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 |
|---|---|---|---|
| Jul 18, 2018 | 2018_420643_0010 | 012333-18 | Resident Quality Inspection |

## Licensee/Titulaire de permis

The Regional Municipality of Peel
7120 Hurontario Street 6th Floor MISSISSAUGA ON L5W 1N4

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

Malton Village Long Term Care Centre
7075 Rexwood Road MISSISSAUGA ON L4T 4M1

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

ADAM DICKEY (643), JULIENNE NGONLOGA (502), THERESA BERDOE-YOUNG (596)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection.**

**This inspection was conducted on the following date(s): June 11-15, and 18-21, 2018.**

**The following Compliance Order follow-up intakes were inspected concurrently with the RQI:**
**Log #002918-18 - related to prevention of neglect;**
**Log #002920-18 - related to training and orientation;**
**Log #003159-18 - related to plan of care for falls prevention and management;**
**Log #003160-18 - related to skin and wound care;**
**Log #003161-18 - related to compliance with manufacturers' instructions; and**
**Log #003162-18 - related to conditions of a license.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Supervisors of Care (SOC), Physician, Program Support Nurse (PN), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Registered Physiotherapist (PT), RAI-MDS Coordinator, Food Service Supervisor (FSS), Personal Care Aides (PCA), Dietary Aides (DA), Residents' Council representatives, residents and family members.**

**During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Falls Prevention**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Skin and Wound Care**
**Training and Orientation**

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

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

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

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 101. (3) | CO #001 | 2017_547591_0015 | 643 |
| LTCHA, 2007 S.O. 2007, c.8 s. 19. (1) | CO #001 | 2017_547591_0015 | 502 |
| O.Reg 79/10 s. 221. (2) | CO #005 | 2017_547591_0015 | 643 |
| O.Reg 79/10 s. 23. | CO #004 | 2017_547591_0015 | 596 |
| O.Reg 79/10 s. 50. (2) | CO #002 | 2017_547591_0015 | 596 |

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

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

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

**s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and are consistent with and complemented each other.

During stage two of the Resident Quality Inspection (RQI), resident #003 was triggered for nutrition and hydration from staff interview during stage one.

Review of the resident's written plan of care indicated that the resident was admitted to the home with identified medical diagnoses. Review of a nutrition assessment for an identified date, indicated that resident #003 required specified estimated calorie and protein daily and the resident goal weight range (GWR) was specified. The plan of care directed staff to provide identified nutrition interventions at meals to meet a specified nutrition goal.

In separate interviews, dietary aide (DA) #104 and personal care aide (PCA) #105 stated

that resident #003 only ate an identified food item during a specified meal. DA #104 indicated that they were aware that the resident required the specified nutrition intervention, but the resident had been only requesting an identified food item one week after their admission in the home. Both PCA #103 and DA #104 stated that the food service supervisor and the registered practical nurse (RPN) were aware that the resident only ate the identified food item at the specified meal.

In separate interviews, RPN #106 and FSS #115 indicated they were not aware that resident #003 was not receiving the identified nutrition intervention. They stated that PCA and dietary staff were expected to inform the registered staff if the resident is refusing the nutrition interventions. The registered staff would then refer the resident to the Registered Dietitian (RD) for re-assessment.

In an interview RD #114 stated they implemented the identified intervention to meet the resident's nutrition goals to address nutrition risks from their past medical history. If the resident refused the interventions for five to six days consecutively nursing staff would send a referral indicating that the interventions are not effective, and they will try to offer a substitute. RD #114 stated the nursing staff had not collaborated with them as the resident had refused the intervention continually and they did not send a dietary referral. [s. 6. (4) (b)]

2. 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.

During stage two of the RQI, resident #004 was triggered for Nutrition and Hydration from census record review during stage one.

Review of resident #004’s health records indicated that they had returned to the home from hospital on an identified date, and was seen by the Nurse Practitioner (NP) following their return from hospital. Progress note from the NP indicated that the resident had a complicated hospital stay, and due to history of congestive heart failure (CHF) would direct staff to conduct weight monitoring every two weeks.

Review of resident #004’s physician orders revealed an order written two days following their return from hospital, ordering weights to be taken now, and every two weeks for a period of two months. Review of resident #004’s weight history in Point-Click Care (PCC) showed weights had been recorded on the following day and again two weeks later The next weight measurement was not completed until one month following the second

measurement, and again the following month.

Review of Resident #004’s Medication Administration Record (MAR) indicated that a weight measurement was scheduled for an identified date four weeks after the initial weight, and documented as “9” – other/ see progress notes. Review of progress notes for the above mentioned identified date, indicated "done on Saturday". No record of a weight measurement for the identified date was found.

Review of the MAR for resident #004 indicated that a weight measurement was scheduled for an identified date eight weeks after the initial weight measurement, and documented as “9” – other/ see progress notes. Review of progress notes for the identified date, indicated that the weight was to be done on shower days. No record of a weight measurement for the above mentioned identified date was found.

In an interview Registered Nurse (RN) #101 indicated that the order was indicated on the electronic MAR (EMAR) to weigh resident #004 every two weeks for two months. RN #101 indicated that if a weight was taken it should have been entered into the weight record on PCC. RN #101 indicated that no record of a weight measurement was found for the two above mentioned identified dates.

In an interview Supervisor of Care (SOC) #107 indicated that if a resident was to be weighed more frequently than on a monthly basis the order would be entered into the EMAR as well as point of care tasks for staff to complete. SOC #107 indicated that registered staff were expected to carry out all orders in the EMAR. SOC #107 stated that resident #004 was not weighed on the two above mentioned identified dates as ordered, and that the care set out in the plan of care was not provided to resident #004 as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

Compliance Order #003 was served on February 7, 2018, under inspection report #2017_547591_0015 with a compliance due date of April 30, 2018. The licensee was ordered to:

1. Ensure the written plan of care for all residents, including resident #085 and #095 was reviewed and revised when care set out in the plan was ineffective.

2. Ensure interdisciplinary strategies and recommendations were communicated to staff, implemented and included in the resident's written plan of care.
3. Ensure PCA staff received training on how and when to notify registered staff when resident care set out in their written plan of care was ineffective.
4. Develop a process for regular auditing and monitoring of written care plans to ensure they have been reviewed as necessary and updated accordingly when care set out in the plan was ineffective.

a. Observations by the inspector on two identified dates during a specified meal service showed resident #095 was seated in their identified ambulation aide by the dining room table for their meals. The inspector was not able to interview resident #095 due to cognitive impairment.

Review of the resident's current written plan of care revealed interventions that directed two staff to assist the resident with ambulation for toileting and to meals. On an identified date, RPN #103 who was the rehabilitation nurse documented that resident #095 was discharged from the identified nursing rehabilitation program because they met their goal, but the resident would continue to walk to the dining room for meals.

In an interview, RPN #103 stated that resident #095 had been discharged from the above mentioned identified nursing rehabilitation program as staff noted that they had become weaker and exhibited an identified responsive behaviour. RPN #103 further stated staff may walk the resident to the dining room table if they requested and that their written plan of care should had been revised to indicate the change in resident care. This contradicted PSW #127's statement that resident #095 never asked staff for assistance to be walked as they could not communicate.

In separate interviews, PCAs #126, #122 and #127 indicated that the registered staff told them to stop assisting resident #095 with walking to the dining room table as the resident indicated they did not want to walk.

In an interview, RN #123 indicated that resident #095 was no longer walking and had been refusing to walk with the physiotherapist.

In an interview RN #129 indicated that resident #095's demeanor had become calm and felt safe in their ambulation aide. The RN indicated that quite often when the staff tried to get them up to walk to the dining room table the resident exhibited identified responsive behaviours. The RN further stated that the team made the decision to stop walking the

resident to the dining room, but continued to assist them to walk when toileting. The RN indicated that that the written plan of care should have been revised accordingly.

b. Due to identified noncompliance with LTCHA 2007, c. 8, s. 6. (10) (c), the sample of residents was expanded to include resident #008.

Review of resident #008's Minimum Data Set (MDS) assessment indicated that the resident required increased monitoring and supervision due to risk for falls and pain. Review of the resident's Morse Falls Risk Assessment indicated that the resident was at risk for falls.

Review of resident #008's progress notes revealed that the resident had seven fall incidents over the past nine months. On an identified date eight months in to the nine month period a referral was sent to the physiotherapist (PT) as the resident was declining and required an identified ambulation aide. The referral also indicated that the resident was still able to ambulate using an ambulation aide but was unsteady. One week later, the PT addressed the referral and recommended specified interventions to manage the resident's mobility needs. The resident required assistance from one staff for transfer and ambulation with an ambulation aide. Two of the above mentioned fall incidents occurred following this assessment and recommendations by the PT.

Review of resident #008's written plan of care revealed that the following strategies:
• Ensure call bell within reach and respond promptly;
• Ensure that the room was free of clutter, with ambulation aide and regularly used personal items within reach;
• Remind resident #008 to use ambulation aide at all times;
• Remind resident #008 to wear proper footwear;
• Resident #008 required more assistance at specified time of day, staff to offer assistance toileting to decrease risk for falls.
Further review of the resident's current written plan of care did not include the above mentioned recommendations made by the PT when there was a change in the resident's condition.

In separate interviews, PCA #127 and RN #123 indicated specified fall hazards for resident #008. RN #123 indicated that they had advised the resident's family, however the specified hazard was not addressed.

In an interview RN #129 indicated that resident #008 had an unsteady gait and pain. The

RN stated that the resident ambulated with a specified aide, and would be assisted with ambulation by staff when unsteady. The RN also indicated that a referral was sent to the PT to assess the resident's ambulation equipment needs.

In an interview, the PT indicated they had assessed resident #008 on an identified date, and recommended the above mentioned specified interventions to manage the resident's mobility needs.The PT further indicated that if the resident continued to have falls while attempting to toilet, the recommendation should include frequent toileting schedule.

In an interview the DOC stated that they directed night shift staff to anticipate resident needs and assist them to toilet frequently as most of resident's falls occurred during a specified shift, while trying to use the washroom. During a follow-up meeting with the specified shift staff, they told the DOC that the strategy was proven to be effective in reducing falls. This strategy was not included in the resident's plan of care. [s. 6. (10)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information**

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

**s. 79. (3) The required information for the purposes of subsections (1) and (2) is,**
**(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)**
**(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)**
**(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)**
**(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)**
**(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)**
**(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)**
**(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)**
**(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)**
**(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)**
**(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)**
**(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)**
**(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)**
**(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)**
**(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)**
**(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)**
**(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)**
**(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that copies of the inspection reports from the last two years for the long term care home were posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations.

During the initial tour of the home the inspector reviewed postings of MOHLTC public inspection reports which were posted in the home. The review failed to reveal a posting for public inspection report #2017_642606_0008 issued on May 12, 2017.

In an interview with the home's administrator, they acknowledged that the above mentioned public inspection report had not been posted in the home, at the time of the observation. [s. 79. (3) (k)]

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

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

**s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,**
**(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).**
**(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's substitute decision maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Record review of the home's medication incident reports, included incident report from an identified date. Under the description of the incident section, it indicated that a registered staff documented that resident #006 was administered an identified medication at an identified administration time, however the resident's medication pouch for that administration time was found by SOC #116 still containing the medication. The above mentioned incident report indicated that follow up and review of safe medication practices would be completed with the staff member. Under the notification section, it did not include documentation that the physician was notified of the medication incident.

Record review of resident #006's EMAR indicated a staff sign-off by RPN #117 for administration of the above mentioned medication at the specified time and date of the medication administration mentioned above.

During interview the DOC reported that the above mentioned registered staff member did not administer the above mentioned identified medication to resident #006 and signed off on the EMAR indicating that it was administered; the pouch with the medication inside was found by a SOC. The DOC indicated that the physician was not notified of the above mentioned medication incident that occurred on the identified date, involving resident #006. [s. 135. (1)]

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**

**Issued on this 3rd day of August, 2018**

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

**Original report signed by the inspector.**

Ontario

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

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

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

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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | ADAM DICKEY (643), JULIENNE NGONLOGA (502), THERESA BERDOE-YOUNG (596) |
| **Inspection No. / No de l'inspection :** | 2018_420643_0010 |
| **Log No. / No de registre :** | 012333-18 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Jul 18, 2018 |
| **Licensee / Titulaire de permis :** | The Regional Municipality of Peel<br>7120 Hurontario Street, 6th Floor, MISSISSAUGA, ON, L5W-1N4 |
| **LTC Home / Foyer de SLD :** | Malton Village Long Term Care Centre<br>7075 Rexwood Road, MISSISSAUGA, ON, L4T-4M1 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Jessica Altenor |

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

**Order # / Ordre no :** 001

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

**Linked to Existing Order / Lien vers ordre existant:** 2017_547591_0015, CO #003;

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

**Order / Ordre :**

The licensee must be compliant with LTCHA 2007, c. 8, s. 6. (10).

Specifically, the licensee must:
1) Ensure that for residents #095, #008 and any other residents, the written plan of care for each resident is reviewed and revised when care set out in the plan is ineffective; and
2) Ensure strategies and recommendations from the interdisciplinary team are communicated to direct care staff, are implemented and are included in the resident's written plan of care.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

Compliance Order #003 was served on February 7, 2018, under inspection report #2017_547591_0015 with a compliance due date of April 30, 2018. The licensee was ordered to:

1. Ensure the written plan of care for all residents, including resident #085 and

#095 was reviewed and revised when care set out in the plan was ineffective.
2. Ensure interdisciplinary strategies and recommendations were communicated to staff, implemented and included in the resident's written plan of care.
3. Ensure PCA staff received training on how and when to notify registered staff when resident care set out in their written plan of care was ineffective.
4. Develop a process for regular auditing and monitoring of written care plans to ensure they have been reviewed as necessary and updated accordingly when care set out in the plan was ineffective.

a. Observations by the inspector on two identified dates during a specified meal service showed resident #095 was seated in their identified ambulation aide by the dining room table for their meals. The inspector was not able to interview resident #095 due to cognitive impairment.

Review of the resident's current written plan of care revealed interventions that directed two staff to assist the resident with ambulation for toileting and to meals. On an identified date, RPN #103 who was the rehabilitation nurse documented that resident #095 was discharged from the identified nursing rehabilitation program because they met their goal, but the resident would continue to walk to the dining room for meals.

In an interview, RPN #103 stated that resident #095 had been discharged from the above mentioned identified nursing rehabilitation program as staff noted that they had become weaker and exhibited an identified responsive behaviour. RPN #103 further stated staff may walk the resident to the dining room table if they requested and that their written plan of care should had been revised to indicate the change in resident care. This contradicted PSW #127's statement that resident #095 never asked staff for assistance to be walked as they could not communicate.

In separate interviews, PCAs #126, #122 and #127 indicated that the registered staff told them to stop assisting resident #095 with walking to the dining room table as the resident indicated they did not want to walk.

In an interview, RN #123 indicated that resident #095 was no longer walking and had been refusing to walk with the physiotherapist.

In an interview RN #129 indicated that resident #095's demeanor had become calm and felt safe in their ambulation aide. The RN indicated that quite often

when the staff tried to get them up to walk to the dining room table the resident exhibited identified responsive behaviours. The RN further stated that the team made the decision to stop walking the resident to the dining room, but continued to assist them to walk when toileting. The RN indicated that that the written plan of care should have been revised accordingly.

b. Due to identified noncompliance with LTCHA 2007, c. 8, s. 6. (10) (c), the sample of residents was expanded to include resident #008.

Review of resident #008's Minimum Data Set (MDS) assessment indicated that the resident required increased monitoring and supervision due to risk for falls and pain. Review of the resident's Morse Falls Risk Assessment indicated that the resident was at risk for falls.

Review of resident #008's progress notes revealed that the resident had seven fall incidents over the past nine months. On an identified date eight months in to the nine month period a referral was sent to the physiotherapist (PT) as the resident was declining and required an identified ambulation aide. The referral also indicated that the resident was still able to ambulate using an ambulation aide but was unsteady. One week later, the PT addressed the referral and recommended specified interventions to manage the resident's mobility needs. The resident required assistance from one staff for transfer and ambulation with an ambulation aide. Two of the above mentioned fall incidents occurred following this assessment and recommendations by the PT.

Review of resident #008's written plan of care revealed that the following strategies:
• Ensure call bell within reach and respond promptly;
• Ensure that the room was free of clutter, with ambulation aide and regularly used personal items within reach;
• Remind resident #008 to use ambulation aide at all times;
• Remind resident #008 to wear proper footwear;
• Resident #008 required more assistance at specified time of day, staff to offer assistance toileting to decrease risk for falls.
Further review of the resident's current written plan of care did not include the above mentioned recommendations made by the PT when there was a change in the resident's condition.

In separate interviews, PCA #127 and RN #123 indicated specified fall hazards

for resident #008. RN #123 indicated that they had advised the resident's family, however the specified hazard was not addressed.

In an interview RN #129 indicated that resident #008 had an unsteady gait and pain. The RN stated that the resident ambulated with a specified aide, and would be assisted with ambulation by staff when unsteady. The RN also indicated that a referral was sent to the PT to assess the resident's ambulation equipment needs.

In an interview, the PT indicated they had assessed resident #008 on an identified date, and recommended the above mentioned specified interventions to manage the resident's mobility needs.The PT further indicated that if the resident continued to have falls while attempting to toilet, the recommendation should include frequent toileting schedule.

In an interview the DOC stated that they directed night shift staff to anticipate resident needs and assist them to toilet frequently as most of resident's falls occurred during a specified shift, while trying to use the washroom. During a follow-up meeting with the specified shift staff, they told the DOC that the strategy was proven to be effective in reducing falls. This strategy was not included in the resident's plan of care.

The severity of this issue was determined to be a level 2 as there was potential for harm to residents #095 and #008. The scope of the issue was a level 2 as it was identified as affecting two out of three residents inspected. The home had a level 4 compliance history as they had ongoing noncompliance with LTCHA 2007, c. 8, s. 6. (10) that included:
- WN, VPC issued February 12, 2016, under inspection report #2016_343585_0001;
- WN, VPC issued April 21, 2016, under inspection report #2016_301561_0008;
- WN issued June 2, 2017, under inspection report #2017_642606_0008; and
- WN, CO issued February 7, 2018, under inspection report #2017_547591_0015, with a compliance due date of April 30, 2018.
(502)

Ontario

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

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

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

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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 21, 2018

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

**Issued on this  18th  day of July, 2018**

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

Ontario

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

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**Name of Inspector /**
**Nom de l'inspecteur :** Adam Dickey

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