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

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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
Feb 5, 2019	2018_520622_0032	025005-17, 025675-17, 026580-17, 027394-17, 028085-17, 001993-18, 003383-18, 004195-18, 006465-18, 008647-18, 017254-18, 018451-18, 022730-18, 023202-18, 024196-18, 025136-18, 028472-18, 028604-18, 031981-18, 032455-18	Critical Incident System

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): December 12, 13, 14, 18, 19, 20, 21, 2018 and January 2, 3, 4, 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 2019.

The following intakes were included in this inspection:

Log #028472-18- follow up to CO #001 related to policy/procedure - pain and falls.
Log #028604-18 – follow up to CO #002 related to programs - nutrition.

Log #026580-17 (Critical Incident System report (CIS) #2088-000029-17), log #025136-18 (CIS #2088-000020-18), and log #027394-17 (CIS #2088-000039-17), log #004195-18 (CIS #2088-000006-18), log #025005-17 (CIS #2088-000026-17) - related to falls resulting in injury with significant change in status and hospital transfer.

Log #024196-18 (CIS #2088-000018-18) – related to improper/incompetent transfer of a resident that results in a fall with injury.

Log #003383-18 (CIS #2088-000003-18), log # 023202-18 (CIS #2088-000017-18), log #031981-18 (CIS #2088-000027-18) – related to alleged resident to resident abuse.

Log #022730-18 (CIS #2088-000016-18) - related to alleged staff to resident verbal and physical abuse.

Log #025675-17 (CIS #2088-000027-17) – related to injury with hospital transfer and significant change in the resident's health status.

Log #032455-18 (CIS #2088-000028-18) – related to unexpected death of a resident.

The following Intakes log #028085-17 (CIS #2088-000040-17), log #018451-18 (CIS #2088-000015-18), log #008647-18 (CIS #2088-000010-18), log #017254-18 (CIS #2088-000014-18), log #006465-18 (CIS #2088-000007-18), log #001993-18 (CIS #2088-000002-18) related to falls resulting in injury with significant change in status and hospital transfer were completed concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Regional Manager of Clinical Services, the Registered Nurse

(RN)/Acting Director of Care, the Associate Director of Care (ADOC), the Office Manager, the Recreation Manager, the Dietary Manager, the Resident Services Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Cooks, Personal Support Workers (PSW), Dietary Aide, a Recreation Aide, and the residents.

During the course of the inspection, the inspector reviewed the applicable critical incident intakes, the licensee's investigation documentation, health records, the Licensee's policies and procedures related to Operation of Mechanical Lifting/Transferring and Repositioning Devices, Skin and Wound care, Dementia Care, Resident Non-Abuse, Falls Prevention, Adverse Events, Critical Incident Reporting, Pleasurable Meal Service Strategies, Nutritional Care and Hydration, staff schedules, the licensee's compliance order follow up documentation including compliance audits, and observed resident care and services.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Critical Incident Response
Falls Prevention
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 30. (2)	CO #002	2018_520622_0018	622
O.Reg 79/10 s. 8. (1)	CO #001	2018_520622_0018	622

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).

Findings/Faits saillants :

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

Critical Incident System report (CIS) #2088-000027-17 indicated that on a specified date, resident #003 sustained a specified injury for which the cause was unknown. The CIS report stated that resident #003 may have caught an extremity in the bed rail.

A review of progress notes documented by the RAI Coordinator #106 dated a specified date indicated that bed rails were being used for positioning.

A review of the care plan indicated that resident #003 did not require bed rails for bed mobility, nor did they have bed rails.

During an observation on December 14, 2018 at approximately 1030 hours inspector #622 observed resident #003 in bed with two bed rails in the up position.

During an interview with inspector #622 on December 14, 2018, Personal Support Worker (PSW) #107 stated that resident #003 used bed rails for positioning and turning in bed. PSW #107 stated that direction for the use of bed rails would be found on resident #003's care plan as well as on point of care (POC). Inspector #622 and PSW #107 reviewed resident #003's care plan and point of care which indicated resident #003

did not require bed rails.

During an interview with inspector #622 on December 19, 2018, the Executive Director (ED) stated that the plan of care encompassed all documentation. The ED stated that since the progress notes and the CIS report indicated the use of bed rails for resident #003 and the care plan indicated bed rails were not used, the plan of care did not offer clear direction. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

Critical Incident System report (CIS) #2088-000028-18 was submitted to the Director under the Long-Term Care Homes Act (LTCHA) related to an incident resulting in the unexpected death of resident #002. The CIS report indicated that on a specified date and time, resident #002 was observed to be in distress and staff attempts to assist the resident were unsuccessful. Resident #002 was transferred to the hospital by ambulance and passed away.

On January 2, 2019, inspector #622 reviewed the winter Menu which the Dietary Manager #120 stated was the menu being offered on the specified date when resident #002 was in distress. The Menu stated on the specified date and time, the following items were being served:
Hawaiian Meat Balls, Steamed Rice, Diced Turnips, Mango and Pineapple or Bacon, Fried egg, baked beans, buttered wheat bread and peach crisp.

On December 20, 2018, inspector #622 reviewed the licensee's investigation documentation which indicated the Executive Director (ED) interviewed multiple staff. The interview notes indicated that:

- PSW #118 had placed the food in front of resident #002 on a specified date and time. PSW #118 stated it appeared as though resident #002 was in distress due to a specific food item as they had not touched anything else on their plate. PSW #118 was not aware that resident #002 required specified intervention at meals.

- On a specified date and time, Cook #116 had not performed the required specified intervention for resident # #002's meal. Cook #116 stated they were aware of their duties as the server, they had looked at the diet binder for direction related to resident #002's meal and could recall that the resident was on a specified diet. Cook #116 further

indicated they were aware of a list on the wall in the servery related to resident #002 but could not recall any further direction related to resident #002's dietary needs.

On January 2, 2019, inspector #622 received the Meal Service report from the dietary binder in the servery from the Dietary Manager #120 dated a specified date. The Meal Service Report indicated that resident #002 required a specified intervention at meals.

A review of the memo which hung in the servery stated resident #002 preferred to receive a specified intervention at meals.

During an interview with inspector #622, Cook #115 stated that direction for diet, texture and preferences would be found in the dietary binder in the servery. Cook #115 further stated that resident #002 required a specified intervention at the servery by the dietary staff and cook #116 should have been aware.

During a telephone interview with inspector #622 on January 4, 2019, Cook #116 stated they had referenced the dietary binder on the specified date and time and could not recall direction that resident #002 required the specified intervention. Cook #116 stated on the specified date and time, they had not performed the specified intervention for resident #002's meal.

During an interview with inspector #622 on December 21, 2018, the Executive Director (ED) stated that it was the responsibility of the dietary person in the servery to give the PSW staff the proper diet and texture. As part of the plan of care, there was a dietary binder in the servery that contained each resident's directions for diet and texture that the dietary staff follow. The ED stated that cook #116 had worked multiple times in that dining area, the direction was very specific and cook #116 had not performed the specified intervention for resident #002's food as directed in 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.

Critical Incident System report (CIS) #2088-000020-18 stated that on a specified date and time, resident #014 had an unwitnessed fall. Resident #014 was complaining of pain, transferred to hospital for assessment and diagnosed with a specified injury.

A review of the Fall Risk Assessment which was current at the time of the fall on the specified date stated that resident #014 was at high risk for falls.

A review of the progress notes dated a specified date and time, indicated that resident #014 had an unwitnessed fall. PSW #135 had indicated that resident #014 was left unattended during a specified care task.

A review of resident #014's care plan which was current at the time of the fall on the specified date, indicated that resident #014 was at high risk for falls. The care plan further indicated during a specified care task for resident #014, staff were to remain in the immediate area (defined as the resident's room by the Associate Director of Care (ADOC)).

During a telephone interview with inspector #622 on January 11, 2019, PSW #135 stated that resident #014 had always been left alone during the specified care task. Inspector #622 and PSW #135 discussed the care plan which indicated staff were to stay in the immediate area while performing the specified care task for resident #014. PSW #135 stated on the specified date they had left resident #014 unattended during the specified care task contrary to the plan of care.

During an interview with inspector #622 on January 11, 2019, Associate Director of Care (ADOC) #101 stated that during the specified care task for resident #014, staff were to stay in the immediate area. ADOC #101 stated that resident #014 had a history of falls and should not have been left alone during the specified care task. [s. 6. (7)]

4. 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.

Critical Incident System report (CIS) #2088-000018-18 stated that on a specified date and time, resident #015 was assisted during a care task using a specified device. PSW #139 used the specified device independently and resident #015 fell sustaining injury.

A review of the care plan which was current at the time of the fall on the specified date indicated that resident #015 required two staff when using the specified device.

During an interview with inspector #622 on January 14, 2019, PSW #138 stated that resident #015 had always required two staff for use with the specified device. PSW #138 stated PSW #139 used the specified device independently and resident #015 fell.

During a telephone interview with inspector #622 on January 14, 2019, RN #128 stated

PSW #139 was alone with resident #015 while using the specified device and resident #015 fell. [s. 6. (7)]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

O. Reg. 79/10, s. 49 (1). states that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

A review of the licensee's procedure for Safe Resident Handling – Operation of Mechanical Lifting/Transferring and Repositioning Devices – INDEX: CARE6-O10.07-LTC dated reviewed March 31, 2018, stated that all staff shall use supplied mechanical lifting and transfer devices to assist with lifting and transferring or repositioning residents as documented within each resident plan of care. Two staff must be present at all times while the mechanical device is in operation. Examples of such devices include but are not limited to mechanical passive lifts, active lifts, sit /stand devices, tub lifts and ceiling lifts.

Critical Incident System report (CIS) #2088-000018-18 stated that on a specified date and time, resident #015 was assisted during a care task using a specified device. PSW #139 used the specified device independently and resident #015 fell sustaining injury.

During an interview with inspector #622 on January 14, 2019, PSW #138 stated that resident #015 had always required two staff while using the specified device. PSW #138 stated that all staff had been trained for the safe and correct use of the specified device during the Safe Ambulation, Lifts and Transfers training (S.A.L.T.) which stated that two staff are required when using the specified device.

During an interview with inspector #622 on January 14, 2019, Associate Director of Care (ADOC) #101 stated that PSW #139 was aware they were supposed to use two staff for the use of the specified device with resident #015. Furthermore, ADOC #101 stated that PSW #139 had chosen to use the specified device with resident #015 independently and as a result resident #015 fell. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance 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 is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #020 and any other resident were protected from abuse by Personal Support Worker (PSW) #109.

In accordance with O.Reg.79/10 s.2(1) defined physical abuse as:
a) the use of physical force by anyone other than a resident that causes physical injury or pain.

In accordance with O.Reg.79/10 s.2(1) defined verbal abuse as:
a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Critical Incident System report (CIS) #2088-000016-18 indicated on a specified date, PSWs #109, #141 and #144 were in resident #020's room providing care. Resident #020 became aggressive with the staff. PSW #109 was alleged to physical and verbally abuse

resident #020.

A review of the licensee's investigation documentation indicated the incident of alleged abuse occurred during a shift on a specified date however was not reported by PSW #144 until five days later.

A review of the schedule dated a specified month indicated that PSW #109 had worked in the home on two dates between the date of incident and the date PSW #109 was placed on administrative leave seven days later.

During a telephone interview with inspector #622 on January 16, 2019, PSW#109 stated they would have worked with resident #020 when they were booked to work on the two dates between the date of incident and the date they were placed on administrative leave seven days later.

During an interview with inspector #622 on January 16, 2019, the Executive Director (ED) stated that the incident occurred on a specified date however was not reported to the Director of Care #145 until five days later. Inspector #622 asked the ED if the residents had been safeguarded from further incidents of alleged abuse by PSW #109 who continued to work on two dates between the date of incident and the date PSW #109 was placed on administrative leave and the ED stated no. [s. 19. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. This licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Critical Incident System report (CIS) #2088-000016-18 indicated on a specified date, PSWs #109, #141 and #144 were in resident #020's room providing care. Resident #020 became aggressive with the staff. PSW #109 was alleged to physically and verbally abuse resident #020. The CIS report was submitted to the Ministry of Health and Long-Term Care three days later.

A review of the licensee's investigation documentation indicated the incident of alleged abuse occurred on a specified shift and date however was not reported immediately by PSW #144 or PSW #141.

During an interview on January 16, 2019, inspector #622 asked the Executive Director (ED) about discrepancies noted in documentation related to the date of occurrence of the alleged staff to resident abuse of resident #020 by PSW #109. Inspector #622 indicated that the CIS report stated the date of occurrence was on a specified date however the licensee's investigation documentation indicated the date of occurrence was five days

earlier. The ED stated that PSW #144 was a new staff member who was afraid to report the allegation of abuse and reported during their shift five days after the incident occurred. The ED stated that the incident was not reported immediately. [s. 24. (1)]

2. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Critical Incident System report (CIS) #2088-000003-18 indicated an incident of alleged resident to resident abuse had occurred between residents #018 and #019 on a specified date and time. The CIS report related to the alleged resident to resident abuse was submitted to the Ministry of Health and Long-Term Care on the following day approximately 14 hours after incident. The CIS report further indicated that the Ministry of Health and Long-Term Care after-hours pager was not notified.

A review of the progress notes documented by RN #105 on point click care indicated on a specified date that there was an incident involving residents #018 and #019, when resident #018 had allegedly displayed abusive behaviour towards resident #019.

During an interview with inspector #622 on January 16, 2019, the Executive Director stated that for incidents of alleged abuse, reporting should be immediate. The ED stated that the incident of alleged abuse of resident #019 by resident #018 was not reported to the Ministry of Health and Long-Term Care (MOHLTC) immediately as Registered Nurse (RN) #105 should have called the after-hours pager. [s. 24. (1)]

3. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Critical Incident System report (CIS) #2088-000017-18 indicated an incident of resident to resident abuse occurred on a specified date and time and was reported on the same date but at an earlier time than the incident was alleged to occur. The CIS report stated that the Ministry of Health and Long -Term Care after-hours pager had not been called.

A review of the progress notes indicated that the alleged incident of resident to resident abuse between resident #023 and #024 had occurred one day prior to the date listed on the CIS report.

During an interview on January 18, 2018, inspector #622 interviewed the ADOC #101 who stated that they were not aware of the incident until the following morning after the incident on a specified date and that was when they submitted the CIS report to the Ministry of Health and Long-Term Care. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #5: 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).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
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. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident 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. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the Director is informed of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition no later than one business day after the occurrence of the incident.

Critical Incident System report (CIS) #2088-000029-17 indicated that resident #006 had a fall incident with injury and hospital transfer which resulted in a significant change in the resident's health status. The fall incident occurred on a specified date and time and was submitted to the Ministry of Health and Long-Term Care three days later. The CIS report further stated on the specified date of occurrence registered nurse (RN) #110 spoke with the resident's family and was aware that resident #006 had sustained a significant injury.

A review of progress notes for the specified date, indicated that the Office Manager #111 had documented attempts to call the Ministry of Health and Long-Term Care to report the fall incident related to resident #006 and the number provided for the Ministry of Health and Long-Term Care stated they were open eight to four and to please report the incident on the next business day.

During an interview with inspector #622 on December 20, 2018, Office Manager #111 stated that when they called the Ministry of Health and Long-Term Care on the specified date to report the fall incident of resident #006, they received the message to report the incident during the next business day. Office Manager #111 stated they would have sent an email to the Director of Care for their follow up.

During an interview with inspector #622 on December 19, 2018, the Executive Director stated that according to the records, the fall incident of resident #006 which occurred on a specified date was submitted to the Ministry of Health and Long-Term Care three days later. [s. 107. (3)]

2. The Licensee has failed to ensure that the Director is informed of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition no later than one business day after the occurrence of the incident.

Critical Incident System report (CIS) #2088-000006-18 indicated there was a fall incident that caused an injury to resident #005 for which the resident was taken to the hospital and resulted in a significant change in their health status. The fall incident occurred on a specified date and was submitted to the Ministry of Health and Long-Term Care two days later.

A review of progress notes on the specified date indicated that resident #005 was admitted to the hospital with a significant injury.

During an interview with inspector #622 on January 9, 2019, the Executive Director (ED) stated the incident related to resident #005's fall had not been submitted to the Ministry of Health and Long-Term Care within the required time frame based on the Director of Care's rationale that not all injuries of that type cause a significant change. The ED stated that they believed the DOC may have realized on a date two days after the incident that there was a change in resident #005's status and submitted at that time. Inspector #622 reviewed the progress notes dated for the specified date of the incident with the ED which indicated the home was aware that resident #005 had suffered a significant injury and was admitted to the hospital. The ED stated that the critical incident was not reported to the Ministry of Health and Long-Term Care within the required time frame. [s. 107. (3)]

3. The licensee has failed to ensure that a licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the outcome or current status of the individual or individuals who were involved in the incident.

Critical Incident System report (CIS) #2088-000029-17 submitted on a specified date and time indicated that resident #006 had a fall and was transferred to the hospital. The documented outcome on the CIS report indicated resident #006 was admitted to the hospital with a significant injury. An amendment was requested by the Ministry of Health and Long-Term Care which included the status of resident #006 upon return from the hospital. No amendments were made by the nursing home to CIS #2088-000029-17 related to the outcome of resident #006 upon return from the hospital.

During an interview with inspector #622 on December 19, 2018, the Executive Director (ED) stated that resident #006's outcome/condition upon return to the nursing home from the hospital had not been updated on the CIS report. [s. 107. (4) 3.]

4. The licensee has failed to ensure that a licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the outcome or current status of the individual or individuals who were involved in the incident.

A review of Critical Incident System report (CIS) #2088-000006-18 indicated on a specified date and time, resident #005 had a fall and was transferred to the hospital. The

documented outcome on the CIS report indicated that resident #005 had sustained a significant injury.

A review of the progress notes indicated that resident #005 was transferred to hospital after a fall on a specified date. The progress notes further indicated that the home was aware that resident #005 had been admitted to the hospital with a significant injury. Resident #005 returned to the nursing home five days after the fall incident.

A review of CIS #2088-000006-18 on the Ministry of Health and Long-Term Care website indicated that an amendment of resident #005's status upon return from hospital was requested by the Ministry of Health and Long-Term Care. No amendments were made by the nursing home to CIS #2088-000006-18 related to the outcome for resident #005 upon return from the hospital.

During an interview with inspector #622 on January 9, 2019, the Executive Director (ED) stated that the outcome/current status of resident #005 on return from the hospital was not included in (CIS) #2088-000006-18. [s. 107. (4) 3.]

5. The licensee has failed to ensure that a licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the outcome or current status of the individual or individuals who were involved in the incident.

Critical Incident System report (CIS) #2088-000039-17 indicated on a specified date, resident #004 had a fall and was transferred to the hospital. The documented outcome/current status of resident #004 on the CIS report indicated that the Director of Care had been informed that resident #004 had a significant injury. An amendment was requested by the Ministry of Health and Long-Term Care requesting the date of resident #004's return and their status upon return.

A review of the progress notes indicated resident #004 was transferred to hospital after a fall on a specified date and the home was aware that the resident was admitted to the hospital with a significant injury. Resident #004 returned to the nursing home five days after the fall incident.

During an interview with inspector #622 on January 9, 2019, the Executive Director (ED)

stated that the outcome/current status of resident #004 on return from the hospital was not included in CIS #2088-000039-17. [s. 107. (4) 3.]

6. The licensee has failed to ensure that a licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: the long-term actions planned to correct the situation and prevent recurrence.

Critical Incident System report (CIS) #2088-000029-17 indicated on a specified date, resident #006 had a fall and was transferred to the hospital. The documented outcome on the CIS report indicated resident #006 was admitted with a significant injury. An amendment was requested by the Ministry of Health and Long-Term Care which included any changes to the plan of care to prevent incident recurrence upon return to the nursing home. No amendments were made to CIS #2088-000029-17 related to any changes to the plan of care to prevent incident recurrence for resident #006 upon return from the hospital.

During an interview with inspector #622 on December 19, 2018, the Executive Director (ED) stated that the long term actions to prevent recurrence of the fall incident for resident #006 were not updated on CIS report #2088-000029-17 to the Ministry of Health and Long-Term Care. [s. 107. (4) 4.]

7. The licensee has failed to ensure that a licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: the long-term actions planned to correct the situation and prevent recurrence.

Critical Incident System report (CIS) #2088-000039-17 indicated on a specified date, resident #004 had a fall and was transferred to the hospital. The CIS report stated that the long-term actions planned to correct the situation and prevent recurrence were to review resident #004's change in status and implement care changes. An amendment was requested by the Ministry of Health and Long-Term Care requesting an update upon resident #004's return from hospital.

A review of the progress notes indicated resident #004 was transferred to hospital after a fall on a specified date, the home was aware that the resident was admitted to the

hospital with a significant injury. Resident #004 returned to the nursing home five days after the fall incident.

During an interview with inspector #622 on January 9, 2019, the Executive Director (ED) stated that they were unsure if the care plan had been updated for resident #004, CIS #2088-000039-17 was not updated to the Ministry of Health and Long-Term Care. [s. 107. (4) 4.]

Issued on this 6th day of February, 2019

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

Original report signed by the inspector.

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) :	HEATH HEFFERNAN (622)
Inspection No. / No de l'inspection :	2018_520622_0032
Log No. / No de registre :	025005-17, 025675-17, 026580-17, 027394-17, 028085-17, 001993-18, 003383-18, 004195-18, 006465-18, 008647-18, 017254-18, 018451-18, 022730-18, 023202-18, 024196-18, 025136-18, 028472-18, 028604-18, 031981-18, 032455-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 5, 2019
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
	Monty Domingo

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur :

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

Order / Ordre :

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

Specifically, the licensee shall:

Develop and implement a process that will:

1) Ensure the care set out in the plan of care for any resident related to dietary interventions reflective of the resident's current needs and provided as specified in the plan of care.

- include strategies that will ensure all dietary and nursing staff are aware of and have access to dietary related interventions in the plan of care for any resident.

2) Ensure the care set out in the plan of care for resident #014 and any other resident related to falls prevention reflective of the resident's current needs and provided as specified in the plan of care.

- PSW #135 shall be educated specific to the licensee's falls prevention program to ensure they are aware of the procedures in place to prevent falls in the home, this education shall be documented.

3) Ensure the care set out in the plan of care for resident #015 and any other resident related to lifts and transfers reflective of the resident's current needs and provided as specified in the plan of care.

- PSW #139 shall be educated specific to safe lifts and transfers to ensure they are aware of the procedures for safe lifts and transfers within the home, this education shall be documented.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

Critical Incident System report (CIS) #2088-000028-18 was submitted to the

Director under the Long-Term Care Homes Act (LTCHA) related to an incident resulting in the unexpected death of resident #002. The CIS report indicated that on a specified date and time, resident #002 was observed to be in distress and staff attempts to assist the resident were unsuccessful. Resident #002 was transferred to the hospital by ambulance and passed away.

On January 2, 2019, inspector #622 reviewed the winter Menu which the Dietary Manager #120 stated was the menu being offered on the specified date when resident #002 was in distress. The Menu stated on the specified date and time, the following items were being served:
Hawaiian Meat Balls, Steamed Rice, Diced Turnips, Mango and Pineapple or Bacon, Fried egg, baked beans, buttered wheat bread and peach crisp.

On December 20, 2018, inspector #622 reviewed the licensee's investigation documentation which indicated the Executive Director (ED) interviewed multiple staff. The interview notes indicated that:

- PSW #118 had placed the food in front of resident #002 on a specified date and time. PSW #118 stated it appeared as though resident #002 was in distress due to a specific food item as they had not touched anything else on their plate. PSW #118 was not aware that resident #002 required specified intervention at meals.

- On a specified date and time, Cook #116 had not performed the required specified intervention for resident # #002's meal. Cook #116 stated they were aware of their duties as the server, they had looked at the diet binder for direction related to resident #002's meal and could recall that the resident was on a specified diet. Cook #116 further indicated they were aware of a list on the wall in the servery related to resident #002 but could not recall any further direction related to resident #002's dietary needs.

On January 2, 2019, inspector #622 received the Meal Service report from the dietary binder in the servery from the Dietary Manager #120 dated a specified date. The Meal Service Report indicated that resident #002 required a specified intervention at meals.

A review of the memo which hung in the servery stated resident #002 preferred

to receive a specified intervention at meals.

During an interview with inspector #622, Cook #115 stated that direction for diet, texture and preferences would be found in the dietary binder in the servery. Cook #115 further stated that resident #002 required a specified intervention at the servery by the dietary staff and cook #116 should have been aware.

During a telephone interview with inspector #622 on January 4, 2019, Cook #116 stated they had referenced the dietary binder on the specified date and time and could not recall direction that resident #002 required the specified intervention. Cook #116 stated on the specified date and time, they had not performed the specified intervention for resident #002's meal.

During an interview with inspector #622 on December 21, 2018, the Executive Director (ED) stated that it was the responsibility of the dietary person in the servery to give the PSW staff the proper diet and texture. As part of the plan of care, there was a dietary binder in the servery that contained each resident's directions for diet and texture that the dietary staff follow. The ED stated that cook #116 had worked multiple times in that dining area, the direction was very specific and cook #116 had not performed the specified intervention for resident #002's food as directed in the plan of care. [s. 6. (7)] (622)

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.

Critical Incident System report (CIS) #2088-000020-18 stated that on a specified date and time, resident #014 had an unwitnessed fall. Resident #014 was complaining of pain, transferred to hospital for assessment and diagnosed with a specified injury.

A review of the Fall Risk Assessment which was current at the time of the fall on the specified date stated that resident #014 was at high risk for falls.

A review of the progress notes dated a specified date and time, indicated that resident #014 had an unwitnessed fall. PSW #135 had indicated that resident #014 was left unattended during a specified care task.

A review of resident #014's care plan which was current at the time of the fall on the specified date, indicated that resident #014 was at high risk for falls. The care plan further indicated during a specified care task for resident #014, staff were to remain in the immediate area (defined as the resident's room by the Associate Director of Care (ADOC)).

During a telephone interview with inspector #622 on January 11, 2019, PSW #135 stated that resident #014 had always been left alone during the specified care task. Inspector #622 and PSW #135 discussed the care plan which indicated staff were to stay in the immediate area while performing the specified care task for resident #014. PSW #135 stated on the specified date they had left resident #014 unattended during the specified care task contrary to the plan of care.

During an interview with inspector #622 on January 11, 2019, Associate Director of Care (ADOC) #101 stated that during the specified care task for resident #014, staff were to stay in the immediate area. ADOC #101 stated that resident #014 had a history of falls and should not have been left alone during the specified care task. [s. 6. (7)] (622)

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.

Critical Incident System report (CIS) #2088-000018-18 stated that on a specified date and time, resident #015 was assisted during a care task using a specified device. PSW #139 used the specified device independently and resident #015 fell sustaining injury.

A review of the care plan which was current at the time of the fall on the specified date indicated that resident #015 required two staff when using the specified device.

During an interview with inspector #622 on January 14, 2019, PSW #138 stated that resident #015 had always required two staff for use with the specified device. PSW #138 stated PSW #139 used the specified device independently and resident #015 fell.

During a telephone interview with inspector #622 on January 14, 2019, RN #128 stated PSW #139 was alone with resident #015 while using the specified device and resident #015 fell. [s. 6. (7)]

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 2 as it related to 43 percent of the residents inspected. The home had a level 4 history of on-going non-compliance with this section of the Act that included:
- Voluntary plan of correction (VPC) issued April 26, 2018 (2018_702197_0008)
- Voluntary plan of correction (VPC) issued January 9, 2018 (2017_520622_0039)
- Written Notification (WN) issued November 3, 2016 (2016_380593_0027).

(622)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 08, 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 5th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

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

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