Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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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
Nov 8, 2018	2018_687607_0005	022504-17, 025356-17, 003791-18, 004946-18, 005811-18	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Thorntonview
186 Thornton Road South OSHAWA ON L1J 5Y2

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

JULIET MANDERSON-GRAY (607)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 23, 28 and March 1, 2, 5, 6, 19, 20, 21, 22, 23, 26 and 28, 2018

During the course of this inspection, two other complaint inspections (Inspection #'s 2018_687607_0004, 2018_687607_0006) (Log #s 023316-17, 024475-17) were completed concurrently related to resident care areas. During this Complaint inspection non-compliance was identified related to s.24 and is being issued under inspection #2018_687607_0006 related to reporting to the Director.

In addition, the following logs were inspected:

Summary of intake Logs:

1) Log # 022504-17, a complaint regarding resident care areas, including medication management, infection control, laundry services, responsive behaviours and prevention of abuse and neglect, nursing and personal support services, continence care and bowel management, falls prevention and management.
2) Log # 003791-18, regarding falls prevention management and responsive behaviours.
3) Log #'s 004946-18 and 02535-17, regarding an alleged resident to resident abuse and responsive behaviours.
4) Log # 005811-18, regarding an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Environment Service Manager (ESM), Physiotherapist (PT), Registered Dietitian (RD), Dietary Manager (DM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aide (HSKP), Laundry Aide (LA), family members and residents.

During the course of inspection, the Inspector reviewed clinical health records, observed staff to residents interactions, resident to resident interaction, reviewed complaint records and applicable policies.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- **11 WN(s)**
- **6 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

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 the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #022504-17 in an identified month, related to falls. The complainant indicated that resident #004 had a fall as result of an improper transfer.

At two identified times, in an identified month, inspector #607, observed a symbol in an identified area related to resident #004, indicating the resident used a specific device to assist with transfers.

A review of current written plan of care indicated the resident required assistance with transfers and had several identified interventions in place.

During interviews on an identified date and time, PSW #106 and RPN #119 both indicated to inspector #607 that resident #004 required staff assistance with transfers and the use of a specific device.

On an identified date and time, inspector #607 observed and verified with RPN #119 that the symbol in the identified area related resident #004, indicated that the resident required staff assistance with transfers using a specific device. The RPN also stated that the symbol located in an identified area related to resident #004, indicated the resident required a specific device, and documentation in the written plan of care indicating the resident required staff assistance for transfers, did not provide clear directions to staff.

During an interview on an identified date and time, the ADOC indicated to the inspector that the licensee's expectation is that written plan of care is to be updated as needed. The ADOC further indicated that if a transfer symbol located in an identified area and the written plan of care for the resident does not coincide, the written plan of care had not provided clear directions to staff.

The licensee failed to ensure that resident #004's written plan of care sets out clear directions to staff and others who provide direct care to the resident. Specifically related to the interventions related to transfer located in an identified area related to resident #004 and the interventions in the resident's written plan of care did not coincide. [s. 6. (1) (c)]

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

The sample size was increased to include resident #004 as there was non-compliance identified related to fall prevention.

On an identified date, at three separate identified times, the inspector observed resident #004 with the use of a specific mobility aid, in an identified area without a specified fall prevention device in place.

A review of resident #004's plan of care related to falls indicated the resident was at risk

for falls, and was to have specific fall prevention device in place.

During an interview on an identified date, PSW #129 and RPN #119 both indicated that resident #004 did not have the fall prevention device attached to their mobility aid. RPN #119 also indicated that care was not provided to the resident as per the plan of care.

During an interview on an identified date, the DOC indicated that if a resident requires a specific device, as identified in the written the plan of care, the licensee's expectation is that the device to be in place and functional.

The licensee failed to ensure that the care set out in resident #004's plan of care was provided to the resident. Specifically, it was noted that the resident did not have an identified device in place as per the plan of care. [s. 6. (7)]

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

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #024475-17 in an identified month, related to resident #005's responsive behaviours not being managed well by the Long-Term Care home.

A review of the current plan of care for resident #005 indicated the resident had several identified interventions in place related to responsive behaviours, including increase monitoring of the resident.

A review of resident #005's progress notes indicated that on an identified date and time, the resident had wandered away, while a staff member was providing increase monitoring of the resident. At the identified time, resident #005 held on to an unidentified resident, when PSW #139 separate both residents and redirected the unidentified resident. While the PSW was redirecting the unidentified resident, resident #005 walked past the PSW and held onto resident #008. Resident #005 let go off resident #008, when the resident lost their balance and fell, resulted in an injury to resident #008.

A review of the video footage on an identified date and time, related to the above identified incident involving resident #005 and #008 verified the same. Further review of the video footage indicated that after resident #008 fell, PSW #139 called for RPN #124, and stayed with resident #008. Resident #005 wandered away from the scene of the incident, while both PSW #139 and RPN #124 attended to resident #008.

During an interview with the Director of Care on an identified date, indicated that the staff who was providing increase monitoring of resident #005 should have been attending to resident #005.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan, as the staff that was providing increase monitoring of resident #005, left the resident unattended, resulting in resident #005 wandering off, subsequently leading to an injury to another resident. [s. 6. (7)]

4. The licensee has failed to ensure that when the resident is reassessed, the plan of care is reviewed and revised at any other time when the resident's care needs change.

The sample size was increased to include resident #008 as there was non-compliance identified related to fall prevention.

A review of the progress notes for resident #008 indicated the resident had a fall on an identified date, that resulted in an injury to the resident.

A review of resident #008's plan of care, indicated that the resident had several interventions in place related to eating. Further review of the plan of care had no documented interventions of resident #008 requiring staff assistance at meals.

During interviews on an identified date, PSW #133 and RPN #130 both indicated that resident #008 required assistance with eating due a recent injury.

On an identified date and time, during two identified meals, the resident was observed trying to eat without the assistance of a staff member.

During an interview on an identified date, the Registered Dietitian indicated that if a resident needs assistance with eating, the registered staff should address this on the plan of care.

The licensee failed to ensure that resident #008 was reassessed and the plan of care was reviewed and revised at any other time when the resident's care needs change. Specifically, the plan of care was not updated to include that the resident required staff assistance during meals, after sustaining an injury. [s. 6. (10) (b)]

5. The sample size was increased to include resident #004 as there was non-compliance identified related to fall prevention.

A review of resident #004's progress notes, indicated that the resident was found in an identified area between two devices. Further review of the progress notes indicated that a couple of staff had to assist in removing the resident's from between the identified devices. The resident was later transferred to hospital and was diagnosed with an injury.

A review of current written plan of care had several interventions in place related transfers.

During an interview on an identified date, PSW #113 indicated that resident #004 had returned from hospital with a diagnosed injury and a specific device to be in place related to the injury. The PSW also indicated resident #004 was being transferred on an identified date with the assistance of PSW #137. PSW #113 indicated there was a transfer symbol located in a specified area belonging to resident #004, that indicated that the resident was to be transferred by two staff via a specific transfer method. PSW #113 also indicated they both questioned if the resident was to be transferred via the identified method and went to confirm the resident's transfer status with RPN #138 and the Physiotherapist (PT), who both indicated that the resident was able to transfer via the identified method. PSW #113 indicated that both staff transferred resident #004 via the identified transfer method, and the resident had indicated being in pain during the transfer. PSW #113 also indicated that all the resident's weight was fully supported by the PSW's during the transfer, but the resident beared weight on both staff, resulting in an injury to the PSW. The PSW further indicated that resident #004 should have been assessed upon returning from hospital by a member of the Safe Lift and Transfer team (SALT) member to determine the residents appropriate transfer status.

The PT indicated to the inspector during an interview on an identified date, that resident #004 was assessed by the PT upon returning from the hospital, but the assessment completed was related to ambulation. The PT indicated that usually a resident transfer status is assessed by the Long-term Care home SALT team and not by the PT.

A review of the SALT assessment record for resident #004 in the home's electronic software two identified date indicated the following:
-Assessment status was in progress, there was no documented evidence to indicate that the assessment was completed related to transfer.
-On the date the staff member was injured, an assessment was completed by a member

of the SALT team to have the resident transfer via a specific device.

During an interview on an identified date, the Executive Director (ED) indicated, that both PSW #113 and #137, had brought forward concerns to the ED on the date staff member was injured, related to resident #004's transfer status and PSW #113 being injured during the transfer. The ED indicated that PSW #137, who assisted with the transfer of the resident is a member of the SALT team. The ED also indicated staff were aware that if a resident was assessed and the transfer was deemed unsafe, the staff were allowed to transfer the resident via a specific device, as per the licensee's policy. The ED indicated that PSW #137 was instructed at the time of the incident to complete a SALT assessment for resident #004. The ED further indicated that when resident #004 returned from hospital on an identified date, the resident transfer status should have been assessed by a member of the SALT team.

The licensee failed to ensure that resident #004 was reassessed, and the plan of care was reviewed and revised at any other time when the resident's care needs change. Specifically, resident #004 had a significant change in health condition related to a fall, was transferred to hospital and was not assessed upon returning, related to the resident transfer needs, until a number of days later, after a staff member was injured during a transfer of the resident. [s. 6. (10) (b)]

6. The licensee has failed to ensure that if the resident is being reassessed, the plan of care is reviewed and revised because care set out in the plan has not been effective, the licensee shall ensure different approaches been considered in the revision of the plan of care.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #024475-17 an identified date, the complainant indicated residents that were having falls and were not being assessed appropriately.

The sample size was increased to include resident #004, as there was non-compliance identified related to fall prevention.

A review of resident #004 clinical health records indicated the resident had a number of falls in specified area, of the identified number of falls, several resulted in injuries to the resident.

A review of resident #004's plan of care on an identified date, indicated that the resident

had several interventions in place related to falls.

During an interview on an identified date, PSW #126 and RPN #127, both indicated that resident #004 was at risk for falls and will often self-transfer to the resident's identified mobility aid. RPN #127 indicated that resident #004's falls only occurred in an identified resident specific area.

During an interview with the ADOC on an identified date, indicated that most of resident #004's fall was related to the resident self transferring and further indicated the interventions in place to prevent resident falls were not effective.

The licensee failed to ensure that when resident #004 was reassessed, different approaches were considered in the revision of the plan of care. Specifically, the resident had a number of falls during a specific identified months, in an identified resident specific area, related to self-transfer, and the interventions in the written plan of care that were in place, were not revised to include different approaches considered, over a specified period. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 ensuring that the plan of care set out clear directions to staff and others who provide direct care to the resident, ensuring that the plan of care was based on an assessment of the resident and the resident's needs and preferences, ensuring that the care set out in the plan of care provided to the resident as specified in the plan and ensuring that if the resident was reassessed, the plan of care was revised because care set out in the plan had not been effective, and different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: 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 any plan, policy, protocol, procedure, strategy or system is complied with.

Under O. Reg. 79/10, r. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Under O. Reg. 79/10, r. 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: 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.

Under O. Reg. 79/10, r. 49. (1) The falls prevention and management program.

A review of the licensee Fall Prevention and Injury Reduction policy #CARE5-010.05 with an identified date, directs:

A Post Fall assessment was to be completed by the nurse immediately following a fall, including vital signs every shift for a minimum of 72 hours.

If a fall was unwitnessed, and the resident did not hit their head, vitals were to be monitored every shift for 72 hours.

The following additional communication and documentation were required:

-For those residents who have a Substitute Decision Maker (SDM), the SDM was to be notified. For those residents who were competent, family members were to be notified with the residents consent.
-All falls are to be entered into the Risk Management Module.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #022504-17 in an identified month, related falls. The complainant indicated resident #002 had a fall and the documentation and assessments surrounding the fall were incomplete.

A review of resident #002's written plan of care indicated the resident had a fall on an identified date, and at the time of the incident, the resident required one staff assistance with transfers. Further review of the written plan of care indicated that the resident was at risk for falls as evidenced by the resident having a witnessed fall in a separate identified month.

During an interview on an identified month, Personal Support Worker #113 indicated that prior to resident #002 falling on an identified date and month, the resident required staff assistance with transfers. The PSW also indicated that when a resident falls, the licensee has a no staff manual lift policy, and further indicated the transfer of a resident who had fallen would have to be carried out with use of a specific device. The PSW indicated after resident #002 fell, PSW student #111 and RPN #124 were observed performing an improper transfer. Both PSW student #111 and RPN #124 were observed transferring resident #002 without the use of the specific device. PSW #113 indicated having a conversation about a week after the incident with the Director of Care (DOC), and the DOC indicated not being aware of the incident, as there was no documentation to support the resident had fallen.

A review of an email with an identified date, sent by the DOC to RPN #124, indicated the DOC had asked the RPN to contact the DOC regarding a fall involving resident #002 and asked the RPN to complete documentation of the incident, in the progress notes, risk management incident and to notify the resident #002's Substitute Decision Maker (SDM) of the incident.

During an interview on an identified date, RPN #124 indicated to the inspector that at

time of the incident, a staff member notified the RPN that resident #002 had a fall. The RPN indicated that PSW student #111 had indicated to the RPN, that during a transfer of resident #002 , the resident's gait became unsteady and the PSW student lowered the resident to a specific area. The RPN also indicated that at the time of the incident, the RPN did not consider the resident being lowered to the specific area by the PSW as a fall. The RPN indicated, an assessment of resident #002 was completed after the incident and there were no injuries noted to the resident. The RPN further indicated the fall incident occurred on an identified shift, was documented on an identified report and the details surrounding the fall incident was passed on to the incoming nurse to notify resident #002's SDM. The RPN also indicated that a post fall assessment, documentation of the incident in progress notes, an incident report and the notification of the residents SDM were not completed, at the time of the incident.

A review of resident #002's clinical health care records, had no documented evidence that resident #002's vital signs were completed for 72 hours after the fall.

Further review of resident #002's clinical health records and verification with the Director of Care indicated that vital signs were not completed for 72 hours related to the incident as per the licensee's policy.

The licensee failed to ensure that its Falls Prevention and Injury Reduction policy #CARES5-010.05 was complied with, as evidenced by when resident #002 had fallen, assessments were not documented immediately, as RPN #124 did not document a post fall assessment immediately after the fall, the falls incident was not entered into the home's electronic software immediately, resident #002 SDM was not notified immediately regarding the fall, until a number of days after the fall, and vital signs were not completed for 72 hours after the fall, as per the licensees policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. Under O. Reg. 79/10, r. 114. (3) (a) Every licensee of a long-term care home shall ensure that the written policies and protocols developed, was implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A review of the licensee Medication policy #CARE13-010-10, titled Use of an identified Therapy, with an identified review date, page 1/2 directs:

An identified medical equipment may be operated by the Nurse and/or Unregulated Care Providers (UCP) who has received appropriate training. Refer to Health and Safety

policies -HS20-P-40, HS20-O-40, HS20-O-41, HS20-O-42, and HS20-O-43.

Further review of the licensee's policy related to title Hazard Management, Portable Medical Equipment Guidelines - Policy # OHS2-O60.06-E1 page 2/5 directs:

Ensure the following safety precautions were carried out during trans filling:
-Trans filling should be carried out at least five feet away from electrical appliances, such as, electric wheelchairs, television, radio and stereo equipment, air conditioning units (wall type or portable) fans, electric razors, hair dryers and space heaters that are energized or in an operating mode;
-After trans filling, the identified portable liquid unit should be separated from the base unit according to the manufacturer's instructions;
-Personal Protective Equipment (PPE) required included thermal gloves to prevent burns.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #022504-17 in an identified month, related to medication administration. The complainant indicated that unregulated staff were being asked to administer an identified medical treatment without the proper training.

On an identified date and time, inspector #607 observed Personal Support Worker (PSW) #120 filled two portable medical equipments without the use of PPE. Observations of the room where the portable equipments were stored had no PPE, no documented instructions or the requirements surrounding the filling of portable equipments.

During an interview on an identified date and time, PSW #120 indicated that upon hire, they were shown by another PSW how to fill the portable medical equipments. The PSW indicated not being aware of the requirement of the use of PPE when trans-filling these equipments. The PSW also indicated there was no PPE or instructions related to trans-filling of the equipments located in the area they were stored.

During interviews on an identified date, PSW #122 and RPN #121, both indicated not being aware that PPE were required when filling the portable equipments.

During an interview on an identified date and time, the ADOC indicated that the licensee's expectation is that all staff are to wear PPE when filling the portable medical equipments.

The licensee failed to ensure that its written policies Policy #OHS2-O60.06-E1 - Hazard Management, Portable Medical Equipment Guidelines, was implemented as PSW #120 and RPN #121, both indicated not having knowledge of the requirement of a PPE to be used when filling the portable medical equipments, as per the licensee's policy. [s. 8. (1) (b)]

3. A review of the licensee Medication policy #CARE13-010-10, titled Use of an identified therapy, with an identified review date, page 1/2 directs:

A specific equipment may be operated by the Nurse and/or Unregulated Care Providers (UCP) who has received appropriate training. Refer to Health and Safety policies -HS20-P-40, HS20-O-40, HS20-O-41, HS20-O-42, and HS20-O-43.

Further review of the licensee Hazard Management, Portable Medical Equipment Guidelines, Policy #OHS2-O60.06-E1, with an identified review date, page 3-5 directs:

Training
1. The supplier is required to ensure that adequate training has been completed and that the employee remains current to the more stringent of either the supplier's or Transport Canada requirements. Training includes potential hazards and recommended safety precautions.
2. Revera employees who may receive these dangerous goods are required to have a current Transportation of Dangerous (TDG) training as required by Transport Canada.
Training
1. Trans filling portable liquid medical units will only be carried out by a trained employee of the supplier.
2. The Executive Director will ensure that any employee using these units has received training from the supplier including instruction on potential hazards and recommended safety precautions.
3. Revera employees who may receive these dangerous goods are required to have a current Transportation of Dangerous (TDG) training as required by Transport Canada.

The licensee's Medication policy #CARE 13-O.10.08 with an identified date, page 1/2, also directs:

Resident will receive assigned medication from the UCP in a safe, competent manner.

The nurse is responsible for:
An initial and ongoing assessment of the stability of the resident.
Completing a resident assessment before assigning/delegating the administration of a PRN medication.
Assessing the predictability of the outcome of care to be provided and assigned/delegated to the UCP.
The appropriate delegation/assigning of tasks to the UCP. Task which required assessment or judgement from the UCP cannot be assigned/delegated.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #022504-17 in an identified month, related to medication administration. The complainant indicated that unregulated staff were being asked to administer medical treatment without the proper training.

According to Health Canada Drug Database November 2017," a drug Identification Number (DIN) is a computer--generated eight digit number assigned by Health Canada to a drug product prior to being marketed in Canada. It uniquely identifies all drug products sold in a dosage form in Canada and was located on the label of prescriptions and over-the-counter drug products that have been evaluated and authorized for sale in Canada. A DIN uniquely identifies the following product characteristics: manufacturer, product name, active ingredient(s), strength(s) of active ingredient(s), pharmaceutical form and route of administration."

During an interview on an identified date and time, the Director of Care (DOC) indicated that the home's supplier for an identified treatment was an external organization. Further review of Health Canada Drug Database indicated that the external organization's product had an identified strength, with an identified DIN.

According to the Nursing Act 1991 "Controlled acts were activities that were considered to be potentially harmful if performed by unqualified persons. The 14 controlled acts established in the Regulated Health Professions Act (RHPA) included:
5. Administering a substance by injection or inhalation.

A review of resident #003's clinical health records indicated the resident had a physician order in place for an identified treatment to be administered based on an identified range and the nurse's assessment.

On an identified date and time, inspector #607 observed Personal Support Worker #120

filled a portable medical equipment and applied the treatment to resident #003 via an identified route. There was no assessment of the resident completed at the time of the administration, by the PSW or by a registered staff member to see if the resident's identified treatment needed titrating.

Further review of resident #003's clinical health records for a specific time period, indicated the resident was assessed and there were several identified occasions when the assessments indicated that the resident would have required the medical treatment to be titrated.

During interviews on an identified date and times, PSW #106, #107 and #108, all indicated that portable medical equipments were filled by PSWs and further indicated that PSWs administers the medical treatment from these equipments to residents within the long-term care home. The PSWs also indicated that the registered staff would let the PSWs know how much treatment was to be administered to a resident, and indicated that this was also written on the resident's portable medical equipments.

During interviews on an identified date and time, RN #104 and RPN #105, both indicated that the identified medical treatment was a drug, is being administered by PSWs and this is delegated by the registered staff.

During an interview on an identified date and time, RPN #121 indicated that PSWs administers an identified medical treatment to residents and also indicated the identified treatment is delegated by the registered staff. RPN #121 further indicated that all PSWs should have training on how to administer the identified treatment to residents.

During an interview on an identified date and time, the Assistant Director Care (ADOC) indicated if there was an order in place related to an identified treatment, the treatment should be treated as a life sustaining treatment and staff was to treat it as such. The ADOC indicating being in the role for two years and have no records that training was provided to the PSWs related to identified treatment and administration.

During an interview on an identified date and time, the DOC indicated that an identified treatment was a drug and required a physician's order. The DOC indicated that registered staff can initiate the administration of the identified treatment, and PSWs can fill the portable medical equipments and administers the identified medical treatment based on an existing order, if delegated by a registered staff, but cannot administer identified treatment if it was related to a new physician's order.

A review of resident #003's clinical health records indicated the resident was to have an identified medical treatment based on the resident assessments and monitoring of the resident. This according to The Regulated Health Professions Act, 1991 exempt a PSW from applying an identified treatment to resident #003 as the resident's needs, response and outcome have not been established overtime and was not predictable.

During an interview with the ADOC on a separate date, indicated there is no documented evidence by the licensee to indicate that PSWs had training on the identified treatment and administration of it.

The licensee failed to ensure that its Medication policy #CARE 13-O.10.08 was complied with, as it directs that task which required assessment or judgement from the Unregulated Care Provider (UCP)/ PSWs cannot be assigned/delegated. Yet observations and interviews with PSWs confirmed that resident #003 who required assessment and judgement related to an identified treatment administration, is delegated to PSWs. The licensee also failed to ensure its Hazard Management, Portable Medical Equipment Guidelines, Policy #OHS2-O60.06-E1, is complied with. Specifically related to training of staff surrounding the treatment.[s. 8. (1) (b)]

4. The licensee has failed to ensure that its Medication policy # CARE13.010.01 was complied with.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #022504-17 on an identified date, related to medication administration. The complainant indicated that unregulated staff were being asked to administer a medical treatment without the proper training.

A review of the home's Medication Administration policy # CARE13.010.01, with an identified date, page 2/3 directs:

Procedure:

Medication must be observed for ingestion, otherwise, it cannot be considered administered.

Medications will not be left unattended for the residents to self administer unless the resident performs self medication administration in adherence to the self medication of

medication procedure.

On an identified date and time, the inspector observed resident #001 with a cup medications in front of them in an identified area, there was another resident seated next to the resident. The nurse was a way from the identified area where the resident was seated.

During interview on an identified date and time, resident #001 indicated the staff would always leave the medications in front of them to be taken.

During an interview on an identified date and time, RPN #101 indicated the licensee's expectation is that staff are to observe residents to ensure ingestion when medications were given.

During an interview on an identified date and time, the DOC indicated the licensee's expectation is when staff are giving medications they are to be standing at a distance and watch the resident if the resident is independent, but not to leave the resident.

The licensee's Medication policy #CARE13.010.01 was not complied with, as RPN #101 did not ensure that when medications were given to resident #001, the medications were observed for ingestion, and therefore the medications were not considered as being administered as per the licensee's policy. [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 ensuring that its policy is complied with and ensure that the written policies and protocols be, developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported is immediately investigated.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #024475-17 in an identified month, related to resident #005's responsive behaviours not being managed well by the Long-term Care home.

A review of resident #005's progress notes by inspector #607, indicated that in an identified month, resident #005 was in the specific area speaking with resident #010 and had wanted the resident to get up, in order to walk with resident #010. Resident #010 refused, and resident #005 walked away but returned, then held onto the resident to get the resident to stand up. Resident #010 yelled and held onto resident #005's to release the resident's grip, which resulted in an injury to resident #005. PSW #140 was able to separate the two residents without any further altercation.

During an interview in an identified month, Registered Practical Nurse (RPN) #138 who was present and had documented the above identified incident in progress notes, verified the same. The RPN further indicated that the incident was reported to the on-call manager at the time, but could not remember which manager it was.

During an interview in an identified month and time, the Executive Director (ED) indicated the above identified incident was documented by the on call manager, but was not investigated.

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported was immediately investigated. Specifically, resident #005's obtained an injury as a result of an altercation with resident #010, and the incident was not investigated. [s. 23. (1) (a)]

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 ensuring that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported is immediately investigated, 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 use safe transferring and positioning devices or techniques when assisting residents.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #022504-17 in an identified month, related to nursing and personal support services. The complainant indicated resident #002 had a fall and the documentation and assessments surrounding the fall were incomplete.

A review of resident #002's written plan indicated the resident had a fall in an identified month, and at the time of the incident, the resident required staff assistant with transfers.

A review of the licensee's Safe Resident Handling policy #CARE6-P10, safe handling skills checklist; Transfer/Lift/Reposition Technique: Assisting a resident from an identified area, with an identified date, page 1/2 directs:

- While assisting resident from an identified position, always request assistance from a co-worker(s) to provide manual assistance, the resident is required to have the lower extremity strength to assist during the transfer from an identified area. If the resident is physically unable to assist themselves to crawl/on all fours position, a specific device must be used or call for an ambulance for assistance.

During an interview on an identified date, Personal Support Worker (PSW) #113 indicated to inspector #607, that prior to resident #002 falling on an identified date, the resident required staff assistance with transfers. The PSW further indicated that when a resident has fallen, a transfer of the resident must be carried out with the use of a specific device, as the licensee has a no staff manual lift policy. The PSW also indicated that after resident #002 fell, PSW student #111 and Registered Practical Nurse (RPN) #124 were observed performing an improper transfer, as they were observed transferring resident #002, without the use of a specific device.

During an interview on an identified date and time, RPN #124 indicated to the inspector that at the time of the incident, a staff member notified the RPN that resident #002 had fallen. The RPN indicated remembering being told by PSW student #111, that while the PSW was in the middle of performing the transfer of resident #002, the resident became unsteady and the PSW lowered the resident to a specific area. The RPN also indicated that at the time, they did not consider the resident being lowered to the specific area a fall. The RPN indicated, an assessment of resident #002 was completed and there were no injuries. The RPN further indicated that after the assessment, the PSW student was instructed by the RPN to assist with transferring resident #002 without the use of a specific device. The RPN indicated at the time of incident, both the RPN and the PSW did not transfer resident #002 with an identified specific device as per the licensee's policy.

During an interview on an identified date and time, the Director of Care (DOC) indicated to inspector #607 that during the investigation of the incident involving resident #002 related to the fall. Registered Practical Nurse (RPN) #124 indicated to the DOC that prior to both the RPN and PSW student #111 transferring resident #002, the resident was assessed as requiring two staff assistance. The RPN also indicated that during the transfer, the resident who was fully supported, beared weight on both staff. The DOC indicated that both RPN #124 and PSW student #111 should have used a specific identified device to transfer resident #002, and further indicated that if the specific device was not used during the transfer, the transfer was considered an improper transfer.

The licensee failed to ensure that when resident #002 had a fall on an identified date, the staff did not use safe transferring and positioning devices or techniques when assisting the resident, as both PSW #111 and RPN #124, were observed transferring resident #002 without the use of a specific device. [s. 36.]

2. The sample size was increased to include resident #008, as there was non-

compliance identified related to falls and transfer.

A review of the progress notes for resident #008 indicated the resident had a fall on an identified date, that resulted in an injury to the resident.

A review of resident #008's current plan of care indicated the resident was screened at risk for falls, and had several identified interventions in place related to falls

A review of the video footage on an identified date and time related to the incident involving resident #008 and the resident falling indicated the following:
-On an identified date and time PSW #139 was observed redirecting an unidentified resident while performing increase monitoring of resident #005. Resident #008 was observed standing in an identified area, while PSW #139 was redirecting the unidentified resident. While PSW #139 was redirecting the unidentified resident, resident #005 passed by PSW #139 and held on to resident #008, resident #008 pulled away from resident #005 and fell. PSW #139 called for RPN #124, and stayed with resident #008. Both PSW #139 and RPN #124 were observed lifting resident #008 from an identified area to a standing position without the use of a specific device. The resident was later transferred to hospital and was diagnosed with an injury.

During an interview on an identified date RPN #124 indicated to the inspector that at time of the incident, a staff member notified the RPN that resident #008 had fallen. The RPN also indicated both the PSW #139 and the RPN lifted resident #008, without the use of a specific device. The RPN further indicated that both the RPN and PSW #139 did not use safe transferring technique to transfer resident #008 as per licensee's policy, which required both staff to use an identified specific device.

The licensee failed to ensure that RPN #124 and PSW #139 use safe transferring technique as both staff were observed transferring resident #008 manually, without the use a specific device as required by the licensee's Safe Resident Handling policy # CARE6-P10. [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 ensuring that staff use safe transferring and positioning devices or techniques when assisting residents with transfers, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is, documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The sample size was increased to include resident #017, as non-compliance was identified related to medication management.

A review of Physician's Order Review with an identified date, indicated that resident #017

was on an identified medication and was to receive the medication orally once per day. A review of the Physician Orders Review with a review date over a three month time period, had documented evidence to indicate the medication was discontinued on an identified date. A review of the Medication Administration Record (MAR) for the identified date indicated that the medication was discontinued, and had documented evidence that the medication was given after it was discontinued. A review of the progress notes, had no documented evidence to indicate that an assessment was completed of the resident, nor was Substitute Decision Maker (SDM) or the Medical Director (MD) notified of the medication incident.

During an interview on an identified date and time, Registered Nurse #104 who discovered the above medication incident, indicated to inspector #607, having no recollection of the medication incident.

During an interview on an identified date and time, the Assistant Director of Care (ADOC) indicated that there was no documentation that resident #017's Substitute Decision Maker and Physician were notified. The ADOC also indicated that corrective actions should have included an assessment of the resident.

During an interview on an identified date and time, the DOC indicated that when there was a medication incident involving a resident. The staff are to document in the progress notes an assessment of the resident, and whether or not there was any adverse effect and or any corrective action that was taken. The DOC also indicated the residents SDM and physician should be notified of a medication incident involving a resident.

The licensee failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health. Specifically, resident #017 receiving a dose of an identified medication, after the medication was discontinued. There was no documented evidence an assessment of the resident completed, after the resident received the dose of the identified medication, and or any corrective action that was taken, as well as the resident's SDM and the physician being notified of the medication incident involving the resident. [s. 135. (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 ensuring that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #022504-17 in an identified month, related to infection control. The complainant indicated the LTC home did not have enough of a specific device to assist with resident's transfers and resident's were sharing these devices between care.

During interviews on an identified date and times, PSWs #106, #107 and #108 all indicated to inspector #607 that the devices for an identified equipment, were not designated for each resident, and that staff were supposed to use the devices between residents. The PSWs indicated that they do not have enough of these devices for each shift, to provide care to residents who required them, and staff do share the devices between residents. The PSWs also indicated that the devices were not disinfected between use, and are only sent to be laundered if soiled.

During an interview on an identified date, the Assistant Director of Care (ADOC) indicated that if the devices were not soiled they can be used for another resident. The ADOC indicated that the expectation was that staff were to disinfect the devices and all staff had training on infection control practices upon hire.

The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program, as interviews with staff indicated that specific devices were being shared by residents and were not disinfected in between use. [s. 229. (4)]

2. The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #022504-17 in an identified month, related to medication administration. The complainant indicated that the home was asking PSWs to fill portable medical devices and applied an identified treatment to residents without the appropriate training.

On an identified date and time, inspector #607 observed two portable medical equipments placed on top of an unclean area on an identified unit. The inspector observed PSW #120 took the two portable equipments from the unclean area, refill them, place them back on the specified area, and pushed the unclean equipment back to another unit. The PSW did not perform hand hygiene, and later was observed placing one of the portable medical equipments on resident #003's mobility aid, and then provide an identified treatment to resident #003.

During an interview on an identified date and time, PSW #120 indicated to the inspector that it was not a common practice for staff to place clean medical equipments on unclean areas, and further indicated the home's expectation is that staff were to carry the identified clean medical equipments separately from the unclean equipment. The PSW indicated the portable medical equipments belonged to resident #003 and #009.

During an interview on an identified date and time, RPN #121 indicated to inspector #607 that the licensee's expectation is that if staff were refilling the portable medical equipments, they were to clean their hands in between filling and administering identified treatment to residents.

During an interview on an identified date and time, the DOC indicated the licensee's expectation is that unclean and clean equipments are to be kept separate and staff are to complete hand hygiene in between resident's care.

The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program, specifically related to PSW #120 was observed portering clean medical equipments on a unclean surface, and did not perform hand hygiene in between transporting the unclean equipment and administering treatment to a resident. [s. 229. (4)]

3. The licensee has failed to ensure that on every shift the symptoms are recorded and that immediate action is taken as required.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #022504-17 in an identified month, related to infection control.

A review of resident #013's clinical health records indicated that the resident had a specific diagnosis. The resident's Physician ordered four different medications over specified identified months, to treat a specific area.

A review of the clinical records for resident #013 over a specified time period, identified that there were no recorded symptoms of infection related to the treatment being provided to the resident on all shifts, for an identified number of shifts, including documentation related to the effectiveness of the medications.

During an interview with RPN #143 on an identified date, the RPN indicated to inspector #607, that staff were to monitor symptoms of infection on every shift if a resident was taking an identified medication, and further indicated that this documentation should be completed in the progress notes or under the vital signs tab in the home's electronic software. The RPN reviewed resident #013's clinical record with the inspector and verified that resident #013's symptoms of infection were not being monitored on every shift.

During an interview on an identified date, the DOC indicated to inspector #607 that the licensee's expectation is that residents are to be monitored for symptoms of infection on all shifts during the course of receiving identified medicated treatments and further indicated that staff should be documenting symptoms of infection in the progress notes. [s. 229. (5) (b)]

4. The sample size was increased to include resident #011 as there was non-compliance identified related to infection control.

A review of resident #011's clinical health records indicated that the resident had a physician's order in place and was receiving and identified medication for an identified diagnosis.

Further review of the clinical health records for resident #011 indicated that over a specified time period, there was no documented evidence to indicate the symptoms of infection were being monitored on every shift. There were identified shifts where the resident symptoms were not documented nor were there evidence of monitoring of the effectiveness of the medication treatment.

During an interview on an identified date, RPN #121 indicated to the inspector that resident's are monitored for symptoms of infection on every shift, and this includes the taking the resident's temperature to ensure symptoms are improving.

During an interview on an identified date and time, the DOC indicated to inspector #607 that the licensee's expectation is that residents are to be monitored for symptoms of infection on all shifts during the course of receiving a specific treatment and further indicated that staff should be documenting symptoms of infection in the progress notes. [s. 229. (5) (b)]

5. The sample size was increased to include resident #012 as there was non-compliance identified related to infection control.

A review of resident #012's clinical health records indicated that the resident had a physician's order in place and was receiving an specific medication for an identified diagnosis.

Further review of the clinical health records for a specified time period, indicated that there was no documented evidence to indicate the symptoms of infection were being monitored on every shift for resident #012. There were identified shifts where there was no monitoring of the effectiveness of the identified treatment.

During an interview on an identified date and time, RN #146 indicated that residents are to be monitored for symptoms of infection on every shift, and this includes the taking the resident's temperature.

During an interview on an identified date and time, the DOC indicated to inspector #607 that the licensee's expectation is that residents are to be monitored for symptoms of

infection on all shifts during the course of receiving identified treatments and further indicated that staff should be documenting symptoms of infection in the progress notes.

The licensee failed to ensure that when resident #011, #012 and #013 were receiving identified treatments for infections, there was no documented evidence of monitoring of the residents' symptoms and responses or the effectiveness of the treatment being taken on several identified shifts. [s. 229. (5) (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 ensuring that staff participate in the implementation of the infection prevention and control program and ensuring that staff on every shift record symptoms of infection in residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 38. Notification re personal belongings, etc.
Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or
(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.

Findings/Faits saillants :

1. The licensee failed to ensure that a resident or the resident's substitute decision-maker was notified when the resident's personal aids or equipment were not in good working order or require repair.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #022504-17 in an identified month, related to falls. The complainant indicated that resident #004 had a fall as result of improper transfer assessments.

During an interview with an unidentified staff member on an identified date, indicated that

resident #004's falls might have been attributed to a broken part to the resident's mobility aid.

On an identified date and times, the inspector observed resident #004's mobility aid was missing an identified part and noted that the resident was not able to position self appropriately because of the missing part.

During an interview with resident #004's Substitute Decision Maker (SDM) indicated not being aware of resident #004's mobility aid missing the identified part until it was brought it to the SDM's attention by the inspector.

During an interview on an identified date, PSW #136 indicated being aware that the identified part was missing from resident #004's mobility aid. The PSW indicated that when a resident's mobility aid was in need of repair, it would have been either reported to the nurse in charge of the unit or be written in the external contracted supplier's binder, located at the nursing station.

A review of the external suppliers binder located by the nursing station failed to locate that there was an entry for the identified part to resident #004's mobility aid, needing repair.

During an interview on an identified date and time, RPN #101 verified that there was no entry for the specified identified part needed to be repair/replace for the resident's mobility aid documented in the external contractor's binder, the RPN made an entry for the specific part to be repaired in the binder while the inspector was present. The RPN further indicated that the resident's mobility aid needing the specific part will be brought to the Physiotherapist's (PT) attention.

During an interview on an identified date and time, the PT indicated when a resident's mobility aid needed repair, staff can either bring it to the PT's attention or make an entry in the external contractor's binder. The PT indicated that staff brought the concern surrounding resident #004's mobility aid needing repair to the PT's attention on the same day. The PT also indicated that they were in the process of looking into replacing the identified part to the resident's mobility aid.

The licensee failed to ensure that when resident #004's mobility aid required an identified part, the resident or the resident's substitute decision-maker was notified that the resident's personal aids or equipment was not in good working order or required repair.

[s. 38. (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is sufficient supply of clean linens, always available in the home for use by the resident.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #022504-17 in an identified month, related to laundry services. The complainant indicated that there were not enough of an identified linen available to assist with the care of residents.

On an identified month, the inspector observed an identified clean linen cart being taken to the unit, the cart had two a specific identified types of linen. A review of the quota listed on the cart indicated the unit should be receiving a specific number of the identified linen.

On an identified month and a separate date, the inspector observed another identified clean linen cart being taken to the unit, the linen cart had an identified number of the specific linen. A review of the quota listed on the cart, indicated the unit should be receiving a specific amount of the identified linen. On the same date and time, the inspector observed a separate identified unit linen cart to have one of the identified linen, while the quota indicated the unit should have received another specific amount.

During interviews on an identified date, PSWs #106, #107 and #108 all indicated not having enough of the identified linen to provide care to residents.

During an interview on an identified date and time, Laundry/housekeeping Aide (HSKP)

#123 indicated there was a shortage of the identified linen and further indicated that the shortage of the linens were noticed by the laundry staff on an ongoing basis. The HSKP staff also indicated that there were not enough of the linen to complete the quota listed on the linen cart for each unit on daily basis. The HSKP staff indicated the Environment Service Manager (ESM) was aware of this shortage and has access to the linen discard forms that were being completed on a monthly basis by the HSKP staff. The HSKP staff further indicated that these forms would normally indicate the amount of linen that was needed by the Long-term care home, and further indicated that this would have included the identified linen in question.

During an interview on an identified date and time, the ESM indicated that the linen carts were stacked and taken to the units at a specified time and the linens on the carts were stacked for a specified time period. The ESM also indicated not being aware of the units not having enough of the identified linen, as this was not communicated by the nursing staff.

The licensee has failed to ensure that there was sufficient supply of clean linens, always available in the home for use by the resident, as the observations of the linen cart and interview with staff by the inspector, indicated there was not sufficient of an identified linen to provide the residents care needs. [s. 89. (1) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: A description of the individuals involved in the incident, including, names of any staff members or other persons who were present at or discovered the incident, and names of staff members who responded or are responding to the incident.

A Critical Incident Report was submitted to the Director on an identified date, for an

allegation of a resident to resident to resident abuse that occurred in an identified month, involving resident #005 and #006, that resulted in an injury to resident #006.

A review of the licensee's video footage on an identified date and time, of the incident, indicated that PSW #142 and #143 were also present and or either responded to the incident, but was not identified in the CIR.

During an interview with the ED on an identified date, verified that PSW #142 and #143 were also present and or either responded to the incident, and their names were not included in the CIR.

The licensee has failed to ensure that the report to the Director included the names of the staff who were present or either discovered the incident specifically related to resident #005. [s. 104. (1) 2.]

2. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons.

A Critical Incident Report was submitted to the Director on an identified date, for an incident that caused an injury to a resident for which the resident was taken to hospital and which results in a significant change in the resident's health status related to resident #005 and #008, that resulted in a injury to resident #008.

A review of the CIR had no documented evidence to indicate resident #005's SDM was notified of the above identified incident.

During an interview on an identified date and time, the ED verified that resident #005 SDM's name was not included in the CIR.

The licensee failed to ensure that the report to the Director indicated, whether resident #005's family member, a person of importance or SDM of the resident(s) involved in the incident was contacted and the name of such person or persons. [s. 104. (1) 3.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Under O Regulation 79/10, r. 107. (7) In this section, "significant change" means a major change in the resident's health condition that, (a) will not resolve itself without further intervention, (b) impacts on more than one aspect of the resident's health condition, and (c) requires an assessment by the interdisciplinary team or a revision to the resident's plan of care.

A Critical Incident Report was submitted to the Director on an identified date, for an Incident that occurred, that caused an injury to a resident for which the resident was taken to hospital and which results in a significant change in the resident's health status, and resulted in a injury to resident #004. According the CIR the resident was found out of their mobility aid between two identified areas.The resident was assessed by a registered staff member and was transferred to an acute care facility at an identified date and time, for further assessments.

A review of the resident #004's clinical health records indicated the resident was assessed by the Physiotherapist related to the fall and injury.

During an interview on an identified date, PSW #106 and RPN #119 indicated that the injury to resident's #004, had resulted in the resident having a significant change. The PSW and RPN further indicated that resident #004 plan of care was revised related to the residents transfer.

During an interview on an identified date, the DOC indicated that a Critical Incident Report (CIR) should have been submitted related to resident #004's fall and fracture as the resident fracture resulted in a significant change.

The licensee failed to ensure that the Director was notified no later than one business day after the occurrence of an incident that caused an injury to resident #004 that results in a significant change in the resident's health condition. Resident #004 sustained a fall that resulted in the resident sent to hospital and returned with an injury. The incident was not reported to the Director until an identified date and the CIR was only submitted as a result of the inspection, after the inspector brought it to the DOC's attention, several business days later. [s. 107. (3)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (3) The quarterly evaluation of the medication management system must include at least,
(a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk; O. Reg. 79/10, s. 115 (3).
(b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act; and O. Reg. 79/10, s. 115 (3).
(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 115 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the quarterly evaluation of the medication management system include reviewing reports of any medication incidents.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #022504-17 in an identified month, related to medication administration. The complainant indicated that unregulated staff were being asked to administer medical treatment without the proper training.

A review of the licensee Professional Advisory Committee (PAC) meeting minutes for an identified time period, had no documented evidence that medications incidents were reviewed during the meetings.

During an interview on an identified date and time, the DOC indicated that medications incidents are reviewed at PAC meetings, and further indicated that in a specific identified month, medication incidents were not reviewed as part of medication quarterly evaluation, as the home was transitioning from one pharmacy to another at the time.

The licensee failed to ensure that the quarterly evaluation of the medication management system included reviewing reports of any medication incidents, as evidenced by the PAC meeting minutes for an identified month, did not include documented evidence of a review of the quarterly medication incidents. [s. 115. (3)]

Issued on this 28th day of November, 2018

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

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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) :	JULIET MANDERSON-GRAY (607)
Inspection No. / No de l'inspection :	2018_687607_0005
Log No. / No de registre :	022504-17, 025356-17, 003791-18, 004946-18, 005811-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 8, 2018
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Thorntonview 186 Thornton Road South, OSHAWA, ON, L1J-5Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Heather Power

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

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 6. of the LTCHA.

Specifically the licensee must:

1. Develop, implement and keep record of a process that documents the review and revision of the plan of care for resident #004 and any other resident determined to be at risks for falls, to ensure:
a) The plan sets out clear directions to staff and others who provide direct care to the residents.
b) The interventions developed related to falls and transfers located in the resident's specified area and the written plan of care coincide with each other, and are clearly documented in the written plan of care.

2. Review and revise the plan of care for resident #004, #005 and #008, and any other residents determined to be at risk for falls, to ensure the care is provided to those resident as specified in the plan of care. Specifically to ensure that fall prevention interventions such as:
a) Fall prevention devices are in place at all times; a monitoring system is in place and keep a documented record that the devices are in place and in good working order and;
b) A monitoring system is in place that staff who provide increase monitoring to residents, are aware of and that staff keep a documented record of the resident's whereabouts, at all times.

3. Review and revise the plan of care for resident #004 and any other residents determined to be at risk for falls, specifically to ensure that:
a) When the care set out in the plan of care had not been effective related to falls, different approaches are considered and document the revision of the plan of care.

b) A tracking process is developed, implemented and documented record is kept of residents who are at for falls to include falls incidents, and the review and revisions of the plan of care.

4. Ensure that all staff who provide direct care to residents in the home are retrained on the Falls Prevention Program, using resident #004, #005 and #008 as case studies to determine strategies that could be used to prevent or mitigate further falls/injuries from occurring, for current residents determined to be at risk for falls, and retain a copy of the education content and the staff training records to be reviewed upon request by the inspector.

5. Develop and implement a process to ensure that resident #004 and any other residents who have fallen and/or transferred to hospital and have returned with a significant change, are:
a) Assessed by a member of the SALT team related to their transfers status and;
b) Ensure that the interventions are incorporated, implemented and documented in the written plan of care and;
c) Keep a documented record of the assessments.

6. Develop and implement a process to ensure that residents #008 and all other residents at risk for falls or who have fallen, are:
a) Assessed and a record of the assessment(s) completed is available for review upon request of the inspector and;
b) Intervention(s) are developed, implemented and documented in the residents' written plan of care.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #022504-17 in an identified month, related to falls. The complainant indicated that resident #004 had a fall as result of an improper transfer.

At two identified times, in an identified month, inspector #607, observed a symbol in an identified area related to resident #004, indicating the resident

used a specific device to assist with transfers.

A review of current written plan of care indicated the resident required assistance with transfers and had several identified interventions in place.

During interviews on an identified date and time, PSW #106 and RPN #119 both indicated to Inspector #607 that resident #004 required staff assistance with transfers and the use of a specific device.

On an identified date and time, inspector #607 observed and verified with RPN #119 that the symbol in the identified area related resident #004, indicated that the resident required staff assistance with transfers using a specific device. The RPN also stated that the symbol located in an identified area related to resident #004, indicated the resident required a specific device, and documentation in the written plan of care indicating the resident required staff assistance for transfers, did not provide clear directions to staff.

During an interview on an identified date and time, the ADOC indicated to the inspector that the licensee's expectation is that written plan of care is to be updated as needed. The ADOC further indicated that if a transfer symbol located in an identified area and the written plan of care for the resident does not coincide, the written plan of care had not provided clear directions to staff.

The licensee failed to ensure that resident #004's written plan of care sets out clear directions to staff and others who provide direct care to the resident. Specifically related to the interventions related to transfer located in an identified area related to resident #004 and the interventions in the resident's written plan of care did not coincide. [s. 6. (1) (c)]

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

The sample size was increased to include resident #004 as there was non-compliance identified related to fall prevention.

On an identified date, at three separate identified times, the inspector observed resident #004 with the use of a specific mobility aid, in an identified area without

a specified fall prevention device in place.

A review of resident #004's plan of care related to falls indicated the resident was at risk for falls, and was to have specific fall prevention device in place.

During an interview on an identified date, PSW #129 and RPN #119 both indicated that resident #004 did not have the fall prevention device attached to their mobility aid. RPN #119 also indicated that care was not provided to the resident as per the plan of care.

During an interview on an identified date, the DOC indicated that if a resident requires a specific device, as identified in the written the plan of care, the licensee's expectation is that the device to be in place and functional.

The licensee failed to ensure that the care set out in resident #004's plan of care was provided to the resident. Specifically, it was noted that the resident did not have an identified device in place as per the plan of care. [s. 6. (7)]

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

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #024475-17 in an identified month, related to resident #005's responsive behaviours not being managed well by the Long-Term Care home.

A review of the current plan of care for resident #005 indicated the resident had several identified interventions in place related to responsive behaviours, including increase monitoring of the resident.

A review of resident #005's progress notes indicated that on an identified date and time, the resident had wandered away, while a staff member was providing increase monitoring of the resident. At the identified time, resident #005 held on to an unidentified resident, when PSW #139 separate both residents and redirected the unidentified resident. While the PSW was redirecting the unidentified resident, resident #005 walked past the PSW and held onto resident #008. Resident #005 let go off resident #008, when the resident lost their balance and fell, resulted in an injury to resident #008.

A review of the video footage on an identified date and time, related to the above identified incident involving resident #005 and #008 verified the same. Further review of the video footage indicated that after resident #008 fell, PSW #139 called for RPN #124, and stayed with resident #008. Resident #005 wandered away from the scene of the incident, while both PSW #139 and RPN #124 attended to resident #008.

During an interview with the Director of Care on an identified date, indicated that the staff who was providing increase monitoring of resident #005 should have been attending to resident #005.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan, as the staff that was providing increase monitoring of resident #005, left the resident unattended, resulting in resident #005 wandering off, subsequently leading to an injury to another resident. [s. 6. (7)]

4. The licensee has failed to ensure that when the resident is reassessed, the plan of care is reviewed and revised at any other time when the resident's care needs change.

The sample size was increased to include resident #008 as there was non-compliance identified related to fall prevention.

A review of the progress notes for resident #008 indicated the resident had a fall on an identified date, that resulted in an injury to the resident.

A review of resident #008's plan of care, indicated that the resident had several interventions in place related to eating. Further review of the plan of care had no documented interventions of resident #008 requiring staff assistance at meals.

During interviews on an identified date, PSW #133 and RPN #130 both indicated that resident #008 required assistance with eating due a recent injury.

On an identified date and time, during two identified meals, the resident was observed trying to eat without the assistance of a staff member.

During an interview on an identified date, the Registered Dietitian indicated that if a resident needs assistance with eating, the registered staff should address this on the plan of care.

The licensee failed to ensure that resident #008 was reassessed and the plan of care was reviewed and revised at any other time when the resident's care needs change. Specifically, the plan of care was not updated to include that the resident required staff assistance during meals, after sustaining an injury. [s. 6. (10) (b)]

5. The sample size was increased to include resident #004 as there was non-compliance identified related to fall prevention.

A review of resident #004's progress notes, indicated that the resident was found in an identified area between two devices. Further review of the progress notes indicated that a couple of staff had to assist in removing the resident's from between the identified devices. The resident was later transferred to hospital and was diagnosed with an injury.

A review of current written plan of care had several interventions in place related transfers.

During an interview on an identified date, PSW #113 indicated that resident #004 had returned from hospital with a diagnosed injury and a specific device to be in place related to the injury. The PSW also indicated resident #004 was being transferred on an identified date with the assistance of PSW #137. PSW #113 indicated there was a transfer symbol located in a specified area belonging to resident #004, that indicated that the resident was to be transferred by two staff via a specific transfer method. PSW #113 also indicated they both questioned if the resident was to be transferred via the identified method and went to confirm the resident's transfer status with RPN #138 and the Physiotherapist (PT), who both indicated that the resident was able to transfer via the identified method. PSW #113 indicated that both staff transferred resident #004 via the identified transfer method, and the resident had indicated being in pain during the transfer. PSW #113 also indicated that all the resident's weight was fully supported by the PSW's during the transfer, but the resident

beared weight on both staff, resulting in an injury to the PSW. The PSW further indicated that resident #004 should have been assessed upon returning from hospital by a member of the Safe Lift and Transfer team (SALT) member to determine the residents appropriate transfer status.

The PT indicated to the inspector during an interview on an identified date, that resident #004 was assessed by the PT upon returning from the hospital, but the assessment completed was related to ambulation. The PT indicated that usually a resident transfer status is assessed by the Long-term Care home SALT team and not by the PT.

A review of the SALT assessment record for resident #004 in the home's electronic software two identified date indicated the following:
-Assessment status was in progress, there was no documented evidence to indicate that the assessment was completed related to transfer.
-On the date the staff member was injured, an assessment was completed by a member of the SALT team to have the resident transfer via a specific device.

During an interview on an identified date, the Executive Director (ED) indicated, that both PSW #113 and #137, had brought forward concerns to the ED on the date staff member was injured, related to resident #004's transfer status and PSW #113 being injured during the transfer. The ED indicated that PSW #137, who assisted with the transfer of the resident is a member of the SALT team. The ED also indicated staff were aware that if a resident was assessed and the transfer was deemed unsafe, the staff were allowed to transfer the resident via a specific device, as per the licensee's policy. The ED indicated that PSW #137 was instructed at the time of the incident to complete a SALT assessment for resident #004. The ED further indicated that when resident #004 returned from hospital on an identified date, the resident transfer status should have been assessed by a member of the SALT team.

The licensee failed to ensure that resident #004 was reassessed, and the plan of care was reviewed and revised at any other time when the resident's care needs change. Specifically, resident #004 had a significant change in health condition related to a fall, was transferred to hospital and was not assessed upon returning, related to the resident transfer needs, until a number of days later, after a staff member was injured during a transfer of the resident. [s. 6.

(10) (b)]

6. The licensee has failed to ensure that if the resident is being reassessed, the plan of care is reviewed and revised because care set out in the plan has not been effective, the licensee shall ensure different approaches been considered in the revision of the plan of care.

The Ministry of Health and Long Term Care (MOHLTC) received an anonymous complaint Log #024475-17 an identified date, the complainant indicated residents that were having falls and were not being assessed appropriately.

The sample size was increased to include resident #004, as there was non-compliance identified related to fall prevention.

A review of resident #004 clinical health records indicated the resident had a number of falls in specified area, of the identified number of falls, several resulted in injuries to the resident.

A review of resident #004's plan of care on an identified date, indicated that the resident had several interventions in place related to falls.

During an interview on an identified date, PSW #126 and RPN #127, both indicated that resident #004 was at risk for falls and will often self-transfer to the resident's identified mobility aid. RPN #127 indicated that resident #004's falls only occurred in an identified resident specific area.

During an interview with the ADOC on an identified date, indicated that most of resident #004's fall was related to the resident self transferring and further indicated the interventions in place to prevent resident falls were not effective.

The licensee failed to ensure that when resident #004 was reassessed, different approaches were considered in the revision of the plan of care. Specifically, the resident had a number of falls during a specific identified months, in an identified resident specific area, related to self-transfer, and the interventions in the written plan of care that were in place, were not revised to include different approaches considered, over a specified period. [s. 6. (11) (b)]

The severity of this issue was determined to be a level 3 as there was actual harm to resident #004 and #008, related to falls. The scope was a level 2 as it related to two of three residents reviewed. The home had a level 3 compliance history as they had one or more related non-compliances in the last 36 months with these section related to s. 6 of the LTCHA that included:

- Voluntary Plan of Correction issued April 18, 2017 (2017_639607_0007);
- Voluntary Plan of Correction issued September 1, 2016 (2016_389601_0022);
- Written Notification issued May 16, 2016, (2016_293554_0009);
- Written Notification issued May 15, 2016, (2016_461552_0007).

(607)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

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 8th day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Juliet Manderson-Gray

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