Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 26, 2020	2019_821640_0031 (A2)	010869-19, 016574-19, 017481-19, 021063-19, 021415-19, 022199-19	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Peel
10 Peel Centre Drive Suite B, 3rd Floor BRAMPTON ON L6T 4B9

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

Tall Pines Long Term Care Centre
1001 Peter Robertson Blvd. BRAMPTON ON L6R 2Y3

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

Amended by HEATHER PRESTON (640) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The CDD was extended to March 20, 2020

Issued on this 26th day of February, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by HEATHER PRESTON (640) - (A2)

Amended 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): November 22, 25, 26 and December 10, 11, 12, 13, 16, 17 and 18, 2019.

During the course of the inspection, the LTCH Inspector toured the home, observed the provision of care, conducted interviews, reviewed clinical records and policy and procedures.

The following Critical Incident (CI) reports were reviewed:

Log #016574-19 regarding a fall resulting in injury

Log #017481-19 regarding a fall resulting in injury

Log #021063-19 regarding a fall resulting in injury and death

Log #021415-19, regarding a fall with injury

Log #022199-19 regarding an unexpected death

The following follow up to Compliance Orders was reviewed:

Log #010869-19 regarding Compliance Order #001 from CI Inspection #2019_787640_0015 related to s. 51 (2) with a compliance due date of August 30, 2019.

PLEASE NOTE: This inspection was conducted concurrently with Complaint Inspection #2019_821640_0032.

During the course of the inspection, the inspector(s) spoke with residents, families, Nursing Attendants (NA), Registered Practical Nurses (RPN), Registered Nurses (RN), Supervisors of Care (SOC), Fall Prevention Program Lead, Continence Care and Bowel Management Lead, Resident Assessment Instrument/Minimum Data Set (RAI/MDS) Coordinator and the Director of Care (DOC).

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Nutrition and Hydration
Personal Support Services
Quality Improvement
Reporting and Complaints

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

- **5 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

(A1)
1. The licensee failed to comply with compliance order (CO) #001 from Inspection #2019_787640_0015 issued May 28, 2019, with a compliance due date of August 30, 2019.

The licensee was ordered to:

Be compliant with O. Reg. 79/10, s. 51 (2).

Specifically, the licensee must ensure that:

a) Residents #001, #003, #005 and #006 and any other resident, have an individualized toileting plan based on an assessment,
b) All direct care staff receive training related to the assessment for, and development of, an individualized toileting plan for residents who are incontinent, and
c) Conduct an audit of residents who are incontinent to determine whether there are individualized toileting plans in place.

The licensee failed to complete item "a" of the compliance order.

The licensee failed to ensure that each resident who was incontinent had an individualized plan to promote and manage bowel and bladder continence based on an assessment.

A) The Ministry Of Long-Term Care (MOLTC) received a Critical Incident report submitted by the licensee on a specific date in October 2019, related to a fall with significant injury resulting in transfer to hospital and subsequent death. Resident #009 had sustained several falls since January 2019 and was assessed to be at high risk for falls.

Resident #009 had a Minimum Data Set (MDS) assessment conducted which assessed the resident to require extensive assistance of one person for their activities of daily living (ADLs). They were incontinent of bowel and occasionally incontinent of bladder. They used briefs. They were not assessed to be on any toileting schedule.

The licensee's policy "Continence Care and Bowel Management Program" with a revised date of October 24, 2016, directed staff to initiate an elimination diary on admission to establish the resident’s individual voiding patterns and routines. Reassess the plan of care quarterly or with change of condition to determine if the continence care interventions were effective and revise the plan of care if necessary. The policy also directed staff to collaborate with the resident or substitute decision maker and interdisciplinary team to conduct a bowel and bladder continence assessment and develop a bowel and bladder continence

plan for the resident.

The resident's plan of care directed staff to toilet the resident before and after breakfast, before and after lunch, before dinner and at bedtime. The resident called if they needed to go to the washroom. Do not waken during the night as per resident request.

The Long-Term Care Homes (LTCH) Inspector reviewed resident #009's clinical record and was unable to locate an assessment associated with their toileting plan.

Supervisor Of Care (SOC) #103, the Continence Care and Bowel Management Program Lead, told the LTCH Inspector that resident #009 did not have a bladder and bowel continence assessment to develop and implement an individualized toileting plan to promote their continence.

B) The MOLTC received a complaint regarding odours of incontinence of identified residents at the home. The LTCH Inspector reviewed and observed residents related to the specific issues identified in the complaint report.

i) Resident #010 was assessed on their MDS assessment to be incontinent of bowel and bladder and used a brief.

Their plan of care directed staff to toilet them before breakfast, before lunch, before dinner and at bedtime. The resident asked staff at other times. They were to be checked and changed twice during night rounds.

PSW #120 said the resident was extensive assistance of one person for toileting.

PSW #120 said they toileted the resident when they got up. They also asked them after lunch. Then the resident would only be taken again on the day shift if the resident asked.

SOC #103 told the LTCH Inspector that residents #010 did not have a bowel and bladder continence assessment to develop and implement an individualized toileting plan to promote their continence.

ii) Resident #008 was assessed to be incontinent of bowel and bladder following their fall on a specified date in September 2019, during a significant change in

condition MDS assessment. They were assessed as using a brief and were not on any scheduled toileting plan. They required total assistance of two persons for toileting.

The LTCH Inspector reviewed the plan of care in place at the time of the inspection which directed staff to: Toilet the resident after breakfast, after lunch, after dinner and check and change twice during night rounds.

An elimination diary, initiated following the fall in September 2019, had five entries during the day shift on a specified date in September 2019, and no other entries completed for the diary. The direction was to complete the elimination diary for four days.

PSWs #117 and #118 said that they toileted the resident when they asked, when they started their shift and at bedtime.

SOC #103 said that resident #008's plan of care was generic, not based on a bowel and bladder continence assessment and not clearly reflective of the resident's individual needs.

iii) Resident #007 was assessed on their MDS assessment to be frequently incontinent of bladder and occasionally incontinent of bowel and they used a brief. They required extensive assistance of staff for toileting.

The plan of care in place at the time of the inspection, directed staff to check and change the resident before breakfast, before lunch, before dinner, at bedtime and twice during the night.

The assessment of the three-day voiding diary conducted in August 2019, identified that the resident was incontinent at specific times of the day and night.

PSWs #101 and #102 said they would toilet the resident before breakfast, before lunch and after lunch. They said they toileted the resident earlier in the day if they needed to use the toilet.

PSWs #121 and #122 said the resident was on a check and change program if they were not awake. When the resident was awake then they went by the times in POC and as per request. The times were not consistent. The PSWs said they toileted resident #007 first thing at the start of their evening shift then they asked

the resident if they wanted to use the toilet after dinner and then right before bedtime.

SOC #103 said the resident's plan of care was generic and not clearly reflective of the resident's individual needs as per the review and assessment of the voiding diary.

iv) Resident #011's MDS assessment assessed the resident to be incontinent of bowel and bladder and they used a brief.

PSW #112 said the resident was not toileted during the night. During the night their brief would be changed.

PSW #113 said that resident #011 was not often taken to the toilet. Staff usually checked the brief and changed it as needed. On the day shift, PSW #113 said they checked and changed the resident in the morning, then they asked the resident before lunch if they needed to be changed or use the toilet. If it was not needed then they would check the resident after lunch.

The plan of care directed staff that the resident was part of an "Incontinent Program: Check and Change Program" and to check the resident for wetness and toilet the resident at specific times during the day and evening shift. No direction was given for the night shift.

The LTCH Inspector reviewed the clinical record, specifically the assessments and the PSW documentation for an elimination diary. Neither was identified in the clinical record.

SOC #103 said there was no bowel and bladder continence assessment conducted or documented to determine the resident's individual toileting needs.

The licensee failed to ensure that residents #007, #008, #009, #010 and #011 had an individualized toileting plan that was based on an assessment. [s. 51. (2) (b)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was reassessed and the plan of care reviewed and revised because the care set out in the plan was not effective, the licensee failed to ensure that different approaches were considered for resident #009.

The licensee reported a fall for resident #009 with significant injury and subsequent death, to the MOLTC on a specific date in October 2019. As a result, the LTCH Inspector reviewed previous falls leading up to this incident.

Since January 2019, resident #009 sustained several falls. On a specific date in June 2018, the resident was assessed at high risk for falls.

The LTCH Inspector reviewed the resident's plan of care in place at the time of

the reported fall in October 2019. Their were generic falls prevention strategies in place. An identified item requiring the resident to activate for assistance, was implemented in August 2019.

The licensee's policy "Post Fall Guidelines", policy #NF-162 with a revised date of April 9, 2018, directed staff to update a resident's plan of care with new/current strategies.

The licensee's policy "Falls Prevention and Management Program" with a revised date of April 9, 2018, directed staff to review equipment needs to improve safety such as bed or chair alarms.

PSWs #114 and #115 and SOC #116 said that the resident was not able to ambulate independently and had been given the identified item to use when they needed assistance. The PSWs said the resident didn't understand directions or cause and effect and often did not use the item for assistance.

The PSWs said that the resident may have benefited from automatic activated items, but they had not been provided one. One specific automatic item was initiated in November 2019, but the resident did not return to the home.

SOC #116, the Falls Prevention Program Lead said they had not implemented the use of an automatic activated item as a different approach for this resident.

The licensee failed to ensure that different approaches were considered when the plan of care was reviewed and revised for resident #009. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance the licensee must ensure that when a resident is reassessed and the plan of care reviewed and revised because the care set out in the plan is not effective, the licensee must ensure that different approaches are considered for residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that residents #007 and #010's plans of care were based on an assessment with respect to sleep patterns and preferences.

i) Resident #007 had a fall with injury in August 2019. Resident #007 was assessed to be at high risk for falls one week prior to this fall.

As part of the licensee's fall prevention program, a possible risk factor for falling was incontinence. The licensee's policy "Falls Prevention and Management Program" directed staff to develop an individualized toileting plan based on an assessment.

The plan of care was reviewed by the LTCH Inspector and it directed staff to check and change the resident throughout the day and at bedtime. No specific times were noted in the plan of care.

The LTCH Inspector did not locate the resident's preferred wake and bed times in the plan of care.

NA #100 and SOC #103 said that in the plan of care, under the "Focus of Sleep and Comfort preferences", the resident's preferred wake and sleep times were to be noted.

NA #100 and SOC #103 were not able to locate the preferred wake and bed times for resident #007.

SOC #103 reviewed the resident's "Nursing Admission Assessment – V3" which stated the preferred bed time but the preferred wake time was not documented.

ii) Resident #010 had a fall on a specific date in November 2019 resulting in injury.

PSW #120 said the resident usually got up mid-morning at which time they would have breakfast. They said this information should be in the plan of care.

The plan of care was reviewed by the LTCH Inspector and it directed staff to toilet the resident before breakfast, before lunch, before dinner and at bedtime and as requested by the resident. The LTCH Inspector did not locate the resident's preferred wake time in the plan of care.

SOC #103 was not able to locate the preferred wake times for resident #010.

The licensee failed to ensure that residents #007 and #010's sleep patterns and preferences were included in their plan of care. [s. 26. (3) 21.]

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 the licensee must ensure that sleep patterns and preferences are included in the resident's plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with O. Reg. 79/10, s. 48 (1), in reference to s. 49, the licensee was required to ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls including the monitoring of residents.

a)Specifically, staff did not comply with the licensee's policy "Post Fall Guidelines", policy #NF-162, with a revised date of April 9, 2018, that directed staff to complete a post fall assessment for all resident falls for two consecutive shifts following the fall using the "Post Fall" progress note.

i) The licensee reported a fall with significant injury and subsequent death to the MOLTC on a specific date in October 2019. As a result, the LTCH Inspector reviewed previous falls leading up to this incident.

On two dates in October 2019, resident #009 fell with no obvious injury documented at either time.

The LTCH Inspector reviewed the clinical record to include progress notes and assessments following both falls.

SOC #116 said following the first fall in October 2019, there was a requirement for staff to complete post fall notes for the following two shifts of nights and days. There was one post fall note documented the following date.

SOC #116 said following the second fall that occurred five days later in October 2019, staff were required to have post fall notes completed for the night and day shift. There was one post fall note documented the following day.

ii) The licensee reported a fall of resident #010 with significant injury identified on a specific date in November 2019 to the MOLTC.

SOC #116 said following the fall there was a requirement for staff to complete post fall notes for the following two shifts of nights and days. They said there was one post fall note documented the following date as the night shift. There was no post fall note documented for the day shift as required.

b)Specifically, staff did not comply with the licensee's policy "Falls Prevention and Management Program" with a revised date of April 9, 2018, that directed staff to conduct head injury routine (HIR) for unwitnessed falls, and "Post Fall Guidelines" policy #NF-162 with a revised date of April 9, 2018, that directed staff to complete HIR for all unwitnessed falls where the resident was unable to identify if they had hit their head or not.

The LTCH Inspector reviewed the clinical record to include progress notes and assessments following falls on two specific dates in October 2019, for resident #009.

The first fall that occurred required there to be HIR completed as the fall was unwitnessed. Resident #009's second fall that occurred five days later, did not require HIR as the resident had informed staff they had not hit their head.

SOC #116 and RN #119 said that all unwitnessed falls required HIR to be initiated. The SOC said if a resident said they had not hit their head, and the nurse documented same, then staff were not expected to initiate HIR. They acknowledged the HIR was expected to be initiated for the first fall in October 2019, following the unwitnessed fall and it had not been.

The licensee failed to ensure that their policies "Post Fall Guidelines" and "Falls Prevention and Management Program" were complied with. [s. 8. (1) (a),s. 8. (1)

(b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed of the unexpected death of resident #002.

On a specific date in November 2019, resident #002 was believed to be suffering a medical emergency. Staff immediately initiated emergency action and called 911. The resident was transported to the hospital.

The home was notified that the resident had passed away the day of arrival at the hospital, two days later.

SOC #104 said that they were off that day and RPN #105 had informed management of the resident's death immediately upon receiving the information. The management team discussed the incident at their morning meeting that day.

The incident was discussed again the following day at the morning meeting of the management team, of which SOC #104 attended. The form was initiated by them following the meeting and submitted to the Director one day late.

SOC #104 said the report of the unexpected death of resident #002 was not immediately reported to the Director. [s. 107. (1)]

Issued on this 26th day of February, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by HEATHER PRESTON (640) - (A2)
Inspection No. / No de l'inspection :	2019_821640_0031 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	010869-19, 016574-19, 017481-19, 021063-19, 021415-19, 022199-19 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 26, 2020(A2)
Licensee / Titulaire de permis :	The Regional Municipality of Peel 10 Peel Centre Drive, Suite B, 3rd Floor, BRAMPTON, ON, L6T-4B9
LTC Home / Foyer de SLD :	Tall Pines Long Term Care Centre 1001 Peter Robertson Blvd., BRAMPTON, ON, L6R-2Y3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dwayne Green

Ontario

Ministry of Long-Term Care

Ministère 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

To The Regional Municipality of Peel, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_787640_0015, CO #001;

Pursuant to / Aux termes de :

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

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must be compliant with s. 51 (2) of O. Reg. 79/10.

Specifically, the licensee must ensure that:

a) Residents #007, #008, #009, #010 and #011 and any other resident, have an individualized toileting plan based on an assessment,

b) All direct care staff receive revised training related to the assessment for and development of, an individualized toileting plan for any resident who is incontinent and,

c) Conduct an audit of all residents to determine those that are incontinent and ensure they have an assessment completed resulting in an individualized toileting plan.

Grounds / Motifs :

(A1)
1. 1. The licensee failed to comply with compliance order (CO) #001 from Inspection #2019_787640_0015 issued May 28, 2019, with a compliance due date of August 30, 2019.

The licensee was ordered to:

Be compliant with O. Reg. 79/10, s. 51 (2).

Specifically, the licensee must ensure that:

a) Residents #001, #003, #005 and #006 and any other resident, have an individualized toileting plan based on an assessment,
b) All direct care staff receive training related to the assessment for, and development of, an individualized toileting plan for residents who are incontinent, and
c) Conduct an audit of residents who are incontinent to determine whether there are individualized toileting plans in place.

The licensee failed to complete item "a" of the compliance order.

The licensee failed to ensure that each resident who was incontinent had an

individualized plan to promote and manage bowel and bladder continence based on an assessment.

A) The Ministry Of Long-Term Care (MOLTC) received a Critical Incident report submitted by the licensee on a specific date in October 2019, related to a fall with significant injury resulting in transfer to hospital and subsequent death. Resident #009 had sustained several falls since January 2019 and was assessed to be at high risk for falls.

Resident #009 had a Minimum Data Set (MDS) assessment conducted which assessed the resident to require extensive assistance of one person for their activities of daily living (ADLs). They were incontinent of bowel and occasionally incontinent of bladder. They used briefs. They were not assessed to be on any toileting schedule.

The licensee's policy "Continence Care and Bowel Management Program" with a revised date of October 24, 2016, directed staff to initiate an elimination diary on admission to establish the resident's individual voiding patterns and routines. Reassess the plan of care quarterly or with change of condition to determine if the continence care interventions were effective and revise the plan of care if necessary. The policy also directed staff to collaborate with the resident or substitute decision maker and interdisciplinary team to conduct a bowel and bladder continence assessment and develop a bowel and bladder continence plan for the resident.

The resident's plan of care directed staff to toilet the resident before and after breakfast, before and after lunch, before dinner and at bedtime. The resident called if they needed to go to the washroom. Do not waken during the night as per resident request.

The Long-Term Care Homes (LTCH) Inspector reviewed resident #009's clinical record and was unable to locate an assessment associated with their toileting plan.

Supervisor Of Care (SOC) #103, the Continence Care and Bowel Management Program Lead, told the LTCH Inspector that resident #009 did not have a bladder and bowel continence assessment to develop and implement an individualized toileting plan to promote their continence.

B) The MOLTC received a complaint regarding odours of incontinence of identified residents at the home. The LTCH Inspector reviewed and observed residents related to the specific issues identified in the complaint report.

i) Resident #010 was assessed on their MDS assessment to be incontinent of bowel and bladder and used a brief.

Their plan of care directed staff to toilet them before breakfast, before lunch, before dinner and at bedtime. The resident asked staff at other times. They were to be checked and changed twice during night rounds.

PSW #120 said the resident was extensive assistance of one person for toileting.

PSW #120 said they toileted the resident when they got up. They also asked them after lunch. Then the resident would only be taken again on the day shift if the resident asked.

SOC #103 told the LTCH Inspector that residents #010 did not have a bowel and bladder continence assessment to develop and implement an individualized toileting plan to promote their continence.

ii) Resident #008 was assessed to be incontinent of bowel and bladder following their fall on a specified date in September 2019, during a significant change in condition MDS assessment. They were assessed as using a brief and were not on any scheduled toileting plan. They required total assistance of two persons for toileting.

The LTCH Inspector reviewed the plan of care in place at the time of the inspection which directed staff to: Toilet the resident after breakfast, after lunch, after dinner and check and change twice during night rounds.

An elimination diary, initiated following the fall in September 2019, had five entries during the day shift on a specified date in September 2019, and no other entries completed for the diary. The direction was to complete the elimination diary for four days.

PSWs #117 and #118 said that they toileted the resident when they asked, when they started their shift and at bedtime.

SOC #103 said that resident #008's plan of care was generic, not based on a bowel and bladder continence assessment and not clearly reflective of the resident's individual needs.

iii) Resident #007 was assessed on their MDS assessment to be frequently incontinent of bladder and occasionally incontinent of bowel and they used a brief. They required extensive assistance of staff for toileting.

The plan of care in place at the time of the inspection, directed staff to check and change the resident before breakfast, before lunch, before dinner, at bedtime and twice during the night.

The assessment of the three-day voiding diary conducted in August 2019, identified that the resident was incontinent at specific times of the day and night.

PSWs #101 and #102 said they would toilet the resident before breakfast, before lunch and after lunch. They said they toileted the resident earlier in the day if they needed to use the toilet.

PSWs #121 and #122 said the resident was on a check and change program if they were not awake. When the resident was awake then they went by the times in POC and as per request. The times were not consistent. The PSWs said they toileted resident #007 first thing at the start of their evening shift then they asked the resident if they wanted to use the toilet after dinner and then right before bedtime.

SOC #103 said the resident's plan of care was generic and not clearly reflective of the resident's individual needs as per the review and assessment of the voiding diary.

iv) Resident #011's MDS assessment assessed the resident to be incontinent of bowel and bladder and they used a brief.

PSW #112 said the resident was not toileted during the night. During the night their brief would be changed.

PSW #113 said that resident #011 was not often taken to the toilet. Staff usually

checked the brief and changed it as needed. On the day shift, PSW #113 said they checked and changed the resident in the morning, then they asked the resident before lunch if they needed to be changed or use the toilet. If it was not needed then they would check the resident after lunch.

The plan of care directed staff that the resident was part of an "Incontinent Program: Check and Change Program" and to check the resident for wetness and toilet the resident at specific times during the day and evening shift. No direction was given for the night shift.

The LTCH Inspector reviewed the clinical record, specifically the assessments and the PSW documentation for an elimination diary. Neither was identified in the clinical record.

SOC #103 said there was no bowel and bladder continence assessment conducted or documented to determine the resident's individual toileting needs.

The licensee failed to ensure that residents #007, #008, #009, #010 and #011 had an individualized toileting plan that was based on an assessment.

The severity of this issue was determined to be level 2, minimal risk, minimal harm. The scope of the issue was determined to be widespread as five of seven residents reviewed did not have an individualized toileting plan. The compliance history was determined to be level 5. Previous compliance order to the same subsection and four or more other compliance orders as follows:

- CO #001 issued February 2, 2017, during RQI Inspection #2017_546585_0001 for s. 69 with a compliance due date of June 29, 2017,

- CO #002 issued February 2, 2017, during RQI Inspection #2017_546585_0001 for s. 110 (1) with a compliance due date of June 29, 2017,

- CO #001 issued May 25, 2018, during RQI Inspection # 2018_724640_0009 for s. 229 (4) with a compliance due date of September 21, 2018,

- CO #002 issued May 25, 2018, during RQI Inspection # 2018_724640_0009 for s. 50 (2) with a compliance due date of August 24, 2018,

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

- CO #003 issued May 25, 2018, during RQI Inspection # 2018_724640_0009 for s. 90 (2) with a compliance due date of July 20, 2018,

- CO #001 issued May 28, 2019 during Critical Incident Inspection #2019_787640_0015 for s. 51 (2) with a compliance due date of August 30, 2019.

(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 20, 2020(A2)

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 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:

Ontario

Ministry of Long-Term Care

Ministère 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

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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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 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 February, 2020 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by HEATHER PRESTON (640) - (A2)

Ontario

Ministry of Long-Term Care

Ministère 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

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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

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