but they were on break and when they tried to call the nurse manager, they could not get through. According to PSW #110, they and PSW #111 got resident #002 up, took them across to their room by holding the resident on each side. PSW #110 stated they noticed an injury. As well, the PSW indicated they did not want to leave resident #002 on the floor because they did not know when the RPN would be back.

An interview with RPN #114 indicated they were informed by PSW #110 that resident #002 had a fall after returning to the unit. RPN #114 stated they assessed the resident in bed and noted that the resident had an injury. The RPN indicated that it was not normal practice for PSWs to move residents before they were assessed by registered staff.

In separate interviews, NM #105 and QCM #106 indicated that in the above situation, the PSWs should not have moved resident #002 before they were assessed by registered staff and confirmed that the PSWs did not follow the home's falls prevention and management policy. [s. 8. (1) (b)] (501)

2. A complaint was made to the MLTC related to the length of time that it took registered staff members to assess resident #010 after they had a fall.

A review of resident #010's progress notes indicated RPN #112 came back from their break and was informed by PSW staff that the resident had a fall. According to this documentation the RPN assessed the resident approximately 25 minutes after the fall.

An interview with a family member of resident #010 who was there at the time of the fall, indicated PSW staff told them a registered nurse was unavailable to assess the resident as they were on break. Resident #010 got themselves up without waiting and the unit nurse assessed the resident in bed after returning from their break.

An interview with RPN #112 indicated they were not contacted immediately by the PSW's who first attended to resident #010 after their fall but were made aware of the fall after they came back from break. RN Float #119 and NM #118 both indicated during separate interviews that they had not been informed of resident #010's fall that shift and could not recall assessing the resident.

An interview with ADOC #107 indicated the home's expectation is for registered staff to be informed immediately after a resident has fallen and if the unit nurse is unavailable, the staff are to contact the float RN or NM. The ADOC confirmed staff failed to follow the home's falls prevention and management policy related to this incident. [s. 8. (1) (b)] (501)

3. 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 system, the system was complied with.

In accordance with O.Reg. 79/10, s. 48(1), the licensee was required to ensure that that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented.

Specifically, staff did not comply with the licensee's policy titled "Falls Prevention and Management", #NURS-13-7, effective July 1, 2019, which indicates that interventions/strategies to reduce risks of falls include the implementation of monitoring devices such as alarms

The MLTC received a CIS report related to resident #004, who sustained a fall with injury that resulted in the resident being hospitalized.

A record review of progress notes for resident #004 indicated they were found by staff in their room and sustained a fall with injury. Staff members responded to the situation and emergency services transferred to resident to the hospital. The resident received treatment at the hospital and was readmitted to the home.

A record review of the home's investigation notes indicated a family member of another co-resident first noticed resident #004 sustained a fall and immediately got assistance from the staff. The family member stated in their interview during the home's investigation that they believed resident #004 required a fall prevention monitoring device as they had seen resident #004 fall in the past.

A record review of PT #120's assessment completed prior to resident #004's fall indicated the resident had a risk for falls and required greater assistance with activities of daily living. During this assessment, the resident and staff members indicated the resident was having a decline in their abilities and required the use of a mobility device.

An interview with PT #120 indicated resident #004 was known to attempt to be independent with activities of daily living and had a fall prevention monitoring device while recumbent however, such a device would have been beneficial for their mobility device as well.

An interview with resident #004's SDM indicated that the resident required assistance with their mobility due to their physical condition. The SDM indicated that resident #004 does not always call for assistance, when needed.

RPN #102 and RPN #124 both stated in their interview resident #004 had a history of not asking for assistance along with identified responsive behaviours. RPN #102 and PSW #109 stated resident #004 would have benefitted from an additional a fall prevention monitoring device prior to their fall.

An interview with ADOC #107 indicated that given resident #004's history, it would have been beneficial for resident #004, to have received an additional fall prevention monitoring device prior to their fall. [s. 8. (1) (b)]

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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The severity of this issue was determined to be a level 2 as there was actual risk of harm to the residents. The scope of the issue was a level 2 as it related to two of four residents reviewed. The home had a level 3 history of on-going non-compliance with this subsection of the Regulation that included:
Voluntary Plan of Correction (VPC) issued May 9, 2017 (2017_527665_0001) and August 1, 2019 (2019_790730_0019).

Additionally, the LTCH has a history of twelve other compliance orders in the last 36 months.
(760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 30, 2020(A2)

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: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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).

Order / Ordre :

The licensee must be compliant with s.6(7) of the LTCH Act.

Specifically, the licensee must:
(a) Ensure resident #002, and any other resident with responsive behaviours, are provided interventions according to their plan of care.
(b) Ensure personal support workers #110 and #111 are provided education related to the implementation of gentle persuasive approach (GPA) and distraction techniques. Keep a document of what this education included, when it was given and by whom.

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

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted a CIS report regarding resident #002 having two falls with injury within a two-week time frame requiring hospitalization.

A review of resident #007's plan of care identified the resident had cognitive impairment and responsive behaviours. Interventions to respond to the resident's responsive behaviours included using specified techniques.

According to progress notes and interviews with PSWs #110 and #111, resident #007 followed the PSWs and a co-resident to a room and tried to enter forcefully. A PSW attempted to prevent the resident from entering by physical means which is when the resident fell. The PSWs admitted they should have used other techniques to deter resident #007 from following them and entering the room.

In separate interviews nurse manager (NM) #105 and QCM #106 indicated that in the above situation, the PSWs did not respond appropriately and confirmed that they did not provide the care as specified in the resident's plan of care.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of four residents reviewed. The home had a level 3 history of on-going non-compliance with this subsection of the Act that included:
Compliance Order (CO) issued June 29, 2018 (2018_630589_0003)
Voluntary Plan of Correction (VPC) issued March 6, 2019 (2019_598570_0003)
Additionally, the LTCH has a history of twelve other compliance orders in the last 36 months.

[s. 6. (7)]

(501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 30, 2020(A2)

Ontario

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Order(s) of the Inspector

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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

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

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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 2 nd day of June, 2020 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by SUSAN SEMEREDY (501) - (A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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