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 sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 12, 2018	2018_520622_0018	009522-18, 015394-18, 016959-18	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

Heartwood
201 - 11th Street East CORNWALL ON K6H 2Y6

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

HEATH HEFFERNAN (622)

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): July 17, 19, 20, 24, 25, 26, 27, 30, 31, 2018

The following intakes were included in this inspection:
Complaint #IL-56879-OT and Complaint #IL-57589-OT - related to falls prevention, pain management, nutrition and hydration and resident care and services.
Critical Incident System Report (CIS) 2088-000013-18 - related to a fall with injury and hospital transfer.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Dietary Manager, the Physician, Registered Dietitian, Registered Nurses, Registered Practical Nurses, Personal Support Workers, the residents and family.

During the course of the inspection, the inspector reviewed the applicable complaint intakes and critical incident, the homes applicable investigation documents, health records, nutritional intake records, the Licensee's policies and procedures related to CARE5-O10.01 related to falls prevention, CARE8-P10 related to pain assessment, CARE7-P10 and CARE7-0.10.02 related to Nutrition, Personal Support Worker job routines and observed resident care and services.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

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

WN #1: The Licensee has failed to comply with 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 :

The Licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, procedure the licensee is required to ensure that the policy, procedure is complied with.

O. Reg. 79/10, s. 48 (1) 4. states that every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
A pain management program to identify pain in residents and manage pain.

A review of the Licensee's Pain Assessment and Management policy/Pain Intervention and Monitoring; INDEX: CARE8-O10.02 dated reviewed: March 31, 2018 indicated new or worsening pain may be identified by the resident, SDM, or unregulated care provider. The unregulated care provider will document pain observed or verbalized and report to the nurse. (During a telephone conversation on August 2, 2018 at 1351 hours, inspector #622 confirmed with the Administrator that UCP is an abbreviation used for an unregulated care provider which is the same as a Personal Support Worker (PSW). The abbreviation PSW will be used within this report.)

A review of the complaint letter received by the licensee on a specified date indicated resident #001 who sustained an injury on a specified date was noted to be in pain and vomited while being transferred by vehicle two days post injury.

A review of the homes complaint investigation documentation indicated:

On a specified date, the Associate Director of Care (ADOC) interviewed PSW #102 who indicated they had provided care for resident #001 prior to the resident's transfer on the

specified date. PSW #102 informed the ADOC that on the date of transfer, resident #001's SDM voiced concern with resident #001's pain and transfer.

On a specified date, PSW #103 provided a written statement during the homes complaint investigation which stated that resident #001 was in pain during the transfer into the vehicle and the SDM voiced concerns.

A review of the home's education and awareness documentation for PSW #102 and PSW #103 indicated on a specified date they assisted resident #001 who was in pain from an injury into a vehicle for transport. The expectations directed to PSW #102 and PSW #103 within the education and awareness document included that any change in health status of the residents including discomfort and or pain is required to be brought to the attention of the registered staff.

During an interview with inspector #622, resident #001's SDM said resident #001 was in pain at the time of transfer and after leaving the nursing home, resident #001's pain continued and were sick to their stomach.

During separate interviews with inspector #622, PSW #102 and #103 stated their responsibility was to ensure that the registered nurse was informed when a resident was noted to have pain symptoms. PSW #102 and #103 stated resident #001 had pain on transfer into the SDMs vehicle. PSW #102 and #103 stated they did not report that resident #001 was in pain to the registered nurse until after the resident left the nursing home's property.

During two separate interviews with inspector #622, the Administrator stated that on a specified date, when PSW #102 and PSW #103 observed resident #001 was in pain on transfer into the SDM's vehicle and the SDM reported resident #001 was in pain, PSW #102 and PSW #103 should have reported the pain to the registered nurse.

Therefore the Licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place a pain management policy and procedure, the licensee was required to ensure that the pain management policy and procedure was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The Licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, procedure, the licensee is required to ensure that the policy, procedure is complied with.

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

A review of the Licensee's Falls Prevention and Injury Reduction - Post Fall Management procedure - INDEX: CARE5-O10.05 reviewed March 31, 2018 indicated the procedure for post fall management would included a post fall assessment being completed by the nurse immediately following the fall including vital signs every shift for a minimum of 72 hours.

A review of the progress notes on point click care indicated resident #001 fell on a specified date. The fall was witnessed, the resident was assessed and no injury was noted.

A review of the hard copy of resident #001's health records, the progress notes and the vital signs tab on point click care indicated there had not been any documentation of vital signs each shift for 72 hours after the fall on the specified date.

During an interview with inspector #622, RPN #114 stated that they could not find the documentation of vital signs being taken each shift for 72 hours after the fall on the specified date. RPN #114 indicated it would be on paper in the hard copy of the resident's record. Inspector #622 along with RPN #114 reviewed point click care progress notes and the hard copy of resident #001's health records and could not locate any documented vital signs for 72 hours after the initial fall assessment of resident #001 on the specified date. RPN #114 stated they did not know if any vital signs had been taken.

During an interview with inspector #622, the Administrator stated that the 72 hour follow up vital sign documentation could not be found, and could not say for sure if the vital signs had been completed every shift for the 72 hours after the fall on the specified date.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as the concern was isolated to one out of three residents reviewed. The home had a level 4 compliance history as they had on-going noncompliance with this section of the Regulation that included: written notification

(WN) issued June 17, 2016 (2017_285126_0011); voluntary plan of correction (VPC) issued August 9, 2016 (2016_290551_0018); VPC issued April 3, 2018 (2018_702197_0008). [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

s. 11 (1) of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8 indicates that every licensee of a long-term care home shall ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

A review of the Licensee's Procedure 2 - Food and Fluid Intake Monitoring, INDEX: CARE7-0.10.02, reviewed March 31, 2018 indicated the PSW staff document food and fluid intake each shift as required including activities and during the night shift.

A review of complaint #IL-56879-OT dated a specified date indicated resident #001 had nothing to eat or drink from the day before at dinner to the next day after a specified time and the family was concerned with resident #001's weight loss.

A review of resident #001's weight documented on Point Click Care (PCC) indicated that for a three month period, there was no weight loss.

A review of the most recent care plan dated a specified date indicated resident #001 was at nutritional high risk due to suboptimal food and nutrient intake contributing to reduced food, fluid and nutrient intake and chronic low body weight.

A review of Point of Care (POC) documentation related to meal intake dated for two months for resident #001, indicated there had been multiple meals not documented.

Inspector #622 added residents #008 and #009 to increase the scope of the inspection as follows:

A review of POC documentation related to meal intake dated for a one month period for resident #008 indicated there had been multiple meals not documented.

A review of POC documentation related to meal intake dated for a one month period for resident #008 indicated there had been multiple meals not documented.

During separate interviews with inspector #622, the Director of Care #109 stated the omission of the meal intake documentation on POC for resident's #001, #008 and #009 did not indicate that the residents had not ate, it meant that the PSW staff did not document the meal intakes as required.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the resident. The scope of the issue was a level 3 as the concern was observed for three out of three residents reviewed. The home had a level 2 compliance history with 1 or more unrelated NC in the last 36 months. [s. 30. (2)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident is reassessed and the plan of care reviewed and revised, 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.

A review of Complaint #IL-57589-OT which indicated on a specified date, resident #001 fell and was transferred to the hospital where it was discovered that resident #001 had sustained a specified injury.

A review of the progress notes dated a specified date, indicated that treatment for the specified injury was pain management.

A review of the physician's orders on the electronic record indicated on a specified date, resident #001 was ordered a specified medication every 4 hours as needed for pain control.
Resident #001 also had an order for a routine analgesic three times daily.

A review of the electronic medication administration records (eMar) dated a specified month, indicated resident #001 received the specified medication for pain without effect at three specified times on a specified date one day post fall.

A review of the corresponding progress notes dated a specified date for the previously mentioned administration of the specified pain medication indicated the medication was ineffective for pain control at three specified times that date and did not indicate further interventions attempted to alleviate the pain.

During an interview with inspector #622, RPN #105 who administered resident #001 one

of the ineffective doses of the specified medication for pain could not recall any further interventions initiated to alleviate resident #001's pain.

During an interview with inspector #622, RPN #104 who administered resident #001 the ineffective doses of the specified medication for pain at two specified times stated they could not recall any further interventions initiated to alleviate resident #001's pain on that date.

During separate interviews with inspector #622, PSW #103 and PSW #112 indicated they had not performed any non-medicinal pain control interventions for resident #001 on the specified date.

During an interview with inspector #622, Registered Nurse (RN) #108 stated when resident #001 was administered the specified medication for pain at three specified times on the specified date without effect, RPNs #104 and #105 should have reported that the pain medication was not effective for resident #001 to the RN as the physician could have been contacted for review of the medication. RN #108 said RPN's #104 and #105 had not informed the RN as expected. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that when a resident is reassessed and the plan of care reviewed and revised, 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.

A review of the complaint email received by Revera Corporate Office on a specified date indicated care concerns pertaining to the transfer of resident #001, neglect of the residents and inadequate living conditions.

A review of the email from Corporate Head Office's Senior Living Advisor indicated they forwarded the email of complaint related to resident #001 to the Administrator on a specified date and time.

A review of the email from the Administrator to the Ministry of Health at MOH-G-HSAPD PIC CIATT General indicated the email of complaint related to resident #001 was sent to the Ministry of Health and Long Term Care almost 24 hours after the complaint was received.

During an interview, Inspector #622 asked the Administrator what the legislated requirement was for reporting written complaints to the Ministry of Health, the Administrator stated immediate. When inspector #622 asked the Administrator if the written complaint email received on a specified date related to resident #001 was reported immediately to the Ministry of Health, the Administrator stated no.

A review of the email trail between a concerned family member and Revera Corporation indicated the Regional Manager – Health and Wellness/East Region 4 at Revera Inc. received the complaint email related to resident #008 on a specified date and time. The complainant indicated there had been concerns related to resident #008 not receiving nourishments and infection control practices within the home. Further review indicated the Regional Manager – Health and Wellness/East Region 4 at Revera Inc. forwarded the written complaint email on a specified date four days later to the National Director Clinical Support for Revera Inc. On a specified date five days after the initial email of complaint was received, the email was forwarded by the National Director Clinical Support for Revera Inc. to the Administrator at the nursing home who submitted the written complaint email to the Ministry of Health on that specified date.

During a second interview related to the complaint email for resident #008, the Administrator stated that the complaint was received by the regional Manager – Health and Wellness/East Region 4 in the Revera chain on a specified date. As the regional Manager – Health and Wellness/East Region 4 was from the retirement side of the business, they may not have been aware of the requirements to report the written letter of complaint immediately. The regional Manager – Health and Wellness/East Region 4 forwarded the email of complaint to the National Director Clinical Support for Revera on a specified date four days later on a holiday weekend, the Management team did not receive the concern until the specified date five days after the initial complaint email was received. The Administrator stated they reported it to the Ministry of Health at that time.

Therefore, the licensee failed to ensure that written complaints concerning the care of residents or the operation of the long-term care home were immediately forward it to the Director. [s. 22. (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 that every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A review of the progress notes on point click care indicated on a specified date and time, resident #001 had a witnessed fall. Resident was up with their walker and fell backwards. Resident was assessed for injury and vital signs were taken. No injury was noted, the Substitute Decision Maker (SDM) was notified.

A review of resident #001's electronic records on point click care and the hard copy of resident #001's health records indicated no risk management documentation or post falls assessment had been completed for the fall resident #001 had on the specified date.

During an interview, RPN #114 and inspector #622 reviewed the documentation on point click care and in the hard copy of resident #001's health records. RPN #114 indicated that a post fall assessment had not been completed for resident #001’s fall on the specified date as the risk management documentation was not completed. RPN #114 stated that risk management documentation and the post fall assessments are completed together.

During an interview, the Administrator stated that the post fall assessment is triggered by the risk management documentation on point click care. If the risk management documentation was not completed for the fall of resident #001 on the specified date, the post fall assessment would not have been done.

Therefore, the licensee failed to ensure that when resident #001 fell on a specified date, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

Issued on this 23rd day of October, 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

Ministére 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) :	HEATH HEFFERNAN (622)
Inspection No. / No de l'inspection :	2018_520622_0018
Log No. / No de registre :	009522-18, 015394-18, 016959-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 12, 2018
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Heartwood 201 - 11th Street East, CORNWALL, ON, K6H-2Y6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Monty Domingo

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 :

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

Order / Ordre :

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

The licensee shall educate Personal Support Worker (PSW) #102, PSW#103 and all other PSWs in the home on the directions contained within the policy: Pain Assessment and Management policy/Pain Intervention and Monitoring; INDEX: CARE8-O10.02 specific to reporting observed pain of residents to the registered nurse. Documentation of the education and staff participation shall be kept.

and

The licensee shall develop, implement and document a plan for monitoring compliance with the directions contained in the policy: Falls Prevention and Injury Reduction - Post Fall Management procedure - INDEX: CARE5-O10.05 specific to 72 hour post fall vital sign assessments of residents who have fallen.

Grounds / Motifs :

1. The Licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, procedure the licensee is required to ensure that the policy, procedure is complied with.

O. Reg. 79/10, s. 48 (1) 4. states that every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
A pain management program to identify pain in residents and manage pain.

A review of the Licensee's Pain Assessment and Management policy/Pain Intervention and Monitoring; INDEX: CARE8-O10.02 dated reviewed: March 31, 2018 indicated new or worsening pain may be identified by the resident, SDM, or unregulated care provider. The unregulated care provider will document pain observed or verbalized and report to the nurse. (During a telephone conversation on August 2, 2018 at 1351 hours, inspector #622 confirmed with the Administrator that UCP is an abbreviation used for an unregulated care provider which is the same as a Personal Support Worker (PSW). The abbreviation PSW will be used within this report.)

A review of the complaint letter received by the licensee on a specified date indicated resident #001 who sustained an injury on a specified date was noted to be in pain and vomited while being transferred by vehicle two days post injury.

A review of the homes complaint investigation documentation indicated:

On a specified date, the Associate Director of Care (ADOC) interviewed PSW #102 who indicated they had provided care for resident #001 prior to the resident's transfer on the specified date. PSW #102 informed the ADOC that on the date of transfer, resident #001's SDM voiced concern with resident #001's pain and transfer.

On a specified date, PSW #103 provided a written statement during the homes complaint investigation which stated that resident #001 was in pain during the transfer into the vehicle and the SDM voiced concerns.

A review of the home's education and awareness documentation for PSW #102 and PSW #103 indicated on a specified date they assisted resident #001 who was in pain from an injury into a vehicle for transport. The expectations directed to PSW #102 and PSW #103 within the education and awareness document included that any change in health status of the residents including discomfort and or pain is required to be brought to the attention of the registered staff.

During an interview with inspector #622, resident #001's SDM said resident

#001 was in pain at the time of transfer and after leaving the nursing home, resident #001's pain continued and were sick to their stomach.

During separate interviews with inspector #622, PSW #102 and #103 stated their responsibility was to ensure that the registered nurse was informed when a resident was noted to have pain symptoms. PSW #102 and #103 stated resident #001 had pain on transfer into the SDMs vehicle. PSW #102 and #103 stated they did not report that resident #001 was in pain to the registered nurse until after the resident left the nursing home's property.

During two separate interviews with inspector #622, the Administrator stated that on a specified date, when PSW #102 and PSW #103 observed resident #001 was in pain on transfer into the SDM's vehicle and the SDM reported resident #001 was in pain, PSW #102 and PSW #103 should have reported the pain to the registered nurse.

Therefore the Licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place a pain management policy and procedure, the licensee was required to ensure that the pain management policy and procedure was complied with. [s. 8. (1) (a),s. 8. (1) (b)]
(622)

2. The Licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, procedure, the licensee is required to ensure that the policy, procedure is complied with.

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

A review of the Licensee's Falls Prevention and Injury Reduction - Post Fall Management procedure - INDEX: CARE5-O10.05 reviewed March 31, 2018 indicated the procedure for post fall management would included a post fall assessment being completed by the nurse immediately following the fall including vital signs every shift for a minimum of 72 hours.

A review of the progress notes on point click care indicated resident #001 fell on a specified date. The fall was witnessed, the resident was assessed and no injury was noted.

A review of the hard copy of resident #001's health records, the progress notes and the vital signs tab on point click care indicated there had not been any documentation of vital signs each shift for 72 hours after the fall on the specified date.

During an interview with inspector #622, RPN #114 stated that they could not find the documentation of vital signs being taken each shift for 72 hours after the fall on the specified date. RPN #114 indicated it would be on paper in the hard copy of the resident's record. Inspector #622 along with RPN #114 reviewed point click care progress notes and the hard copy of resident #001's health records and could not locate any documented vital signs for 72 hours after the initial fall assessment of resident #001 on the specified date. RPN #114 stated they did not know if any vital signs had been taken.

During an interview with inspector #622, the Administrator stated that the 72 hour follow up vital sign documentation could not be found, and could not say for sure if the vital signs had been completed every shift for the 72 hours after the fall on the specified date.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as the concern was isolated to one out of three residents reviewed. The home had a level 4 compliance history as they had on-going noncompliance with this section of the Regulation that included: written notification (WN) issued June 17, 2016 (2017_285126_0011); voluntary plan of correction (VPC) issued August 9, 2016 (2016_290551_0018); VPC issued April 3, 2018 (2018_702197_0008). [s. 8. (1) (a),s. 8. (1) (b)] (622)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 14, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Order / Ordre :

The Licensee must be compliant with O. Reg. 79/10, s. 30 (2).

The licensee shall develop, implement and document a plan for monitoring compliance with the directions contained in the policy: Food and Fluid Intake Monitoring, INDEX: CARE7-0.10.02 specific to the documentation of food and fluid intake each shift for residents #008 and #009 and all other residents.

Grounds / Motifs :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

s. 11 (1) of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8 indicates that every licensee of a long-term care home shall ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

A review of the Licensee's Procedure 2 - Food and Fluid Intake Monitoring, INDEX: CARE7-0.10.02, reviewed March 31, 2018 indicated the PSW staff document food and fluid intake each shift as required including activities and during the night shift.

A review of complaint #IL-56879-OT dated a specified date indicated resident #001 had nothing to eat or drink from the day before at dinner to the next day after a specified time and the family was concerned with resident #001's weight loss.

A review of resident #001's weight documented on Point Click Care (PCC) indicated that for a three month period, there was no weight loss.

A review of the most recent care plan dated a specified date indicated resident #001 was at nutritional high risk due to suboptimal food and nutrient intake contributing to reduced food, fluid and nutrient intake and chronic low body weight.

A review of Point of Care (POC) documentation related to meal intake dated for two months for resident #001, indicated there had been multiple meals not documented.

Inspector #622 added residents #008 and #009 to increase the scope of the inspection as follows:

A review of POC documentation related to meal intake dated for a one month period for resident #008 indicated there had been multiple meals not documented.

A review of POC documentation related to meal intake dated for a one month period for resident #008 indicated there had been multiple meals not documented.

During separate interviews with inspector #622, the Director of Care #109 stated the omission of the meal intake documentation on POC for resident's #001, #008 and #009 did not indicate that the residents had not ate, it meant that the PSW staff did not document the meal intakes as required.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the resident. The scope of the issue was a level 3 as the concern was observed for three out of three residents reviewed. The home had a level 2 compliance history with 1 or more unrelated NC in the last 36 months. [s. 30. (2)] (622)

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

Ministére 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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 14, 2018

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 12th day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

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Name of Inspector / Nom de l'inspecteur : Heath Heffernan

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