Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 26, 2017	2017_654605_0011	016794-16, 017067-16, 017339-16, 017567-16, 017599-16, 020093-16, 023346-16, 026985-16, 027373-16, 028855-16, 032162-16, 032181-16, 034391-16, 001094-17, 001554-17, 002306-17, 003559-17, 005251-17, 006570-17, 007476-17, 008454-17, 008730-17, 008737-17, 008803-17, 010316-17, 011318-17, 013282-17	Critical Incident System

Licensee/Titulaire de permis

WEST PARK HEALTHCARE CENTRE
82 BUTTONWOOD AVENUE TORONTO ON M6M 2J5

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

WEST PARK LONG TERM CARE CENTRE
82 BUTTONWOOD AVENUE TORONTO ON M6M 2J5

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

SARAH KENNEDY (605), DEREGE GEDA (645), IVY LAM (646), JANET GROUX (606), VERON ASH (535)

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): May 29, 30, 31, June 1, 2, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 30, July 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20 and 21, 2017.

The following critical incident intakes were inspected: 016794-16 (related to plan of care and transferring and positioning techniques), 017067-16 (related to prevention of abuse and neglect), 017339-16 (related to prevention of abuse and neglect), 017567-16 (related to prevention of abuse and neglect), 017599-16 (related to responsive behaviours), 020093-16 (related to plan of care and transferring and positioning techniques), 023346-16 (related to responsive behaviours), 026985-16 (related to responsive behaviours and reporting and complaints), 027373-16 (related to responsive behaviours), 028855-16 (related to responsive behaviours), 032162-16 (related to safe and secure home), 032181-16 (related to prevention of abuse and neglect), 034391-16 (related to prevention of abuse and neglect), 001094-17 (related to plan of care and transferring and positioning techniques), 001554-17 (related to pain management and falls prevention), 002306-17 (related to prevention of abuse and neglect), 003559-17 (related to plan of care and transferring and positioning techniques), 005251-17 (related to prevention of abuse and neglect), 006570-17 (related to plan of care), 007476-17 (related to prevention of abuse and neglect), 008454-17 (related to falls prevention), 008730-17 (related to plan of care), 008737-17 (related to reporting certain matters to the Director and plan of care), 008803-17 (related to plan of care), 010316-17 (related to prevention of abuse and neglect), 011318-17 (related to prevention of abuse and neglect) and 013282-17 (related to plan of care).

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), registered nursing staff, Physiotherapist (PT), Social Worker (SW), Personal Support Workers (PSWs), residents and Substitute Decision Makers (SDMs).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home

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

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

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

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

Specifically failed to comply with the following:

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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).

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

Findings/Faits saillants :

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

A review of a Critical Incident Report (CIR) revealed the home received a concern that an identified resident had been receiving one staff personal care, while the plan of care directed two person assist for all types of care.

A review of the resident's written care plan revealed that the resident is a two person assist for all personal care. A review of the home's investigation notes revealed that the home had reviewed the surveillance camera for the identified date and unit and determined that an identified Personal Support Worker (PSW) had entered the resident's room room multiple times, independently.

An interview with the identified PSW confirmed that he/she provided care for the resident alone. He/she stated that he/she was aware that the resident was a two person assist for

personal care but his/her colleague was busy and he/she decided to provide the care by him/herself.

An interview with the Executive Director (ED) confirmed that the PSW failed to provide care to the resident as per the plan of care. [s. 6. (7)]

2. A review of a CIR revealed an identified resident was transferred to hospital due to a change in his/her health condition.

A review of the resident's physician orders and lab results from an identified period of time revealed the resident had a diagnosis of a condition and related lab values were within the normal range. Further review indicated the resident had a history of having abnormal lab values and in the past had been sent to hospital. On an identified date, the resident's lab values were at a critical level outside of the normal range.

A review of the resident's progress notes revealed on the identified date, an RPN assessed the resident as prompting further assessment. The RPN contacted the attending physician and received an order to transfer the resident to the hospital. The resident returned to the home the following morning after receiving medical attention.

A review of the resident's physician orders from an earlier time period revealed the resident should receive lab work on identified time intervals. This was signed off by two registered staff. A review of the resident's medication quarterly review indicated the lab work was to continue as ordered. A review of the resident's labs revealed he/she had labs completed once, and no other time thereafter.

Interviews with RPNs indicated registered staff are responsible to process and complete all physician orders and complete any lab requisitions. An identified RPN further indicated the requisition for the resident was not completed.

An interview with CPL indicated registered staff are responsible to complete the lab requisition when lab work has been ordered and this was not completed for the resident. [s. 6. (7)]

3. A review of a CIR, submitted by the home, revealed an identified resident sustained a fall on an identified date. The resident suffered an injury and was sent to hospital.

A review of the resident's progress notes revealed the resident fell on the floor inside

his/her room. Review of progress notes related to the incident revealed the resident stated he/she got out of bed to go to the washroom without calling for help. Inspector #605 attempted to interview the resident but he/she could not recall any details.

A review of the resident's written care plan from the time of the incident as well as the current care plan revealed the resident should have a device in place to minimize risk of falls. Interviews with staff who were working at the time of the incident revealed they could not recall if the device was applied at that time.

An observation during the course of the inspection revealed the resident did not currently have the device in place.

An interview with the falls prevention management lead/Registered Nurse (RN) confirmed the device was not in place, as per expectation. Interviews with staff revealed no one could identify how long the device had not been in place.

An interview with the ED revealed the expectation is for residents' to be provided care, as specified in the plan. [s. 6. (7)]

4. A review of a CIR from an identified date revealed improper/incompetent care and treatment of an identified resident.

A record review revealed the identified resident was admitted to the home with no diagnoses of an identified medical condition. The progress notes revealed that on an identified date the resident experienced what was thought to be the identified medical condition and was transferred to hospital for testing. Testing revealed no ill effects. The progress notes also revealed that on another identified date the resident experienced similar symptoms while care was being provided by a PSW and again was transferred to hospital resulting in an admission for assessment and treatment related to the identified medical condition. According to the progress notes and physician's orders, the resident returned to the home and was started on medication. Lab work, over the course of identified time intervals, was ordered.

The progress notes and an interview with a RPN confirmed that registered staff members were challenged to ensure the resident was administered the appropriate dosage of the prescribed medication. The Medication Administration Record (MAR) revealed that on an identified date, the medication was changed with favorable acceptance by the resident. However, the laboratory levels continued to fluctuate but with no adverse symptoms from

the resident while lab values were outside of the normal range.

Further record review revealed that on an identified date, the resident had lab work completed and the result was faxed and received by the home. An identified lab level was reported outside of the normal range. The physician visited the home, however lab values were not available to the physician for treatment on that day since the lab result was situated in an unknown location. The progress notes and staff interview confirmed that two days later the resident experienced symptoms of a medical condition and was sent to hospital where he/she was admitted, diagnosed with the medical condition and received treatment.

During interviews, RPN's stated that they did not receive a call from the lab company reporting the abnormal values which was the usual practice when laboratory values were outside the normal range. A RPN stated that he/she was unsure when to call the physician with laboratory values that were outside the normal range.

An interview with the Director of Care (DOC) confirmed that the expectation is for registered staff to review laboratory results, initial the document and contact the physician to report abnormal laboratory values immediately so that treatment can be initiated as soon as possible. [s. 6. (7)]

5. A review of a CIR from an identified date revealed improper/incompetent care and treatment of an identified resident.

A record review revealed the resident was admitted to the home with identified medical conditions. The home’s Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessed the resident as frequently incontinent. He/she was assessed to wear an incontinent product. A review of the written care plan indicated a hydration focus with a goal of maintaining a daily fluid intake and interventions in place to monitor for signs of dehydration included offering water at medication passes and continued review of medications to identify use of medication that may contribute to fluid maintenance. The resident was prescribed and administered an identified medication with at least monthly monitoring.

A record review revealed that during an identified month, the resident’s total fluid intake was below 1500 mls for 19 out of 28 days and the resident's urine output was significantly decreased according to the PSW documentation. During an interview, a PSW stated that the resident previously voided a lot in his/her incontinent product;

however, a few shifts prior to a hospital transfer on an identified date, the resident's incontinent product remained dry during changes, and those incidents were reported to the registered staff. In addition, the MAR indicated that registered staff continued to administer an identified medication until it was discontinued by the physician.

A record review revealed the primary physician assessed the resident on an identified date and wrote an order for lab work to be completed. The lab work was completed and faxed to the home the following day. The lab results revealed an identified marker was outside of normal range. The progress notes and Digital Prescriber's Orders revealed after reviewing the lab work, assessing the resident, and discussing the information with the resident's substitute decision maker (SDM), the physician ordered the resident to be transferred to acute care hospital due to the abnormal lab level. The progress notes revealed the resident returned to the home with a diagnosis of a medical condition which required new interventions.

During an interview, a registered staff member stated that he/she received the resident's lab result from the laboratory, but was unsure how to interpret the result. The staff stated that because the physician's next visit to the home was the following day he/she did not contact the physician to report the abnormal level.

During an interview with the DOC, he/she stated that the expectation is for registered staff to review laboratory results, initial the document and contact the physician to report abnormal laboratory values immediately so that treatment can be initiated as soon as possible. [s. 6. (7)]

6. A review of a CIR revealed an identified resident sustained a fall.

A record review revealed on an identified date an identified resident was assessed for toileting as not able to attempt without physical help and requiring two plus persons physical assist.

A record review and a staff interview with an identified PSW confirmed that on an identified date, the PSW assisted the resident back to his/her room to provide evening care and settle the resident to bed for the evening. The PSW sat the resident on the toilet and momentarily left the resident unattended to retrieve something which was set out on top of the night stand in the resident's room. According to the PSW, the resident must have attempted to stand up and he/she then fell to the left of the toilet onto the floor, causing injury. The resident was transferred to hospital and required treatment.

During interviews a PSW and RN stated that the resident would self-transfer and was unsteady on his/her feet; therefore, he/she required monitoring at all times while toileting and providing care. Both staff also stated that the resident required at least two persons so that one person could physically stay with the resident while the other person provide the care and gather clothing and supplies as needed. During an interview, a PSW stated that he/she knew the resident very well and would sometimes provide care to the resident by him/herself. The PSW further stated that the unit was very busy that evening and his/her partner was supporting other residents on the unit. However, he/she realized that it was a mistake to leave the resident on the toilet unattended even for that brief moment. The PSW acknowledged being aware of the information in the written care plan which listed two plus staff to toilet the resident.

During an interview, the DOC stated that the expectation is for all direct care staff to follow the written care plan when providing care to residents. [s. 6. (7)]

7. A review of a CIR, revealed an identified resident was sent to the hospital and was found with an injury of unknown cause. The CIR noted the resident had two documented falls on two identified dates.

A review of the resident's written care plan revealed that the resident was at high risk for falls. Interventions were identified in the care plan.

Observations of the resident during the course of the inspection revealed that the resident did not have all of the identified interventions in place. Interviews with a PSW and RPN confirmed that the resident did not have the identified interventions in place.

An interview with a PSW revealed that he/she has not seen one of the identified interventions in place since three days ago and this was reported to a RN. A PSW further revealed that he/she has not seen the resident with his/her interventions implemented for about a month.

Interviews with a RPN and a CPL revealed that it is the PSWs who should tell the registered staff if the any of the interventions are not functioning. RPN and CPL further revealed that they were not informed of the resident's interventions not being in place or not functioning.

An interview with a RN revealed that no one had informed him/her about any concerns

regarding the resident's falls prevention interventions. The RN and RPN further revealed that the interventions should be in place for the resident as per his/her written care plan.

An interview with the DOC revealed that the interventions should have been provided for the resident as per his/her written plan of care.

The scope of the non-compliance is isolated as it related to three residents. The severity of the non-compliance is actual harm/risk. The home has on-going noncompliance with s. 6 (7). As a result of the scope, severity and compliance history, a compliance order is warranted. [s. 6. (7)]

8. The licensee has failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

A review of a CIR submitted by the home revealed an identified resident was sent to hospital and diagnosed with an injury of unknown cause. The CIR noted the resident had two documented falls.

A review of the resident's written care plan in the PSW's routine binder revealed that it was the admission care plan available to PSWs with no updated care plans printed for the PSWs.

A review of the resident's current written care plan in PointClickCare (PCC) revealed that the care plan was updated after admission. Specifically, falls interventions were added and updated.

An interview with a PSW revealed that he/she was unsure of one of the new falls interventions. When the PSW looked in the PSW routine/flowsheet binder, he/she was unable to locate information regarding the resident's falls interventions.

Interviews with a PSW and RN revealed that the PSW's do not have access to PCC, and would refer to the PSW routine/flowsheet binder for information on what care to provide for residents. The RN further revealed that the written care plan found in the PSW routine/flowsheet binder did not include the updated falls interventions.

An interview with the CPL and falls prevention management lead/RN revealed that strategies used to mitigate resident falls are expected to be in the PCC care plan and

that the registered staff are expected to print a copy of the written care plan for the PSW flowsheet binder quarterly, or immediately after changes are made to residents written care plan to make the care plan available for PSWs.

An interview with the DOC revealed that the written care plan should be updated quarterly or whenever there is a change in the resident's care, and that there should have been an updated written care plan for the identified resident available in the PSW routine/flowsheet binder for the PSWs. [s. 6. (8)]

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

a. A review of a CIR, submitted by the home, revealed an identified resident was sent to hospital and was found with an injury of unknown cause.

A review of the resident's written care plan on PCC revealed that the resident was at high risk for falls. Interventions were identified.

A review of the resident's Daily Care Flow Sheet in the PSW binder revealed that for an approximately one month period no documentation was recorded on the devices section of the flow sheet for two of the falls intervention devices, on all shifts. Provision of two other falls intervention devices were also not documented, for a period of three days.

Observations of the resident during the course of the inspection revealed that all of the identified falls intervention devices were in place.

An interview with a PSW revealed that the staff do provide the resident with his/her falls interventions, but did not document in the flowsheet.

b. A review of an identified resident's current written care plan revealed that the resident uses a falls prevention device.

A review of the resident's Daily Care Flow Sheet from a period of two weeks, revealed that there was no documentation for the identified falls prevention device applied on day shifts for a period of 13 days, evening shifts for 4 days and night shifts for 11 days.

Observations during the course of the inspection revealed that the resident had his/her falls prevention device in place.

Interviews with two RAI Coordinators revealed the resident had his/her falls prevention device applied, but staff members have not been documenting in his/her flowsheet.

c. A review of an identified resident's current written care plan revealed the resident has three falls prevention devices.

A review of the resident's Daily Care Flow Sheet revealed that there was no documentation of the identified falls prevention devices over an identified period of time.

Observations during the inspection revealed that the resident had the identified falls prevention devices in place.

Interviews with a PSW and RPN revealed that PSWs do provide the resident with his/her falls prevention devices, but the staff have not been documenting the provision of these interventions.

Interviews with the CLP, two RAI Coordinators and the RAI back-up coordinator revealed that staff have not been documenting the provision of care for the three identified residents mentioned above.

An interview with an Assistant Director of Care (ADOC) confirmed that staff should document in the flowsheet when they provide residents with falls prevention devices and it is the home’s expectation for staff to document the care provided as set out in the plan of care. [s. 6. (9) 1.]

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

A review of a CIR revealed an identified staff member witnessed a resident approach and exhibit an identified response behaviour toward another resident. Later on the same day, another CIR reported the same resident exhibiting an identified responsive behaviour towards another resident.

A review of the resident's progress notes indicated the resident was admitted to the home and was identified with a history of an identified behaviour, along with other

diagnoses.

A review of the resident's written care plan from an identified date indicated the resident has identified behaviours and when the resident refuses staff direction, staff have in place identified interventions.

Further review of the resident's progress notes between a two week period, indicated prior to the incident noted above, there had been several incidents of the resident exhibiting identified behaviours and that interventions in place had not been effective.

Interviews with two PSWs indicated they could not remember the resident very well as the resident was not in the home for very long. They indicated the resident's written care plan directed staff to continually monitor and remove and redirect the resident when he/she was exhibiting identified responsive behaviours toward another resident.

An interview with a PSW revealed the resident was a concern with other residents and stated the resident had exhibited identified responsive behaviours toward other residents. The PSW indicated the resident would be unmanageable and would be put in his/her room to calm down and this was not always effective.

An interview with a PSW indicated when the resident was displaying responsive behaviours during care staff are directed to leave him/her and re-approach at a later time and revealed the resident would continue to exhibit identified responsive behaviour toward others. At the end of the shift he/she stated that he/she finds care can be provided to the resident due to him/her being exhausted from his/her behaviours.

A review of the resident's written care plan from an identified date indicated for a period of one week the written care plan had not been updated to reflect new interventions to manage the resident’s identified responsive behaviours. Review of the progress notes indicated between the same period of time there had been four incidents of the resident exhibiting responsive behaviours toward other co-residents.

Further review of the resident's progress notes revealed the resident was referred for a external consultation and was assessed and referred for further assessment.

The inspector attempted to contact an identified RPN on two occasions and was unsuccessful.

Interviews with a CPL indicated the home's practice is when interventions in the written care plan are not effective, the resident is reassessed to assist in identifying the triggers and suggest other interventions to try.

The resident's plan of care was not being revised when care set out in the plan was not effective and different approaches were not considered in the revision of the plan of care. [s. 6. (11) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A review of the home's Falls Management Program policy, RC-06-04-01, Post Fall Clinical Pathway, revised May 2016, revealed that a resident fall is any unintentional change in position where the resident ends up on the floor, ground, or other lower level (CIHI Manual 2010) and that a focused assessment by the first registered staff person on the scene may include an assessment of range of motion, and that a clinical decision will be made the registered staff to move or not move the resident.

A review of a CIR reported resident to resident abuse.

A review of a resident's progress notes indicated the resident was brought to the dining room area with a PSW who indicated the resident had been the recipient of a co-residents identified responsive behaviours causing a resident fall. The progress notes indicated the PSW indicated that he/she did not witness the interaction but heard the impact of a resident falling to the floor. The home’s surveillance camera confirmed the incident occurred.

Further review of progress notes indicated the identified PSW witnessed the resident lying on the floor and assisted the resident off the floor by him/herself instead of calling for other staff and the charge nurse for assistance. The progress notes indicated that a RPN informed the PSW that when a resident has fallen, he/she should call other staff immediately and not to get the resident up.

The inspector made several attempts to contact the identified PSW and was unsuccessful.

An interview with a RPN indicated the PSW informed him/her that he/she assisted the resident off the floor after the resident fell and walked him/her to the nursing station to be assessed. The RPN indicated he/she informed the PSW that when a resident has fallen, the staff are to immediately call the registered staff for the resident to be assessed prior to assisting the resident off the floor. The RPN indicated the PSW did not do this and assisted the resident off the floor before being assessed by a registered staff.

The licensee failed to ensure that the home’s fall policy was complied with. [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 to ensure that the home's Falls Management Program policy, RC-06-04-01, Post Fall Clinical Pathway, revised May 2016, 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 residents were protected from abuse by anyone.

A review of a CIR reported resident to resident abuse.

A review of an identified resident's progress notes revealed the resident was admitted to the home with identified medical diagnoses. The progress notes indicated that the SDM of the resident told the home that the resident had a history of responsive behaviours and may be a risk to others.

An interview with the resident's SDM indicated that a few days prior to the resident's admission to the home, the resident had exhibited responsive behaviours. The SDM indicated he/she informed the home of his/her concerns about the resident having the identified responsive behaviours and indicated that he/she requested that the resident be closely monitored.

An interview with a RPN indicated that the SDM informed him/her during the admission interview of previously mentioned behaviours. The RPN indicated the SDM did not provide any details about his/her behaviours. The RPN stated DOS monitoring was

initiated for the resident as part of the home’s admission practice to monitor and assess all newly admitted residents for behaviours. The RPN indicated all residents newly admitted to the home are monitored using a DOS record to observe for any signs of responsive behaviours. The RPN further indicated that the PSWs are responsible to report to the charge nurse when they observe any increase in responsive behaviours.

Further review of progress notes from an identified date, revealed the resident exhibited responsive behaviours. It was documented that the resident had responsive behaviours. Further review of the progress notes indicated the SDM had called the home and informed the staff of another responsive behavoiur. The progress notes indicated that the resident refused identified care measures. There was no evidence in the progress notes that any other interventions were initiated to manage the resident's potential for displaying responsive behaviours other than the DOS monitoring record.

Further review of the resident's progress notes indicated that the resident was observed by staff to be exhibiting responsive behaviours. The progress notes indicated the resident was in and identified place for a number of hours when the resident was observed exhibiting responsive behaviours.

An interview with another identified resident revealed the resident entered his/her room and was exhibiting an identified responsive behaviour toward him/her. The resident stated when he/she told the resident no, he/she further exhibited a responsive behaviour.

An interview with a PSW indicated he/she had just started an identified shift when the injured resident's call bell rang and he/she went to answer it. The PSW indicated when he/she arrived to the resident's room, he/she observed the resident in bed with an identified injury. The PSW indicated that he/she witnessed the other resident standing in the room and had observed the room to be in an identified condition. The PSW indicated he/she encouraged the standing resident to leave the room with him/her but when they were in the hallway, he/she ran away and was attempting to get into another resident’s room but was unable to because the doors of the room were closed. The PSW indicated the resident refused to be redirected and was showing increased identified responsive behaviour when he/she was approached.

Interviews with three PSWs indicated the resident had exhibited identified responsive behaviours towards everyone on the identified date, which started prior to the identified shift.They indicated he/she was unmanageable and would not listen to direction from staff.

An interview with a RPN indicated the identified resident continued to exhibit identified responsive behaviours toward staff and others.

Further interviews with two RPNs indicated that 911 emergency and the medical director were notified of the incident. The resident was sent to hospital.

Interviews with a PSW, two RPNs and CPL confirmed the injured resident was treated and also sent to hospital. [s. 19. (1)]

2. A CIR reported resident to resident abuse.

A review of an identified resident's progress notes indicated that the resident was brought to the dining room area by agency PSWs who informed a RPN that they found the resident laying on the floor. The progress notes indicated a PSW did not witness the fall but told the RPN that he/she heard the impact of the resident falling to the floor. The progress notes indicated that the incident was captured on the home's surveillance camera. The footage showed two residents having a verbal exchange, and then one resident exhibiting an identified responsive behaviour toward the other, causing the resident to fall to the floor.

Inspector #606 attempted to interview both residents. Neither resident could recall the incident. The inspector attempted to contact an identified PSW for an interview with no success.

An interview with the RPN revealed he/she recalled an agency PSW bringing the resident who was found on the floor to the nursing station and indicated the PSW heard a loud noise. The RPN indicated the PSW did not witness how the resident fell. The RPN further revealed that the resident who was found on the floor stated the other resident had exhibited an identified responsive behaviour causing him/her to fall.

A review of the identified resident's plan of care, from an identified date, revealed a potential for complications for responsive behaviours and directed staff to advise and monitor the resident to ensure he/she will not approach other residents, especially the injured resident. The written plan of care also indicated for staff to monitor his/her whereabouts every half hourly for the safety of the resident and the others.

Interviews with a PSW and RPN indicated the resident does not like other residents

getting into his/her personal space and may display identified behaviours of shouting and indicated the resident is provided redirection and was monitored for his/her whereabouts on an ongoing basis.

A review of the other resident's plan of care, from an identified date, indicated the resident has responsive behaviors and may exhibit those towards others. The written plan of care identified interventions to respond to the resident's identified responsive behaviours.

An interview with a PSW indicated the injured resident also exhibits identified responsive behaviours. The PSW stated all staff working during the shift have the responsibility to monitor and redirect the resident to prevent incidents from occurring.

An interview with a CPL indicated the resident has the identified behaviours and does not display the identified behaviours towards others unless the other resident triggers them. Further interview with CPL revealed the resident's identified responsive behaviours are a concern and triggers have been identified. CPL indicated staff monitored and separated the two residents when they were near each other to prevent any interaction between the two. CPL #110 indicated from the home's investigation he/she was aware that these two residents had an interaction resulting in one resident falling to the floor and sustaining an injury.

The home did not protect the resident from abuse. [s. 19. (1)]

3. A review of a CIR from an identified date reported resident to resident abuse.

A review of a resident's progress notes from an identified date indicated prior to the above mentioned incident, the resident had exhibited identified responsive behaviours towards co-residents on four occasions. The progress notes indicated the above mentioned incident was the second incident between him/herself and another identified resident. Another CIR was submitted to the MOHLTC that reported the resident had exhibited an identified responsive behaviour towards the other resident.

A review of the identified resident's written plan of care indicated that the resident has responsive behaviors with identified triggers. The written plan of care indicated that the resident does not like certain items and directed staff to redirect other residents when potential triggers arise. Review of the resident's progress notes indicated additional strategies were added in the resident's plan of care to include DOS monitoring and other

monitoring. Resident had been transferred to hospital on an identified date with no new orders.

Further review of progress notes indicated the resident was followed on a regular basis by a consultant. The progress notes further indicated that the resident had identified triggers.

A review of the progress notes from an identified period of time indicated the DOS records indicated that during the previous two week observation, the resident exhibited episodic periods of an identified responsive behaviour.

Both resident's could not recall the incident.

An interview with a PSW revealed he/she overheard the interaction and he/she separated the residents. The PSW indicated both residents have identified behaviours and were monitored on a regular basis.

Interviews with two PSWs revealed the resident has identified responsive behaviours and triggers had been identified. They stated that after the incident they noticed the other resident had an injury.

An interview with a CPL indicated the resident has identified responsive behaviours and the home has put in place various interventions to manage these. However, the CPL indicated the resident had exhibited identified responsive behaviours.

The home failed to protect a resident from abuse. [s. 19. (1)]

4. A review of a CIR reported resident to resident abuse.

A review of the identified resident's chart revealed he/she has an ongoing history of displaying identified responsive behaviors.

A review of another resident's chart revealed he/she has a high tendency of displaying responsive behaviours.

A review of progress notes revealed both identified residents were in the hallway on an identified date. One resident approached the other and an exchange of words ensued. One resident then started to exhibit identified responsive behaviours toward the co-

resident.

A review of the first resident's plan of care indicated the resident has responsive behaviors with identified triggers.

A review of the second resident’s written plan of care indicated the resident had further identified responsive behaviours with identified triggers. Further review indicated staff were to redirect away from other residents when they observe this behaviour.

An interview with the first resident revealed he/she was unable to recall the incident. The second resident was not interviewed due to cognitive impairment.

A review of the home's investigation revealed the first resident was captured on the home’s surveillance camera exhibiting an identified responsive behaviour toward the other resident.

Interviews with two PSWs revealed the identified resident has identified responsive behaviours.

An interview with a CPL revealed the resident has identified responsive behaviours and exhibits those toward others. The CPL indicated that one resident caused an identifeid injury to another resident.

The home failed to protect the identified resident from abuse. [s. 19. (1)]

5. A review of a CIR reported resident to resident abuse.

A review of the CIR indicated that on an identified date, a resident was witnessed by a PSW exhibit an identified responsive behaviour toward another resident. The PSW witnessed this.

A review of the identified resident's progress notes indicated the resident was admitted to the home 15 days before the above mentioned incident. The resident was admitted with a history of responsive behaviours. Further review of the resident's progress notes indicated that there had been several incidents of the resident displaying the identified responsive behaviours. The progress notes indicated that the interventions in place had not always been effective.

A review of the resident's progress notes from an identified date indicated the resident had an intervention put in place and prior to the intervention the resident had been exhibiting the identified responsive behaviours. Further review indicated that after the intervention, some of the identified behaviours continued.

It was documented that he/she was witnessed exhibiting behaviours on identified date. There was no evidence in the progress notes that indicated any follow up to manage the identified behaviours, other than re-direction. The identified behaviours persisted over an identified period of time.

A review of the resident's written plan of care identified some interventions to manage the resident's behaviours. A review of the resident's written care plan from another date indicated no further updates or revisions to address the resident’s ongoing behaivours. Further review of his/her written care plan indicated a review and revision of the resident's written care plan was initiated late to address the resident’s behaviours, a day after the interaction between the other resident.

The resident is deceased and the victim was not able to be interviewed as he/she is cognitively impaired.

Interviews with two PSWs indicated the resident's plan of care had interventions in place. An interview with a PSW revealed the resident exhibits behaviours towards other residents and interventions were not always effective.

An interview with a PSW indicated when the resident was displaying responsive behaviours during care interventions were identified.

Interviews with two PSWs and a CPL confirmed the other resident was injured .

The home failed to protect a resident from abuse. [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 to ensure residents are protected from abuse by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of a CIR revealed a resident sustained a fall which resulted in an injury.

A record review and a staff interview with a PSW confirmed that on an identified date the PSW assisted the resident back to his/her room to provide evening care and settle the resident to bed for the evening. The PSW sat the resident on the toilet and momentarily left the resident unattended to retrieve something which was set out on top of the night stand in the resident's room. According to the PSW, the resident must have attempted to stand up and he/she fell to the left of the toilet onto the floor, causing injury. The resident was transferred to hospital and required treatment.

The progress notes and an interview with a RPN revealed that when the resident returned from hospital, the registered staff did not document the neurological assessment or head injury routine (HIR) immediately. According to the registered staff, HIR should have been completed every eight hours for 72 hours.

An interview with the DOC revealed that the expectation is for registered staff to complete and document a HIR every eight hours as per policy. [s. 30. (2)]

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 any action taken with respect to a resident under a program, including assessments, reassessments, interventions, and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

A review of a CIR revealed a resident was diagnosed with an injury. The cause of the injury was unknown and an investigation was initiated.

A review of the resident's written care plan from the time of the incident revealed staff are to transfer the resident a specific way. A review of the home's investigation notes revealed the surveillance camera was reviewed for three days leading up to the diagnosis of the injury and revealed four identified PSWs were not bringing the appropriate transfer device into the resident's room.

Interviews with three PSWs revealed nothing unusual occurred during any of the transfers leading up to the diagnosis of the injury. However, all PSWs confirmed that they had all been using the wrong transfer device. The three PSWs confirmed that the way they were transferring the resident was unsafe.

An interview with the ED confirmed that the resident was not transferred properly using the transfer device outlined in the written care plan, as per expectation. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of a CIR revealed a resident sustained a fall on an identified date. The resident suffered injury. The resident was diagnosed with an identified injury and was sent to hospital.

A review of the resident's progress notes revealed the resident fell on the floor inside his/her room. A review of progress notes related to the incident revealed the resident stated he/she got out of bed to go to the washroom without calling for help. Inspector #605 attempted to interview the resident but he/she could not recall any details about the fall.

A review of the resident's chart revealed a post-fall assessment was not completed after the fall. Further record review also revealed the resident also experienced a fall on a previous identified date. The resident was found on the floor beside his/her bed, no injuries noted. Record review also revealed a post-fall assessment using the clinically appropriate tool was not completed.

An interview with the falls prevention management lead confirmed a post-fall assessment, using the clinically appropriate assessment instrument, was not completed on both of the identified dates.

An interview with the ED revealed the expectation is for staff to complete a post-fall assessment, using a clinically appropriate assessment instrument after a resident has a fall. [s. 49. (2)]

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure when the resident’s pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A review of a CIR revealed a resident was sent to hospital and diagnosed with an injury.

A review of the resident's progress notes revealed on an identified date a late progress note was initiated by a RPN. The note revealed a PSW reported to the RPN in the morning that the resident had an identified are of the body requiring further assessment. Writer assessed resident’s area of the body and did not see much difference from the opposite area of the body. Writer asked the PSW to monitor. Before lunch the PSW brought the resident to the nursing station and asked the RPN to assess the area of the body again. At this time the area of the body had changed. Note was left in doctor binder.

Interviews with two PSWs revealed that they were working together on days when they noticed an area of the resident's body required further assessment and reported this to the RPN. PSWs revealed resident was saying he/she was in pain at this time. Before lunch both PSWs stated they brought the resident back to the RPN to assess.

An interview with the RPN revealed he/she looked at the resident's area of the body before breakfast when it was initially reported to him/her that the resident required further assessment. The RPN stated that at this time the resident was not in pain. The RPN revealed before lunch that the PSWs brought the resident back for the RPN to look at. At this time his/her identified body area had changed and the resident was in pain. The RPN stated that if a resident complains of pain or has a change of condition the expectation is for staff to complete a pain assessment on PCC. A review of documentation on PCC revealed a pain assessment was not completed during the morning or before lunchtime on the identified date.

An interview with the a ADOC confirmed the expectation is for staff to complete a clinically appropriate pain assessment on PCC and this assessment was not completed for the resident when he/she first experienced pain. [s. 52. (2)]

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 when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee shall ensure that, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A review of a CIR revealed a resident exhibited identified responsive behaviours and injured another resident.

A record review of the resident's progress notes revealed he/she had identified medical diagnoses. Further review indicated the SDM of the resident stated the resident has had exhibited the identified responsive behaviours.

A review of the home's policy "Responsive Behaviours", RC-17-01-04, last updated February 2017,indicated that each resident will be assessed and observed for indicators of responsive behaviours on admission, quarterly, and as needed; all new or escalated instances of responsive behaviours will be reported, recorded and investigated on an ongoing basis. The home will implement and evaluate strategies and interventions to prevent, minimize and address responsive behaviours. Further review indicated the home uses the Documentation Observation System (DOS) record to monitor and record residents for behaviours.

A review of the resident's DOS record for the date of the incident indicated the resident was exhibiting the identified responsive behaviours over a period of time.

Interviews with a SW, CPL, RN and PSW revealed that all residents admitted to the home are assessed and observed for indicators of responsive behaviours and this is documented on the DOS record. Staff stated that any changes are reported to the charge nurse for follow-up.

An interview with a PSW indicated that he/she was working on the identified date, but he/she did not recall the resident exhibiting the responsive behaviours. The PSW also indicated that if there had been an escalation in the resident’s behaviour, he/she would have to inform the charge nurse of the behaviours so that registered staff could follow-up.

An interview with a RN indicated he/she was the charge nurse the date of the incident and he/she was not informed that there was any change to the resident's behaviour. He/she revealed the reason was likely related to the resident being newly admitted to the home.

Two CPLs indicated that the home’s practice is for staff to notify the charge nurse anytime there is an escalation in a resident’s behaviours so the resident can be reassessed and interventions can be put in place to manage the behaviours. Actions were not taken to respond to the needs of the identified resident, including assessments, reassessments and interventions. [s. 53. (4) (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 shall ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure every resident has the right to be treated with courtesy and respect in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A review of the a CIR revealed it was reported by a resident that when he/she asked a PSW to toilet him/her, he/she was told to go in his/her incontinent product. The resident reported feeling emotionally distraught. The staff member was removed from the schedule pending an investigation.

An interview with the resident revealed he/she recalled the incident and at that time he/she could use the washroom with assistance and did not want to go to the washroom in his/her product. The resident could not recall how the incident made him/her feel at the time.

An interview with the PSW revealed at the time of the incident he/she did not want to toilet the resident on her own because the resident seemed unsteady on his/her feet. A review of the resident's written care plan revealed one to two staff were required for transfer to the toilet. An interview with the PSW revealed he/she does not remember what he/she said to the resident, but she/he stated perhaps something came out the wrong way.

An interview with the ED revealed the home's expectation is to treat all residents with courtesy and respect. The PSW failed to treat the resident with courtesy and respect. [s. 3. (1) 1.]

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

Specifically failed to comply with the following:

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that if not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

A CIR was received by the Director on an identified date related to a fall sustained by a resident.

A record review revealed the resident sustained an injury and was transferred to hospital after a fall. The home submitted a CIR to the Director. Additional information was requested; specifically, level of assistance required with toileting. As of the time of the inspection, the home did not provide the information.

An interview with the DOC confirmed the home did not provide a final report to the Director, as per expectation. [s. 104. (3)]

WN #11: 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. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

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

The Director received a CIR related to the improper/incompetent care and treatment of a resident.

A record review revealed on an identified date, the physician assessed a resident and wrote an order for lab work. The laboratory results were faxed to the home and the document revealed that a lab marker was outside of the normal range. Record review revealed that after reviewing the labs and assessing the resident, the physician ordered the resident to be transferred to acute care hospital due to a significant change in status. The resident returned to the home on a later date with a new medical diagnosis.

The incident occurred on an identified date and the Director was informed three days later. The home reported the critical incident as an improper/incompetent treatment of a resident that resulted in harm or risk to the resident; and therefore the incident should be reported to the Director no later than one business day after the occurrence of the incident. [s. 107. (3) 4.]

Issued on this 5th day of October, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SARAH KENNEDY (605), DEREGE GEDA (645), IVY LAM (646), JANET GROUX (606), VERON ASH (535)
Inspection No. / No de l'inspection :	2017_654605_0011
Log No. / No de registre :	016794-16, 017067-16, 017339-16, 017567-16, 017599-16, 020093-16, 023346-16, 026985-16, 027373-16, 028855-16, 032162-16, 032181-16, 034391-16, 001094-17, 001554-17, 002306-17, 003559-17, 005251-17, 006570-17, 007476-17, 008454-17, 008730-17, 008737-17, 008803-17, 010316-17, 011318-17, 013282-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 26, 2017
Licensee / Titulaire de permis :	WEST PARK HEALTHCARE CENTRE 82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5
LTC Home / Foyer de SLD :	WEST PARK LONG TERM CARE CENTRE 82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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To WEST PARK HEALTHCARE CENTRE, 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) (b)

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 shall prepare, submit and implement a plan to ensure laboratory tests and treatment as a result of abnormal laboratory tests, are provided to residents as specified in the plan of care. The plan shall include:

1. The development of a clinical/laboratory guideline indicating normal and abnormal routine laboratory values, including but not limited to identified lab values. Ensure the guideline is easily accessible by registered staff.
2. Training for all registered staff related to the use of the clinical/laboratory guidelines. Training for all registered staff on how to contact the primary or on-call physician immediately to report clinical/laboratory test values outside the normal values indicated in the guidelines.
3. The development of a system to ensure all laboratory requisition forms are completed as ordered by the physician/nurse practitioner.
4. Registered staff to review, sign and date all laboratory test results indicating that they received and reviewed the residents' test results

The plan is to be submitted via email to inspector sarah.kennedy@ontario.ca by October 27, 2017.

Grounds / Motifs :

1. A review of a CIR revealed an identified resident was transferred to hospital due to a change in his/her health condition.

A review of the resident's physician orders and lab results from an identified period of time revealed the resident had a diagnosis of a condition and related lab values were within the normal range. Further review indicated the resident had a history of having abnormal lab values and in the past had been sent to

hospital. On an identified date, the resident's lab values were at a critical level outside of the normal range.

A review of the resident's progress notes revealed on the identified date, an RPN assessed the resident prompting further assessment. The RPN contacted the attending physician and received an order to transfer the resident to the hospital. The resident returned to the home the following morning after receiving medical attention.

A review of the resident's physician orders from an earlier time period revealed the resident should receive lab work on identified time intervals. This was signed off by two registered staff. A review of the resident's medication quarterly review indicated the lab work was to continue as ordered. A review of the resident's labs revealed he/she had labs completed once, and no other time thereafter.

Interviews with RPNs indicated registered staff are responsible to process and complete all physician orders and complete any lab requisitions. An identified RPN further indicated the requisition for the resident was not completed.

An interview with CPL indicated registered staff are responsible to complete the lab requisition when lab work has been ordered and this was not completed for the resident. (606)

2. A review of a CIR from an identified date revealed improper/incompetent care and treatment of an identified resident.

A record review revealed the resident was admitted to the home with identified medical conditions. The home's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessed the resident as frequently incontinent. He/she was assessed to wear an incontinent product. A review of the written care plan indicated a hydration focus with a goal of maintaining a daily fluid intake and interventions in place to monitor for signs of dehydration included offering water at medication passes and continued review of medications to identify use of medication that may contribute to fluid maintenance. The resident was prescribed and administered an identified medication with at least monthly monitoring.

A record review revealed that during an identified month, the resident's total fluid intake was below 1500 mls for 19 out of 28 days and the resident's urine output

was significantly decreased according to the PSW documentation. During an interview, a PSW stated that the resident previously voided a lot in his/her incontinent product; however, a few shifts prior to a hospital transfer on an identified date, the resident's incontinent product remained dry during changes, and those incidents were reported to the registered staff. In addition, the MAR indicated that registered staff continued to administer an identified medication until it was discontinued by the physician.

A record review revealed the primary physician assessed the resident on an identified date and wrote an order for lab work to be completed. The lab work was completed and faxed to the home the following day. The lab results revealed an identified marker was outside of normal range. The progress notes and Digital Prescriber's Orders revealed after reviewing the lab work, assessing the resident, and discussing the information with the resident's substitute decision maker (SDM), the physician ordered the resident to be transferred to acute care hospital due to the abnormal lab level. The progress notes revealed the resident returned to the home with a diagnosis of a medical condition which required new interventions.

During an interview, a registered staff member stated that he/she received the resident's lab result from the laboratory, but was unsure how to interpret the result. The staff stated that because the physician's next visit to the home was the following day he/she did not contact the physician to report the abnormal level.

During an interview with the DOC, he/she stated that the expectation is for registered staff to review laboratory results, initial the document and contact the physician to report abnormal laboratory values immediately so that treatment can be initiated as soon as possible. (535)

3. A review of a CIR from an identified date revealed improper/incompetent care and treatment of an identified resident.

A record review revealed the identified resident was admitted to the home with no diagnoses of an identified medical condition. The progress notes revealed that on an identified date the resident experienced what was thought to be the identified medical condition and was transferred to hospital for testing. Testing revealed no ill effects. The progress notes also revealed that on another identified date the resident experienced similar symptoms while care was being

provided by a PSW and again was transferred to hospital resulting in an admission for assessment and treatment related to the identified medical condition. According to the progress notes and physician's orders, the resident returned to the home and was started on medication. Lab work, over the course of identified time intervals, was ordered.

The progress notes and an interview with a RPN confirmed that registered staff members were challenged to ensure the resident was administered the appropriate dosage of the prescribed medication. The Medication Administration Record (MAR) revealed that on an identified date, the medication was changed with favorable acceptance by the resident. However, the laboratory levels continued to fluctuate but with no adverse symptoms from the resident while lab values were outside of the normal range.

Further record review revealed that on an identified date, the resident had lab work completed and the result was faxed and received by the home. An identified lab level was reported outside of the normal range. The physician visited the home, however lab values were not available to the physician for treatment on that day since the lab result was situated in an unknown location. The progress notes and staff interview confirmed that two days later the resident experienced symptoms of a medical condition and was sent to hospital where he/she was admitted, diagnosed with the medical condition and received treatment.

During interviews, RPN's stated that they did not receive a call from the lab company reporting the abnormal values which was the usual practice when laboratory values were outside the normal range. A RPN stated that he/she was unsure when to call the physician with laboratory values that were outside the normal range.

An interview with the Director of Care (DOC) confirmed that the expectation is for registered staff to review laboratory results, initial the document and contact the physician to report abnormal laboratory values immediately so that treatment can be initiated as soon as possible.

The scope of the non-compliance is isolated as it related to three residents. The severity of the non-compliance is actual harm/risk. The home has on-going noncompliance with s. 6 (7). As a result of the scope, severity and compliance history, a compliance order is warranted. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 22, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 26th day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Sarah Kennedy

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