Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

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

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

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

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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 25, 2019 | 2019_804600_0022 | 004682-19, 010630-19, 012794-19, 014798-19, 015924-19, 017171-19, 018007-19 | Critical Incident System |

## Licensee/Titulaire de permis

Villa Colombo Homes for the Aged Inc.
40 Playfair Avenue TORONTO ON M6B 2P9

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

Villa Colombo Homes for the Aged
40 Playfair Avenue TORONTO ON M6B 2P9

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

GORDANA KRSTEVSKA (600), JULIEANN HING (649)

## 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): October 2, 3, 4, 8, 9, 10, 21, 22, 23, 24, 25, 28, 2019.**

**The following intakes were completed in this Critical Incident System report inspection:**
**CIS: #004682-19, related to Respiratory Outbreak,**
**#010630-19, #012794-19, #014798-19, #015924-19, #018007-19, related to falls,**
**#017171-19, related to not proper transfer.**

**PLEASE NOTE: A non-compliance related to LTCHA, 2007, c.8, s. 6. (1) (c), s. 6. (7), and s. 6. (9) (1), identified in a concurrent inspection #2019_751649_0020, (Log #014078-19) were issued in this report.**

**During the course of the inspection, the inspector(s) spoke with the Director of Resident Services (DRS), Director of Nursing Unit (DNU), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Personal Support Workers (PSW), Substitute Decision Maker (SDM) and residents.**

**During the course of the inspection, the inspectors conducted observations of the home including resident home areas, the provision of residents' care, resident and staff interactions, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Infection Prevention and Control**

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

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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

**Specifically failed to comply with the following:**

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

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

**s. 6. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**Findings/Faits saillants :**

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

The Ministry of Long Term Care (MLTC) received a Critical Incident System (CIS) report on an identified date, detailing an incident involving resident #002 which resulted in transfer to hospital for further assessment and diagnosis of an injury to an identified body part requiring intervention.

A review of resident #002's health record indicated they were at risk for incident and required a specified level of assistance for an identified activity of daily living after returning from hospital on an identified date.

On a specified date in the morning, Inspector #763 observed resident #002's room. Written instruction sheets were displayed on a wall: one displaying a picture and another displaying a written instruction sheet regarding the level of assistance required.

The next morning, Inspector #763 observed PSW #102 and RPN #103 providing morning care to resident #002 in their room and assisting resident #002 with an activity of

daily living, using a specified level of assistance.

During an interview, PSW #102 indicated that they are not the regular direct care staff assigned to resident #002, but they were assigned to the resident's care for that shift. PSW #102 indicated that they checked a resident's plan of care and communicated with other staff to determine what kind of assistance the resident may require for their care. When asked about the two instruction sheets explaining resident #002's care needs displayed in their room, PSW #102 noted the two instruction sheets were unclear, indicating different level of assistance, which was why they confirmed with RPN #103 about resident #002's care needs before helping them. PSW #102 also noted that when they see similar instruction sheets in other residents' rooms, they provide those residents with the safer care method just to ensure their safety.

During an interview, RPN #103 indicated that resident #002 was at high risk for incident and required an identified level of assistance for one of the activities of daily living. RPN #103 helped PSW #102 during resident #002's morning care on the identified date and communicated to them that resident #002 required more assistance for care. RPN #103 indicated that the home uses the instruction sheets displayed in resident #002's room to communicate the plan of care to staff for resident #002. RPN #103 acknowledged that the pictures and instruction sheets of resident #002's assistance level in the room were unclear.

During an interview, PT #106 stated that only one logo should be displayed in a resident's room to communicate to staff the type of care assistance a resident requires. PT #106 stated that one of the written instruction sheets found in resident #002's room during inspection (indicating the identified level of assistance) was an instruction that is shared by the physiotherapy department with the nursing staff to provide communication of the resident's care needs after the intervention. PT #106 stated this instruction sheet was posted by nursing staff at the resident's bedside, but should have been taken down on an identified date, when resident #002 was reassessed by PT #106, and the instruction sheet was no longer current. PT #106 acknowledged that the identified picture and instruction sheet of resident #002's assistance level could be unclear to staff, as the information provided was outdated.

During an interview, Director of Nursing Unit (DNU) #104 confirmed the instruction sheets displayed for resident #002 constitute their plan of care, and that staff have responsibility to review unclear information and update it as needed based on the resident's current plan of care.

Record review, observations and interviews confirmed that the licensee failed to ensure resident #002's written plan of care set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The MLTC received a complaint on an identified date, related to concerns about the frequency of identified care provided to resident #003.

A review of the resident's plan of care and point of care (POC) documentation indicated a discrepancy in the frequency in which identified care was provided to resident #003.

A review of resident #003's written plan of care directed staff to check and assist the resident at identified times and as needed (PRN).

A review of the POC documentation indicated that PSWs have been documenting that resident #003 was checked and/ or assisted at a specified time.

In an interview with PSW #109, they acknowledged that the resident's plan of care and POC care times were confusing and stated they should correspond.

In an interview with DNU #119, they acknowledged that the resident's plan of care and POC care times should be the same therefore, the directions were not clear to staff and others who provide direct care to resident #003. [s. 6. (1) (c)]

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

The MLTC received a CIS report on an identified date detailing an incident involving resident #004 which resulted in transfer to hospital for further assessment and diagnosis of injury to an identified body part requiring a treatment. An amendment to the original CIS report indicated that resident #004's bed alarm was not sounding at the time of the incident because the resident removed the alarm, and that a new bed alarm sensor pad was provided to the resident after returning from hospital.

A review of resident #004's health record indicated they were at risk for incident. Interventions in the plan of care prior to the indicated incident included a specified intervention. A review of POC documentation on an identified date, indicated direct care staff responded "N/A - Not applicable" for all three shifts when asked to answer the

identified care question as part of resident #004's care record.

During an interview, PSW #105 noted that when they document N/A for the above indicated care question, they mean that the chair or bed alarm, bed alarm sensor pad is unavailable on that shift. PSW #105 indicated they worked on the identified date and completed POC documentation on their shift, indicating the chair or bed alarm sensor was not available. PSW #105 noted that they worked a few shifts before the identified date and resident #004's bed alarm sensor pad was missing during that time, which they reported to their supervisor.

During an interview, PSW #107 indicated they worked during the shift when resident #004 had the reported incident. PSW #107 noted they could not find resident #004's alarm at the time of the incident as it was unavailable. The PSW acknowledged that the resident had instances where they removed the alarm on their own, but not during this particular shift as the alarm was unavailable. PSW #107 provided increased monitoring for the resident during their shift because an alarm was unavailable, but the incident still occurred.

A further review of resident #004's health record indicated that resident #004 required a bed alarm sensor pad as part of their prevention plan of care after returning from hospital on an identified date. Staff progress notes on the two following dates, indicated the need to acquire a bed alarm sensor pad as none were found on the unit.

During an interview, RN #108 indicated that there were no bed alarm sensor pads available on the unit for resident #004 to use after they returned from hospital on the identified date. They indicated that didn't have time to check for more sensor pads in storage on the main floor of the home, so they communicated the need to find the bed alarm sensor pad to the oncoming shift.

During an interview, DNU #104 stated that the home has adequate incident prevention equipment available in the home, which are stored on the units as well as on the main floor as a backup. DNU #104 indicated that, when equipment is not readily available on their units, staff are responsible to get this equipment from storage rooms on other units, or the storage room on the main floor; if the equipment is not readily available, the plan of care is not being followed.

Record review and interviews confirmed that the licensee failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan. [s. 6.

(7)]

4. The MLTC received a CIS report on an identified date, related to an incident that took place on a specified date, involving resident #010. While resident #010 was being assisted for an assessment by two PSWs they had an incident, resulting in them sustaining an injury on an identified body part with existing skin impairment. The resident was transferred to hospital for further assessment.

Further review of the CIS and the home's progress notes indicated that the resident returned from hospital on a specified date, with no diagnosis of an injury. The resident received identified treatment for the injury to their body part on an existing skin impairment, and was ordered oral treatment for a week.

A review of the resident's plan of care under one of the activities of daily living indicated that the resident required a specified level of assistance by an identified number of staff. According to the PT's progress notes of the resident's assessments, they were using the assistive device for the identified activity of daily living since the beginning of the year. The resident's plan of care was not followed on the identified date, when the resident attempted to stand and sustained an injury to an existing skin impairment on their identified body part.

In an interview, resident #010, told the inspector when they were told that they will be assessed, they forgot about their decreased ability to ambulate and asked the staff for some assistance so they can ambulate. While attempting to ambulate the resident had an incident and they sustained injury to their identified body part that required treatment.

In an interview with PSW #116, who assisted with resident #010's transfer on an identified date told the inspector that they asked PSW #118 how they were going to assess the resident and the resident responded that they were going to try and help themselves. According to the PSW they were assisting the resident. They were both on the resident's left side. The PSW explained that the resident had a small incident and they assisted them back to their mobility device. PSW #116 then saw that the resident's identified body part was injured and stated that the resident always has a dressing on their body part. According to PSW #116 they thought that the resident had hit their body part on the metal of the equipment but were not certain. The inspector inquired what assistance the resident required for activity of daily living according to their plan of care and the PSW responded they have been using a specified assistive device to assist the resident with the activity by two staff. The inspector further inquired if the resident

required the specified assistive device with a specified level of staff for the identified activity why was the resident being assisted accordingly and without the specified assistive device. The PSW responded that the resident had their own mind to say what they wanted and told them they were able to be independent, and they believed them. PSW #116 acknowledged that the resident's plan of care had not been followed when they assisted the resident with PSW #118, and they sustained an injury to their identified body part.

In an interview, PSW #118 told the inspector that the resident stated that they could ambulate and explained they have their own mind, and very particular with what they want; they do not argue with the resident. During the activity they stood behind the resident and PSW #116 assisted. After the resident moved forward they suddenly went back, and they eased the resident back into their assistive device. The PSW further explained that the resident's identified body part must have hit the device as their body part was injured. They acknowledged that the resident required assistance for the identified activity. The inspector further inquired why the resident's plan of care was not followed. The PSW told the inspector that the resident wanted to stand. PSW #118 acknowledged that the resident's plan of care was not followed.

In an interview with RN #117, they told the inspector that they were not present when the resident was assessed and was told by the staff that the resident had small incident and sustained an injury on their identified body part. The inspector asked if the resident's plan of care was followed and they acknowledged that it was not and stated it was not the safest choice made by the staff. They explained that the resident was very vocal about wanting to ambulate and capable of making their own decisions. The RN further stated they understood that staff wanted to respect the resident's autonomy.

In an interview with DNU #104, they acknowledged that the resident's plan of care had not been followed. [s. 6. (7)]

5. Resident #013 was selected for sample expansion related to non-compliance with resident #010.

An observation on an identified date, at approximately 1030 and 1050 hours respectively by Inspector #649 indicated that resident #013 was assisted by PSWs #116 and #120 before an identified activity of daily living and by PSWs #116 and #121 after their activity, using the an identified device instead of using the specified device as was specified in their plan of care.

A review of the resident #013's plan of care under an identified activity indicated that they required the use of the specified device with an identified level of assistance with the identified activity. According to the resident assessment instrument – minimum data set (RAI-MDS) indicated the resident was to be assisted for the identified activity of daily living and was unable to attempt one of the tests without physical assistance.

In an interview, PSW #120 who assisted the resident with the identified activity of daily living on the identified date acknowledged that the resident was assisted using the identified device. According to the PSW they were not familiar with the resident and explained they had never worked with them before and had only worked on the unit the last two days. The PSW further stated they heard PSW #116 calling for help and when they arrived the resident was already affixed to the identified device.

In an interview, PSW #121, who assisted the resident with the identified activity of daily living on the identified date acknowledged that the resident was assisted using the identified device. The PSW told the inspector they were not familiar with the resident and had never worked with them before; they were only helping with the resident's transfer because PSW #116 had called for assistance.

In an interview with PSW #116, they acknowledged that they had assisted resident #013 twice on the identified date: before and after an identified activity using the identified device and confirmed that they had not followed the resident's plan of care when assisting the resident. According to the PSW, they were aware that the PT had not changed the resident's activity status, but they felt that the resident was getting stronger, and capable of using the identified device and following directions. They further told the inspector they did not usually use the identified device to assist the resident and acknowledged it was the first time they worked with PSW #120.

PSW #116 was the same staff involved in resident #010's transfer on an identified date, when they sustained an injury to their identified body part while they were being transferred by two staff without the specified device.

In an interview with DNU #104, they acknowledged that the resident's plan of care was not followed as they required the specified device for all assistance of identified activity. [s. 6. (7)]

6. The licensee has failed to ensure that the provision of care set out in the plan of care

was documented for the resident.

The MLTC received a CIS report on an identified date, regarding an incident that happened on a specified date involving resident #005 which resulted in transfer to hospital for further assessment and diagnosis of an injury to an identified body part requiring intervention.

A review of resident #005's health record indicated that the resident was identified at risk for incident due to change in health condition. The staff developed a plan of care to prevent incident. Some of the interventions set in the plan of care for the PSW to prevent the resident from incident was to provide an identified care, monitor the resident for incident and for a specified care activity, to check or assist the resident in bed at an identified frequency.

A review of the PSW daily Documentation Survey record for two months indicated that the PSW were to monitor the resident for incident and for a specified care activity, to check and assist the resident in bed at the identified times. Further review of the record from identified dates showed that the above-mentioned interventions were not documented. At the time when the resident had a incident and sustained an injury, PSW #125 indicated that they assisted the resident with the identified activity prior the incident, but were not able to document because they did not have time. A review of the record from other identified dates indicated, the intervention for incident prevention and specified activity as indicated above were also not documented.

Interviews with PSWs #125 and #131 indicated that they try to document as they go along with providing care to the residents, but sometimes, they don't have time to complete the documentation, as they focus on providing care to the residents.

In an interview, the DRS stated that the staff was provided with portable ipads so they can have it accessible and be able to document after they provide care to residents and they are expected to document accurately. The DRS acknowledged that the staff had not completed the documentation of the care that they provided to resident #005. [s. 6. (9) 1.]

7. The MLTC received a complaint on July 17, 2019, related to concerns about the frequency of identified care provided to resident #003.

A review of point of care (POC) documentation indicated that the provision of care related to two specified care activity schedules were not documented for resident #003

on identified dates.
In an interview with PSW #114 who worked on the identified dates they told the inspector that they assisted the resident with the identified activities on both dates but did not have time to document.

In an interview with PSW #113 who worked on the identified date the PSW told the inspector that they had provided care the resident at the time specified but did not have enough time to document.

In an interview with DNU #119, they explained that if staff did not document the care there is no proof that the care was provided and expected that the provision of care set out in the plan of care for resident #003 was documented. [s. 6. (9) 1.]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance - to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident,***
***- to ensure that the provision of care set out in the plan of care was documented for the resident, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #002's bed alarm sensor pad was maintained in a safe condition and in a good state of repair.

The MLTC received a CIS report on an identified date, detailing an incident involving resident #002 which resulted in transfer to hospital for further assessment and diagnosis of an injury of an identified body part requiring a specified treatment

A review of resident #002's health record indicated they were at risk for incident. Use of a bed alarm sensor pad was a specified incident prevention intervention for resident #002 since return. Resident #002's plan of care also indicated the following intervention:
- Ensure the bed alarm sensor pad is properly installed and is in use when the resident is in bed.

On an specified date in the morning Inspector #763 observed PSW #102 and RPN #103 providing morning care to resident #002 in their room. Inspector #763 observed the safety device in an identified location, however the device did not sound when the resident was assisted with an identified activity of daily living. The inspector asked RPN #103 to show how the safety device works, and RPN #103 noted the safety device was not working, because the batteries were dead. RPN #103 indicated they would change the batteries right away.

During an interview, PSW #102 and RPN #103 confirmed that the safety device was not in a good state of repair during morning care on the identified date.

During interview with DNU #104, they stated that all direct care staff are responsible for checking that equipment used for residents such as safety devices/bed alarm sensor pad are in a good state of repair to ensure resident safety.

Record review, observations and interviews confirmed that the licensee failed to ensure resident #002's bed alarm sensor pad was maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair;***
***to ensure that the Director is informed of an incident that caused an injury to resident #004, for which the resident was taken to a hospital and that resulted in a significant change, no later than one business day after the occurrence of the incident., to be implemented voluntarily.***

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**WN #3: 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):**
**4. Subject to subsection (3.1), 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.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to resident #004, for which the resident was taken to a hospital and that resulted in a significant change, no later than one business day after the occurrence of the incident.

The MLTC received a CIS report on an identified date, detailing an incident on a specified date involving resident #004 which resulted in transfer to hospital for further assessment and diagnosis of injury of an identified body part requiring a specified treatment.

A review of resident #004's health record included a progress note, indicating that staff called the hospital to get an update on resident #004's condition after the incident. Staff were notified that resident #004 sustained an injury of an identified body part requiring a specified treatment.

During an interview, DNU #104 confirmed they submitted the CIS report on an identified date as they were not in the home on the specified date. DNU #104 confirmed that when they are unavailable at the home, another staff member should submit the CIS report no later than one business day after the occurrence of the incident mentioned above.

Record review and interviews confirmed late reporting of a CIS report involving resident #004. [s. 107. (3) 4.]

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**Issued on this 1st day of December, 2019**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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

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

**Public Copy/Copie du public**

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | GORDANA KRSTEVSKA (600), JULIEANN HING (649) |
| **Inspection No. / No de l'inspection :** | 2019_804600_0022 |
| **Log No. / No de registre :** | 004682-19, 010630-19, 012794-19, 014798-19, 015924-19, 017171-19, 018007-19 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Nov 25, 2019 |
| **Licensee / Titulaire de permis :** | Villa Colombo Homes for the Aged Inc.<br>40 Playfair Avenue, TORONTO, ON, M6B-2P9 |
| **LTC Home / Foyer de SLD :** | Villa Colombo Homes for the Aged<br>40 Playfair Avenue, TORONTO, ON, M6B-2P9 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Tracey Comeau |

To Villa Colombo Homes for the Aged Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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**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 LTCHA 2007, c. 8, s. 6(7).

Specifically, the licensee must:
1) Ensure that resident #004 and all other residents who are at risk for falls, are provided with falls prevention and management interventions including bed alarm sensor pads as per their plan of care.

2) Ensure that residents #010 and #013 and all other residents who require assistance, are provided with assistance during transfer, as per their plan of care.

3) Ensure that registered staff and PSWs are knowledgeable about residents' transfer requirements and review their plan of care prior to providing care.

4) Develop and implement an auditing system to ensure staff are providing care to residents as set out in the plan of care related to the provision of fall prevention and management interventions; and assistance with transfers.

5) Conduct audits on bath/shower days, of residents who require the use of a mechanical lift on all shifts, to ensure compliance with their plan of care.

6) Maintain a written record of audits conducted in the home. The written record must include the date of the audit including which shift, the residents' name and room number, staff member(s) audited, the name of the person completing the audit, the outcome of the audit, and the follow up action.

7) Provide re-training to all PSWs working in the home on the home's transfer policy. The training should include but not be limited to:
(i) use of the correct transfer equipment specified in the residents' plan of care.
(ii) the risk to residents' when the incorrect lift type is used during a transfer.
(iii) how to manage residents who request a different level of transfer assistance other than what is specified in the plan of care, before a reassessment is completed.

A record of the training provided must be maintained that includes the topic covered, staff attendance records, date of the education and who provided the education.

**Order(s) of the Inspector**

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

**Ordre(s) de l'inspecteur**

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

**Grounds / Motifs :**

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

The MLTC received a CIS report on an identified date detailing an incident involving resident #004 which resulted in transfer to hospital for further assessment and diagnosis of injury to an identified body part requiring a treatment. An amendment to the original CIS report indicated that resident #004's bed alarm was not sounding at the time of the incident because the resident removed the alarm, and that a new bed alarm sensor pad was provided to the resident after returning from hospital.

A review of resident #004's health record indicated they were at risk for incident. Interventions in the plan of care prior to the indicated incident included a specified intervention. A review of POC documentation on an identified date, indicated direct care staff responded "N/A - Not applicable" for all three shifts when asked to answer the identified care question as part of resident #004's care record.

During an interview, PSW #105 noted that when they document N/A for the above indicated care question, they mean that the chair or bed alarm, bed alarm sensor pad is unavailable on that shift. PSW #105 indicated they worked on the identified date and completed POC documentation on their shift, indicating the chair or bed alarm sensor was not available. PSW #105 noted that they worked a few shifts before the identified date and resident #004's bed alarm sensor pad was missing during that time, which they reported to their supervisor.

During an interview, PSW #107 indicated they worked during the shift when resident #004 had the reported incident. PSW #107 noted they could not find resident #004's alarm at the time of the incident as it was unavailable. The PSW acknowledged that the resident had instances where they removed the alarm on their own, but not during this particular shift as the alarm was unavailable. PSW #107 provided increased monitoring for the resident during their shift because an alarm was unavailable, but the incident still occurred.

A further review of resident #004's health record indicated that resident #004 required a bed alarm sensor pad as part of their prevention plan of care after

returning from hospital on an identified date. Staff progress notes on the two following dates, indicated the need to acquire a bed alarm sensor pad as none were found on the unit.

During an interview, RN #108 indicated that there were no bed alarm sensor pads available on the unit for resident #004 to use after they returned from hospital on the identified date. They indicated that didn't have time to check for more sensor pads in storage on the main floor of the home, so they communicated the need to find the bed alarm sensor pad to the oncoming shift.

During an interview, DNU #104 stated that the home has adequate incident prevention equipment available in the home, which are stored on the units as well as on the main floor as a backup. DNU #104 indicated that, when equipment is not readily available on their units, staff are responsible to get this equipment from storage rooms on other units, or the storage room on the main floor; if the equipment is not readily available, the plan of care is not being followed.

Record review and interviews confirmed that the licensee failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan. (600)

2. The MLTC received a CIS report on an identified date, related to an incident that took place on a specified date, involving resident #010. While resident #010 was being assisted for an assessment by an identified number of staff, they had an incident, resulting in them sustaining an injury on an identified body part with existing skin impairment. The resident was transferred to hospital for further assessment.

Further review of the CIS and the home's progress notes indicated that the resident returned from hospital on a specified date, with no diagnosis of an injury. The resident received identified treatment for the injury to their body part on an existing skin impairment, and was ordered oral treatment for a week.

A review of the resident's plan of care under one of the activities of daily living indicated that the resident required a specified level of assistance by an identified number of staff. According to the PT's progress notes of the resident's

assessments, they were using the assistive device for the identified activity of daily living since the beginning of the year. The resident's plan of care was not followed on the identified date, when the resident attempted to stand and sustained an injury to an existing skin impairment on their identified body part.

In an interview, resident #010, told the inspector when they were told that they will be assessed, they forgot about their decreased ability to ambulate and asked the staff for some assistance so they can ambulate. While attempting to ambulate the resident had an incident and they sustained injury to their identified body part that required treatment.

In an interview with PSW #116, who assisted with resident #010's transfer on an identified date told the inspector that they asked PSW #118 how they were going to assess the resident and the resident responded that they were going to try and help themselves. According to the PSW they were assisting the resident. They were both on the resident's left side. The PSW explained that the resident had a small incident and they assisted them back to their mobility device. PSW #116 then saw that the resident's identified body part was injured and stated that the resident always has a dressing on their body part. According to PSW #116 they thought that the resident had hit their body part on the metal of the equipment but were not certain. The inspector inquired what assistance the resident required for activity of daily living according to their plan of care and the PSW responded they have been using a specified assistive device to assist the resident with the activity by two staff. The inspector further inquired if the resident required the specified assistive device with a specified level of staff for the identified activity why was the resident being assisted accordingly and without the specified assistive device. The PSW responded that the resident had their own mind to say what they wanted and told them they were able to be independent, and they believed them. PSW #116 acknowledged that the resident's plan of care had not been followed when they assisted the resident with PSW #118, and they sustained an injury to their identified body part.

In an interview, PSW #118 told the inspector that the resident stated that they could ambulate and explained they have their own mind, and very particular with what they want; they do not argue with the resident. During the activity they stood behind the resident and PSW #116 assisted. After the resident moved forward they suddenly went back, and they eased the resident back into their

assistive device. The PSW further explained that the resident's identified body part must have hit the device as their body part was injured. They acknowledged that the resident required assistance for the identified activity. The inspector further inquired why the resident's plan of care was not followed. The PSW told the inspector that the resident wanted to stand. PSW #118 acknowledged that the resident's plan of care was not followed.

In an interview with RN #117, they told the inspector that they were not present when the resident was assessed and was told by the staff that the resident had small incident and sustained an injury on their identified body part. The inspector asked if the resident's plan of care was followed and they acknowledged that it was not and stated it was not the safest choice made by the staff. They explained that the resident was very vocal about wanting to ambulate and capable of making their own decisions. The RN further stated they understood that staff wanted to respect the resident's autonomy.

In an interview with DNU #104, they acknowledged that the resident's plan of care had not been followed. (600)

3. Resident #013 was selected for sample expansion related to non-compliance with resident #010.

An observation on an identified date, at approximately 1030 and 1050 hours respectively by Inspector #649 indicated that resident #013 was assisted by PSWs #116 and #120 before an identified activity of daily living and by PSWs #116 and #121 after their activity, using the an identified device instead of using the specified device as was specified in their plan of care.

A review of the resident #013's plan of care under an identified activity indicated that they required the use of the specified device with an identified level of assistance with the identified activity. According to the resident assessment instrument – minimum data set (RAI-MDS) indicated the resident was to be assisted for the identified activity of daily living and was unable to attempt one of the tests without physical assistance.

In an interview, PSW #120 who assisted the resident with the identified activity of daily living on the identified date acknowledged that the resident was assisted

using the identified device. According to the PSW they were not familiar with the resident and explained they had never worked with them before and had only worked on the unit the last two days. The PSW further stated they heard PSW #116 calling for help and when they arrived the resident was already affixed to the identified device.

In an interview, PSW #121, who assisted the resident with the identified activity of daily living on the identified date acknowledged that the resident was assisted using the identified device. The PSW told the inspector they were not familiar with the resident and had never worked with them before; they were only helping with the resident's transfer because PSW #116 had called for assistance.

In an interview with PSW #116, they acknowledged that they had assisted resident #013 twice on the identified date: before and after an identified activity using the identified device and confirmed that they had not followed the resident's plan of care when assisting the resident. According to the PSW, they were aware that the PT had not changed the resident's activity status, but they felt that the resident was getting stronger, and capable of using the identified device and following directions. They further told the inspector they did not usually use the identified device to assist the resident and acknowledged it was the first time they worked with PSW #120.

PSW #116 was the same staff involved in resident #010's transfer on an identified date, when they sustained an injury to their identified body part while they were being transferred by two staff without the specified device.

In an interview with DNU #104, they acknowledged that the resident's plan of care was not followed as they required the specified device for all assistance of identified activity.

The severity of this issue was determined to be level 3 as there was actual harm to the residents. The scope of the issue was level 2 as it related to two of the three resident's reviewed. The home had a level 3 history as they had on-going-non-compliance with this subsection of the LTCHA in the last 36 months, that included:
Written notification (WN) issued June 23, 2017, (2017_642606_0005);

Written notification (WN) issued July 17, 2018, (2018_654618_0014);
Compliance Order (CO) issued October 10, 2018, (2018_634513_0009);
Voluntary plan of correction (VPC) issued November 3, 2018, (2018_634513_0013);
Voluntary plan of correction (VPC) issued February 21, 2019, (2019_631210_0001); (600)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Apr 16, 2020

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

**Issued on this 25th day of November, 2019**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Gordana Krstevska

**Service Area Office /**
**Bureau régional de services :** Toronto Service Area Office