Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 09, 2017;	2017_584161_0007 (A1)	002987-17	Complaint

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

GARRY J. ARMSTRONG HOME
200 ISLAND LODGE ROAD OTTAWA ON K1N 5M2

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

LINDA HARKINS (126) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The submission date for the compliance plan for Orders #001 and #002 have been extended to September 15, 2017 .The compliance due date for Orders # 001 and #002 have been extended to December 1, 2017. These changes have been made as per the request of the licensee.

Issued on this 9 day of August 2017 (A1)

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

Original report signed by the inspector.

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

LINDA HARKINS (126) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 22, 23, 24, 27, 28, 2017, March 1, 2, 6, 7, 8, 9, 10, 2017.

During the course of the inspection, the inspector(s) reviewed the identified resident's health care records, unit daily records on identified dates, nursing routines, in-service content related to the prevention of abuse, staff education history reports, the licensee's investigation notes and relevant correspondences as well as the licensee's policies and procedures titled: "Abuse – 750.65" revision date September 2016; "Assessment: Head Injury – 315.11" revision date September 2013; "Critical Incident System – Mandatory and Critical Incident Reporting – 750.56" revision date September 2016; "Disclosure – 750.118" revision date July 2016; "Falls Prevention Program" revision date March 2016; "Least Restraints - 335.10" revision date January 2017; "Lifting and Transferring Program – 350-05" revision date August 2016.

During the course of the inspection, the inspector(s) spoke with the identified resident and their Substitute Decision Maker (SDM), Personal Support Workers (PSW) , Registered Practical Nurses (RPN), a Registered Nurse (RN), Administrative Assistant, Social Worker, Program Manager of Personal Care (PMOPC), two Program Managers of Resident Care (PMORC) and the home's Acting Administrator.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

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

6 WN(s)
1 VPC(s)
2 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. 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 :

The licensee failed to ensure that resident #001 was protected from neglect by PSW #104.

As per O. Reg. 79/10, s.5. "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

In summary, after a review of documentation and staff interviews; on an identified date in December 2016 at approximately 0500 hours, resident #001 was found in bed by PSW #112 and PSW #113 with a facial injuries; the cause of the resident's injuries were unknown. On the identified date in December 2016 at the beginning of the changeover to the evening shift, PSW #104 admitted to RPN #108 that while preparing resident #001 for bed at approximately 1800 hours the evening before, he had removed the resident's lap belt and table top restraints and left the resident alone in her/his room while he assisted another staff member. When he returned to resident #001's room, PSW #104 found the resident lying on the floor. He transferred resident #001 to bed and observed that the resident was making sounds of distress and had incurred facial injuries. PSW #104 did not inform any registered nursing staff of the occurrence and as a result, resident #001 did not receive any nursing treatment or care for her/his facial injuries until 11 hours later; on the identified date in December 2016 at approximately 0500 hours.

In January 2017 the licensee submitted a Critical Incident Report (CIR) to the Director. This CIR indicated that resident #001 was found in bed, in the early morning of an identified date in December 2016 with facial injuries; the cause of the resident's injuries were unknown. The licensee had commenced their

investigation into the incident and suspected that resident #001 had been neglected by PSW #104 and had notified the resident's Substitute Decision Maker (SDM).

On February 2, 2017 the Ministry of Health and Long-Term Care Infoline received a complaint from resident #001's SDM expressing concerns regarding the unexplained facial injuries to the resident that were discovered in the early morning on the identified date in December 2016.

Resident #001 was admitted to the home in October 2015 with multiple medical diagnoses. Due to the degree of cognitive impairment coupled with her/his physical limitations, resident #001 was dependent on staff to anticipate her/his needs and provide assistance with all her/his activities of daily living. Resident #001 was transferred from bed to chair with the assistance of two people and a mechanical lift. Resident #001 was at high risk for falls and required the use of physical restraints, bedrails and frequent monitoring.

A review of the nursing staff schedule indicated that on the day before the identified date in December 2016, PSW #112 and PSW #113 worked the night shift from 2300 hours to 0700 hours the following morning, which was the identified date in December 2016. They were assigned to the provision of care and services to resident #001. During interviews with PSW #112 held on February 28, 2017 and March 1, 2017, PSW #112 indicated to Inspector #161 that during the night routine on the identified date in December 2016, both he and PSW #113 made hourly breathing and safety rounds on all the residents. During these hourly rounds, with the use of a flashlight, they observed resident #001 from the doorway of the resident's room. Resident #001 was lying in bed, with her/his face turned away from the doorway; the resident's blankets were on, both bedrails were in the upright position and resident #001 was breathing. PSW #112 and PSW #113 did not turn and reposition resident #001 during the night because if the resident was woken up, resident #001 would demonstrate responsive behaviours. During interviews with PSW #112 held on February 28, 2017 and March 1, 2017, PSW #112 indicated to Inspector #161 that during the early morning of the identified date in December 2016 at approximately 0500 hours, PSW #112 and PSW #113 went into resident #001's room to change the resident's continence product. They noticed dry blood on the floor near the resident's bed, blood on the resident's pillowcase and blood on the green pad that the resident #001 was lying on. When PSW #112 and PSW #113 turned resident #001 over onto her/his back, they observed that the resident had facial injuries. PSW #112 and PSW #113 immediately alerted RPN

#105 who assessed resident #001's vital signs, level of pain and initiated the home's head injury assessment and neurological status procedure.

On March 1, 2017, RPN #108 indicated to Inspector #161, that on the identified date in December 2016 he worked the day shift from 0700 hours to 1500 hours on the unit where resident #001 resided. At shift report that morning, RPN #108 was informed by the night RPN #105, that resident #001 had been found in bed at 0500 hours with unexplained facial injuries. The night RPN #105 further indicated to RPN #108 that this information had not been reported to her by RPN #115, who had worked the previous evening. A subsequent discussion was held on March 1, 2017 with RPN #115 who indicated to Inspector #161 that she worked from 1500 hours to 2300 hours during the evening before the identified date in December 2016. RPN #115 indicated to Inspector #161 that PSW #104 did not report to her that evening that resident #001 had experienced a fall nor had facial injuries. A review by Inspector #161 of resident #001's of that evening's progress notes and the Unit Daily Record, Monitoring and Observation Record – Physical Functioning, observed that there was no documentation of falls, unexplained facial injuries nor any other concerns regarding resident #001 during the evening of the day before the identified date in December 2016.

On March 1, 2017, RPN #108 indicated to Inspector #161 that on the day shift of the identified date in December 2016, he asked the PSWs if there were any wandering residents on the unit who were capable of physical aggression. The PSW's indicated that there were no residents on the unit who would have been capable of injuring resident #001. RPN #108 monitored resident #001 throughout the day shift and notified the resident's SDM of the resident's unexplained facial injuries found earlier that morning. RPN #108 informed resident #001's SDM that the home did not know the cause of the resident's injuries and that an investigation would be conducted by the home.

On March 1, 2017, RPN #108 indicated to Inspector #161 that on the identified date in December 2016, he asked the PSW's coming on duty for the evening shift, if they had any information regarding the unexplained facial injuries discovered during the night on resident #001. PSW #104 indicated to RPN #108 that he had worked the previous evening shift from 1500 hours to 2300 hours and was assigned to the provision of care and services to resident #001. RPN #108 indicated to Inspector #161 during a discussion on March 1, 2017, that PSW #104 told him that at approximately 1800 hours the evening before, he had removed the tabletop restraint from resident #001's wheelchair, which in turn, had caused

resident #001 to fall and thus caused the injuries to the resident's face. According to the licensee's investigation notes, in January 2017, PSW #104 told the PMORC #106 that he found resident #001 on the floor with facial injuries. PSW #104 indicated that he panicked and didn't tell anyone about the incident.

According to the licensee's investigation notes in January 2017, PSW #104 told the licensee's investigators that resident #001 was sitting in her/his wheelchair in her/his room and that he was preparing the resident for bed. PSW #104 removed resident #001's lap belt restraint, wheelchair foot pedals, table top restraint and the resident's shirt. He placed a fresh shirt on resident #001 for sleeping. PSW #104 was unsure if he had reapplied the table top restraint before he left the resident's room to assist another staff member. When PSW #104 returned to resident #001's room, the resident was lying on the floor. PSW #104 picked up resident #001 and placed the resident in bed. PSW #104 indicated to PMORC #106 that although he knew that he was supposed to transfer resident #001 with a mechanical lift, he chose not to. The resident was making sounds of distress. PSW #104 observed that resident #001 had facial injuries and there was blood on the bed sheets. PSW #104 washed resident #001's face and changed the bed sheets. PSW #104 checked on resident #001 frequently and had applied ice to the resident's eye. PSW #104 further indicated to PMORC #106, that he did not report the incident to anyone including registered nursing staff because he was afraid that his employment would be terminated.

As a result of the actions/inactions of PSW #104 during the evening before the identified date in December 2016, resident #001 did not receive any nursing assessment, treatment or care for her/his facial injuries until 11 hours later; on the identified date in December 2016 at approximately 0500 hours.

In addition, the licensee failed to ensure that resident #001 was protected from neglect in that the licensee:
- failed to ensure that their written policy "Abuse - #750.65, revision/review date September 2016." was complied with (Refer to Written Notification #3).
- failed to ensure that when a person had reasonable grounds to suspect that resident #001 had been neglected, that staff immediately report the suspicion and information upon which it was based to the Director (Refer to Written Notification #4) [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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).

Findings/Faits saillants :

The licensee failed to ensure that resident #001 was provided care interventions to minimize her/his risk of falls and safe transfers, as specified in the plan.

On January 5, 2017 the licensee submitted a CIR to the Director. This CIR indicated that resident #001 was found in bed, in the early morning on an identified date in December 2016 with facial injuries; the cause of the resident's injuries were unknown.

On February 2, 2017 the Ministry of Health and Long-Term Care Infoline received a complaint from resident #001's SDM expressing concerns regarding the unexplained facial injuries to the resident that were discovered in the early morning on the identified date in December 2016.

Resident #001 was admitted to the home in October 2015 with multiple medical diagnoses. Due to the degree of cognitive impairment coupled with her/his physical limitations, resident #001 was dependent on staff to anticipate her/his needs and provide assistance with all her/his activities of daily living. Resident #001 was

transferred from bed to chair with the assistance of two people and a mechanical lift. Resident #001 was at high risk for falls and required the use of physical restraints, bedrails and frequent monitoring.

According to resident #001's plan of care dated three days before the identified date in December 2016, interventions to minimize the risk of falls included: (1) a lap belt with 14 pound pressure release when the resident was seated in a wheelchair; (2) a table top with a rear closure when the resident was seated in a wheelchair; (3) two full bedrails in the upright position when the resident was in bed and (4) assistance of two people with a mechanical lift for transfers.

On an identified date in December 2016, PSW #112 and PSW #113 worked the night shift from 2300 hours to 0700 hours the following morning. They were assigned to the provision of care and services to resident #001. As previously indicated in Written Notification #1, during the early morning of the day after the identified date in December 2016 at approximately 0500 hours, PSW #112 and PSW #113 went into resident #001's room to change the resident's continence product. When PSW #112 and PSW #113 turned resident #001 over onto her/his back, they observed that the resident had facial injuries. PSW #112 and PSW #113 immediately alerted RPN #105 who assessed resident #001's vital signs, level of pain and initiated the home's head injury assessment and neurological status procedures.

On the identified date in December 2016, RPN #108 asked the PSW's coming on duty for the evening shift, if they had any information regarding the unexplained facial injuries discovered during the previous night on resident #001. PSW #104 indicated to RPN #108 that he had worked the previous evening shift from 1500 hours to 2300 hours and was assigned to the provision of care and services to resident #001. On March 2, 2017 during an interview, RPN #108 indicated to Inspector #161 that on the identified date in December 2016, PSW #104 told him that at approximately 1800 hours the evening before, he had removed the tabletop restraint from resident #001's wheelchair which caused resident #001 to fall and sustain facial injuries.

According to the licensee's investigation notes, on an identified date in January 2017, PSW #104 told the PMORC #106 that he found resident #001 on the floor with facial injuries. PSW #104 indicated that he panicked and didn't tell anyone about the incident. On an identified date in January 2017, it was documented in the licensee's investigation notes that PSW #104 told the licensee's investigators, that

resident #001 was sitting in her/his wheelchair in her/his room and that he was preparing the resident for bed. PSW #104 removed resident #001's lap belt restraint, wheelchair foot pedals, table top restraint and the resident's shirt. He placed a fresh shirt on resident #001 for sleeping. PSW #104 was unsure if he had reapplied the table top restraint before he left the resident's room to assist another staff member. When PSW #104 returned to resident #001's room, the resident was on the floor. PSW #104 picked up resident #001 and placed her/him in bed. PSW #104 indicated to PMORC #106 that although he knew that he was supposed to transfer resident #001 with a mechanical lift, he chose not to. The resident was making sounds of distress. PSW #104 observed that resident #001 had facial injuries and there was blood on the bed sheets. PSW #104 washed resident #001's face and changed the bed sheets. PSW #104 indicated that he checked on resident #001 frequently and that he had applied ice to the resident #001's eye.

On an identified date in December 2016, PSW #104 did not provide care to resident #001 as set out in the planned care related to minimization of the risk of falls and safe transfers. PSW #104 removed both the lap belt and table top restraints from resident #001 while the resident was sitting in her/his wheelchair and left the resident alone in her/his room. When PSW #104 returned to resident #001's room, he found the resident lying on the floor with facial injuries. PSW #104 picked resident #001 up from the floor and transferred the resident to bed without the assistance of two people and a mechanical lift. [s. 6. (7)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

The licensee failed to ensure that their written policy "Abuse - #750.65, revision/review date September 2016." is complied with.

On February 22, 2017 Inspector #161 requested and received the licensee's written policy titled "Abuse - #750.65, revision/review date September 2016." Inspector #161 reviewed the licensee's written policy which indicated on page 3 that a person must report immediately any suspicion or allegation of resident abuse to the Charge Nurse.

On January 5, 2017 the licensee submitted a CIR to the Director. This CIR indicated that resident #001 was found in bed, in the early morning on an identified date in December 2016 with facial injuries; the cause of the resident's injuries were unknown. The licensee suspected neglect by PSW #104 and were proceeding with the investigation.

Resident #001 was admitted to the home in October 2015 with multiple medical diagnoses. Due to the degree of cognitive impairment coupled with her/his physical limitations, resident #001 was dependent on staff to anticipate her/his needs and provide assistance with all her/his activities of daily living. Resident #001 was transferred from bed to chair with the assistance of two people and a mechanical lift. Resident #001 was at high risk for falls and required the use of physical restraints, bedrails and frequent monitoring.

On the day before the identified date in December 2016, PSW #112 and PSW #113 worked the night shift from 2300 hours to 0700 hours the following morning. They were assigned to the provision of care and services to resident #001. As previously indicated in Written Notification #1, during the early morning of the identified date in December 2016 at approximately 0500 hours, PSW #112 and PSW #113 went into resident #001's room to change the resident's continence product. When PSW #112 and PSW #113 turned resident #001 over onto her/his back, they observed that the resident had facial injuries. PSW #112 and PSW #113 immediately alerted RPN #105 who assessed resident #001's vital signs, level of pain and initiated the home's head injury assessment and neurological status procedures.

On the day shift of the identified date in December 2016, RPN #108 asked the PSWs if there were any wandering residents who were capable of physical aggression in the resident care unit. The PSW's indicated to RPN #108 that there were no residents on the unit who would have been capable of injuring resident #001.

At the beginning of the evening shift on the identified date in December 31, RPN #108 asked the PSWs coming on duty if they had any information regarding the unexplained facial injuries discovered during the night on resident #001. PSW #104 indicated to RPN #108 that he had worked the previous evening shift from 1500 hours to 2300 hours and was assigned to the provision of care and services to resident #001. RPN #108 indicated to Inspector #161 during a discussion on March

1, 2017, that PSW #104 told him that at approximately 1800 hours the evening before the identified date in December 2016, he had removed the tabletop restraint from resident #001's wheelchair, which in turn, had caused resident #001 to fall and thus caused the injuries to the resident's face. According to the home's investigation notes on an identified date in January 2016, PSW #104 told the PMORC #106 that he found resident #001 on the floor with facial injuries. PSW #104 indicated that he panicked and didn't tell anyone about the incident.

On March 1, 2017 during an interview with Inspector #161, RPN #108 indicated that he had discussed with another registered nursing staff member on duty on the identified date in December 2016, the information that PSW #104 had provided to him regarding the cause of resident #001's fall and facial injuries. RPN #108 indicated to Inspector #161 that the registered nursing staff member told him not to document the information in the resident chart. When asked by Inspector #161 the name of the registered nursing staff member who had advised him of above, RPN #108 could not recall the registered nursing staff member's name. RPN #108 further indicated to Inspector #161 that he knew there would be an investigation by management and that they would learn what PSW #104 had done. According to the licensee's investigation notes on an identified date in February 2017, RPN #108 indicated to the licensee's investigators that he did not document what PSW #104 had reported to him because he did not want it to be hearsay nor be an official account of what had occurred. Furthermore, RPN #108 did not report any of the information provided to him by PSW #104 to the Charge Nurse. [s. 20. (1)]

2. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall:

-clearly set out what constitutes neglect in their policy titled Abuse, #750.65 last revision/review date September 2016."

As per O. Reg. 79/10, s. 5:" neglect" means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The licensee's written policy defines neglect as: "includes but is not limited to withholding food and/or health services; deliberately failing to meet a dependent resident's needs; shunning."

Inspector #161 noted that the licensee's definition of neglect did not clearly set out the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. In addition, the policy did not discriminate between neglect and emotional abuse. The word "shunning" was used as an example for both definitions.

- contain an explanation of the duty under section 24 of the Act to make mandatory reports.

As per LTCHA, 2007 S.O. 2007, c.8, s.24 (1), a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006.

Inspector #161 noted that the licensee's written policy did not contain an explanation of the duty under section 24 of the Act to make mandatory reports. [s. 20. (2)]

Compliance Order #001 under LTCHA 2007 S.O. 2007, c.8, s. 19(1) will be served on the licensee. [s. 20. (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 the licensee's policy to promote zero tolerance of abuse and neglect of residents is complied with and shall include, at a minimum, c.8, s.20(2) with any requirement respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations and deal with any additional matters as may be provided for in the regulations, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director including (1) Improper or incompetent treatment of care of a resident that resulted in harm or a

risk of harm, (2) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

On an identified date in January 2017, the licensee submitted a CIR to the Director. This CIR indicated that resident #001 was found in bed, in the early morning on an identified date in December 2016 with facial injuries; the cause of the resident's injuries were unknown. The CIR indicated that the licensee suspected neglect by PSW #104 and were proceeding with the investigation.

Resident #001 was admitted to the home in October 2015 with multiple medical diagnoses. Due to the degree of cognitive impairment coupled with her/his physical limitations, resident #001 was dependent on staff to anticipate her/his needs and provide assistance with all her/his activities of daily living. Resident #001 was transferred from bed to chair with the assistance of two people and a mechanical lift. Resident #001 was at high risk for falls and required the use of physical restraints, bedrails and frequent monitoring.

On the day before the identified date in December 2016, PSW #112 and PSW #113 worked the night shift from 2300 hours to 0700 hours the following morning. They were assigned to the provision of care and services to resident #001. As previously indicated in Written Notification #1, during the early morning of the identified date in December 2016 at approximately 0500 hours, PSW #112 and PSW #113 went into resident #001's room to change the resident's continence product. When PSW #112 and PSW #113 turned resident #001 over onto her/his back, they observed that the resident had facial injuries. PSW #112 and PSW #113 immediately alerted RPN #105 who assessed resident #001's vital signs, level of pain and initiated the home's head injury assessment and neurological status procedures. RPN #105 documented her assessment and actions in the resident's progress notes, Neurological Flow Sheet, Pain Assessment Record and in the Unit Daily Record: 24 hour Resident Condition Report. On the identified date in December 2016 at 0546 hours, RPN #105 sent an email to the PMORC #106 and the PMOPC regarding resident #001's unexplained facial injuries.

On the identified date in December 2016, RPN #108 worked the day shift from 0700 hours to 1500 hours on the unit where resident #001 resided. At shift report that morning, RPN #108 was informed by the night RPN #105, that resident #001 had been found in bed at 0500 hours with unexplained facial injuries. The night RPN #105 further indicated to RPN #108 that this information had not been reported to her by RPN #115, who had worked the previous evening.

On the day shift of the identified date in December 2016, RPN #108 asked the PSWs if there were any wandering residents who were capable of physical aggression in the resident care unit. RPN #108 proceeded to send an email to the PMORC #106 and the PMOPC regarding resident #001's unexplained facial injuries.

On February 23, 2017, Inspector #161 interviewed the PMORC #106. She indicated to inspector #161 that both she and the PMOPC had been on vacation on the identified date in December 2016 and early January 2017 and that PMORC #116 was on-call for staff to contact if required.

On March 1, 2017 during an interview with Charge Nurse RN #102, she indicated to Inspector #161 that she was concerned regarding resident #001's unexplained facial injuries. Charge Nurse RN #102 further indicated that on an identified date in January 2017 at 1530 hours, she sent an email to the PMORC #106 and the PMOPC regarding resident #001's unexplained facial injuries. Charge Nurse RN #102 provided Inspector #161 with a copy of this email in which she described resident #001's facial injuries, the cause of which was unknown, and that this was very concerning to her. Charge Nurse RN #102 did not immediately report her suspicions of abuse and the information upon which they were based to the Director.

On March 1, 2017 during an interview with PMORC #116, she indicated to Inspector #161 that she was the on-call manager during the time that PMORC #106 and the PMOPC had been on vacation. She further indicated to inspector #161 that she had not been informed of the unexplained facial injuries discovered on resident #001 in the early morning hours on the identified date in December 2016 nor the suspicion of a possible wandering resident who would have been capable of physical aggression towards resident #001.

On January 5, 2017, the PMORC #106 submitted a CIR related to abuse/neglect to the Director which was considered twice by RPN #108 on the identified date in December 2016. RPN #108 first considered this on the identified date in December 2016 at 0700 hours when he was told by the night RPN #105 of the resident #001's unexplained facial injuries; and then again at the beginning of the evening shift, when PSW #104 told him about his neglectful actions. These suspicions did not come to the attention of PMORC #106 until her return to work on an identified date in early January 2017 and had reviewed her emails that included one dated a few

days earlier in January 2017 from RN #102 sharing her concerns of resident #001's unexplained facial injuries.

Compliance Order #001 under LTCHA 2007 S.O. 2007, c.8, s. 19(1) will be served on the licensee. [s. 24. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the restraining of resident #001 by a physical device may be included in a resident's plan of care only if the restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision maker of the resident with authority to give that consent.

The plan of care for resident #001 dated three days before the identified date in December 2016 was reviewed by Inspector #161 and it was noted that resident #001 required three restraints for safety purposes: (1) a lap belt with 14 pound pressure release when the resident was seated in a wheelchair; (2) a table top with a rear closure when the resident was seated in a wheelchair; and (3) two full bedrails in the upright position when the resident was in bed.

On March 6, 2017 inspector #161 reviewed the health care records of resident #001 with RN #102 and RPN #117. There were no consents found in the resident's health care records that indicated that either the resident' or their SDM had consented to the use of a table top with a rear closure nor two full bedrails in the upright position when resident #001 was in bed.

On March 6, 2017 RN #102 and the PMOPC #118 indicated to Inspector #161 that they would immediately obtain consent from resident #001's SDM for (1) the use of a table top with a rear closure when the resident was seated in a wheelchair; and (2) two full bedrails in the upright position when resident was in bed. [s. 31. (2) 5.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

3. The type of physical restraint ordered
5. The person who applied the device and the time of application
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.

On an identified date in January 2017 the licensee submitted a CIR to the Director. This CIR indicated that resident #001 was found in bed, in the early morning of an identified date in December 2016 with facial injuries; the cause of the resident's injuries were unknown.

Resident #001 was admitted to the home in October 2015 with multiple medical diagnoses.

On an identified date in October 2016 resident #001's attending physician had ordered three physical restraints, specifically; (1) a lap belt with 14 pound pressure release when the resident was seated in a wheelchair; (2) a table top with a rear closure when the resident was seated in a wheelchair; and (3) two full bedrails in the upright position when the resident was in bed.

On March 1, 2017, RPN #108 indicated to Inspector #161 that on an identified date in December 2016, RPN #108 asked the PSW's coming on duty for the evening

shift, if they had any information regarding the unexplained facial injuries discovered during the night on resident #001. PSW #104 told RPN #108 that at approximately 1800 hours the evening before, he had removed the tabletop restraint from resident #001's wheelchair, which in turn, had caused resident #001 to fall and thus caused the injuries to the left side of the resident's face.

It was documented on resident #001's Restraint/PASD Monitoring Forms for October, November, December 2016, January and February 2017 that each monthly form was used to document both the resident's table top and bedrail restraints. The Restraint/PASD Monitoring Forms did not differentiate between the two types of physical restraints applied to resident #001, and thus it was unknown (1) which physical restraint had been applied, (2) the person who applied the device and the time of application, (3) all assessment, reassessment and monitoring, including the resident's response, and (4) every release of the device and all repositioning.

There was no documentation on resident #001's Restraint/PASD Monitoring Form, on the day before the identified date in December 2016 from 1500 hours to 2300 hours, to indicate that the lap belt or table top restraints had been applied or released. On the following day, PSW #104 indicated to RPN #108 that during the evening before the identified date in December 2016, PSW #104 had removed the tabletop restraint from resident #001's wheelchair, which in turn, had caused resident #001 to fall and sustain facial injuries. The licensee's investigation notes on an identified date in January 2017 reflected that PSW #104 had indicated to the licensee's investigators, that he had removed resident #001's lap belt and table top restraints on evening before the identified date in December 2016.

There was no documentation on Resident #001's Restraint/PASD Monitoring Form during the night of the identified date in December 2016 from 2400 hours to 0700 hours that indicated that the resident's two bed rails had been in the upright position during those hours. During interviews conducted on February 28, 2017 and March 1, 2017, PSW #112 told Inspector #161 that he and PSW #113 had observed throughout the night of the identified date in December 2016 that resident #001's two bed rails were in the upright position.

There were no Restraint/PASD Monitoring Forms for February and March 2017 for resident #001's lap belt with 14 pound pressure release, that had been applied when the resident was seated in a wheelchair. On five identified dates in February 2017 and three identified dates in March 2017, Inspector #161 observed resident

#001 seated in her/his wheelchair with the prescribed lap belt applied. On March 6, 2017 RN #102 indicated to Inspector #161 and the PMOPC that whenever resident #001 was seated in her/his wheelchair, a lap belt restraint had been applied. RN #102 also indicated to Inspector #161 and the PMOPC that the staff had not initiated a Restraint/PASD Monitoring Form for the lap belt restraint applied daily on resident #001. On March 6, 2016 RN #102 and PMOPC indicated to inspector #161 that they would immediately ensure that a Restraint/PASD Monitoring Form for resident #001's lap belt restraint would be initiated. [s. 110. (7) 6.]

Issued on this 9 day of August 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LINDA HARKINS (126) - (A1)

Inspection No. / No de l'inspection : 2017_584161_0007 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 002987-17 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Aug 09, 2017;(A1)

Licensee / Titulaire de permis :
CITY OF OTTAWA
Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2

LTC Home / Foyer de SLD :
GARRY J. ARMSTRONG HOME
200 ISLAND LODGE ROAD, OTTAWA, ON, K1N-5M2

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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To CITY OF OTTAWA, 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. 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).

Order / Ordre :

(A1)
This plan must be submitted in writing by September 15, 2017 to Kathleen Smid, LTCH Inspector Nursing at 347 Preston Street, 4th floor, Ottawa Ontario K1S 3J4 OR by fax at 613-569-9670.

The licensee shall review and revise its written policy titled "Abuse - 750.65" to include at a minimum c.8, s.20(2) of the LTCHA, 2007 any requirement respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; to clearly set out what constitutes abuse and neglect; contain an explanation of the duty to make appropriate mandatory reports under s. 24(10 of the LTCHA, 2007.

The licensee shall develop and implement an educational program to ensure that all staff are educated on the licensees' written policy "Abuse - #750-65" as referred to above. The licensee shall ensure that a documented record of the educational program is kept in the home that includes the date, subject heading, educational content and the staff name who has been educated.

This plan must also include target dates, person responsible for ensuring completion of each item above, and the plan to monitor compliance with the licensee's written policy titled "Abuse - #750.65."

Grounds / Motifs :

1. The licensee failed to ensure that resident #001 was protected from neglect by PSW #104.

As per O. Reg. 79/10, s.5. “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

In summary, after a review of documentation and staff interviews; on an identified date in December 2016 at approximately 0500 hours, resident #001 was found in bed by PSW #112 and PSW #113 with a facial injuries; the cause of the resident’s injuries were unknown. On the identified date in December 2016 at the beginning of the changeover to the evening shift, PSW #104 admitted to RPN #108 that while preparing resident #001 for bed at approximately 1800 hours the evening before, he

had removed the resident's lap belt and table top restraints and left the resident alone in her/his room while he assisted another staff member. When he returned to resident #001's room, PSW #104 found the resident lying on the floor. He transferred resident #001 to bed and observed that the resident was making sounds of distress and had incurred facial injuries. PSW #104 did not inform any registered nursing staff of the occurrence and as a result, resident #001 did not receive any nursing treatment or care for her/his facial injuries until 11 hours later; on the identified date in December 2016 at approximately 0500 hours.

In January 2017 the licensee submitted a Critical Incident Report (CIR) to the Director. This CIR indicated that resident #001 was found in bed, in the early morning of an identified date in December 2016 with facial injuries; the cause of the resident's injuries were unknown. The licensee had commenced their investigation into the incident and suspected that resident #001 had been neglected by PSW #104 and had notified the resident's Substitute Decision Maker (SDM).

On February 2, 2017 the Ministry of Health and Long-Term Care Infoline received a complaint from resident #001's SDM expressing concerns regarding the unexplained facial injuries to the resident that were discovered in the early morning on the identified date in December 2016.

Resident #001 was admitted to the home in October 2015 with multiple medical diagnoses. Due to the degree of cognitive impairment coupled with her/his physical limitations, resident #001 was dependent on staff to anticipate her/his needs and provide assistance with all her/his activities of daily living. Resident #001 was transferred from bed to chair with the assistance of two people and a mechanical lift. Resident #001 was at high risk for falls and required the use of physical restraints, bedrails and frequent monitoring.

A review of the nursing staff schedule indicated that on the day before the identified date in December 2016, PSW #112 and PSW #113 worked the night shift from 2300 hours to 0700 hours the following morning, which was the identified date in December 2016. They were assigned to the provision of care and services to resident #001. During interviews with PSW #112 held on February 28, 2017 and March 1, 2017, PSW #112 indicated to Inspector #161 that during the night routine on the identified date in December 2016, both he and PSW #113 made hourly breathing and safety rounds on all the residents. During these hourly rounds, with the use of a flashlight, they observed resident #001 from the doorway of the resident's

room. Resident #001 was lying in bed, with her/his face turned away from the doorway; the resident's blankets were on, both bedrails were in the upright position and resident #001 was breathing. PSW #112 and PSW #113 did not turn and reposition resident #001 during the night because if the resident was woken up, resident #001 would demonstrate responsive behaviours. During interviews with PSW #112 held on February 28, 2017 and March 1, 2017, PSW #112 indicated to Inspector #161 that during the early morning of the identified date in December 2016 at approximately 0500 hours, PSW #112 and PSW #113 went into resident #001's room to change the resident's continence product. They noticed dry blood on the floor near the resident's bed, blood on the resident's pillowcase and blood on the green pad that the resident #001 was lying on. When PSW #112 and PSW #113 turned resident #001 over onto her/his back, they observed that the resident had facial injuries. PSW #112 and PSW #113 immediately alerted RPN #105 who assessed resident #001's vital signs, level of pain and initiated the home's head injury assessment and neurological status procedure.

On March 1, 2017, RPN #108 indicated to Inspector #161, that on the identified date in December 2016 he worked the day shift from 0700 hours to 1500 hours on the unit where resident #001 resided. At shift report that morning, RPN #108 was informed by the night RPN #105, that resident #001 had been found in bed at 0500 hours with unexplained facial injuries. The night RPN #105 further indicated to RPN #108 that this information had not been reported to her by RPN #115, who had worked the previous evening. A subsequent discussion was held on March 1, 2017 with RPN #115 who indicated to Inspector #161 that she worked from 1500 hours to 2300 hours during the evening before the identified date in December 2016. RPN #115 indicated to Inspector #161 that PSW #104 did not report to her that evening that resident #001 had experienced a fall nor had facial injuries. A review by Inspector #161 of resident #001's of that evening's progress notes and the Unit Daily Record, Monitoring and Observation Record – Physical Functioning, observed that there was no documentation of falls, unexplained facial injuries nor any other concerns regarding resident #001 during the evening of the day before the identified date in December 2016.

On March 1, 2017, RPN #108 indicated to Inspector #161 that on the day shift of the identified date in December 2016, he asked the PSWs if there were any wandering residents on the unit who were capable of physical aggression. The PSW's indicated that there were no residents on the unit who would have been capable of injuring resident #001. RPN #108 monitored resident #001 throughout the day shift and

notified the resident's SDM of the resident's unexplained facial injuries found earlier that morning. RPN #108 informed resident #001's SDM that the home did not know the cause of the resident's injuries and that an investigation would be conducted by the home.

On March 1, 2017, RPN #108 indicated to Inspector #161 that on the identified date in December 2016, he asked the PSW's coming on duty for the evening shift, if they had any information regarding the unexplained facial injuries discovered during the night on resident #001. PSW #104 indicated to RPN #108 that he had worked the previous evening shift from 1500 hours to 2300 hours and was assigned to the provision of care and services to resident #001. RPN #108 indicated to Inspector #161 during a discussion on March 1, 2017, that PSW #104 told him that at approximately 1800 hours the evening before, he had removed the tabletop restraint from resident #001's wheelchair, which in turn, had caused resident #001 to fall and thus caused the injuries to the resident's face. According to the licensee's investigation notes, in January 2017, PSW #104 told the PMORC #106 that he found resident #001 on the floor with facial injuries. PSW #104 indicated that he panicked and didn't tell anyone about the incident.

According to the licensee's investigation notes in January 2017, PSW #104 told the licensee's investigators that resident #001 was sitting in her/his wheelchair in her/his room and that he was preparing the resident for bed. PSW #104 removed resident #001's lap belt restraint, wheelchair foot pedals, table top restraint and the resident's shirt. He placed a fresh shirt on resident #001 for sleeping. PSW #104 was unsure if he had reapplied the table top restraint before he left the resident's room to assist another staff member. When PSW #104 returned to resident #001's room, the resident was lying on the floor. PSW #104 picked up resident #001 and placed the resident in bed. PSW #104 indicated to PMORC #106 that although he knew that he was supposed to transfer resident #001 with a mechanical lift, he chose not to. The resident was making sounds of distress. PSW #104 observed that resident #001 had facial injuries and there was blood on the bed sheets. PSW #104 washed resident #001's face and changed the bed sheets. PSW #104 checked on resident #001 frequently and had applied ice to the resident's eye. PSW #104 further indicated to PMORC #106, that he did not report the incident to anyone including registered nursing staff because he was afraid that his employment would be terminated.

As a result of the actions/inactions of PSW #104 during the evening before the identified date in December 2016, resident #001 did not receive any nursing

assessment, treatment or care for her/his facial injuries until 11 hours later; on the identified date in December 2016 at approximately 0500 hours.

In addition, the licensee failed to ensure that resident #001 was protected from neglect in that the licensee:
- failed to ensure that their written policy "Abuse - #750.65, revision/review date September 2016." was complied with (Refer to Written Notification #3).
- failed to ensure that when a person had reasonable grounds to suspect that resident #001 had been neglected, that staff immediately report the suspicion and information upon which it was based to the Director (Refer to Written Notification #4) [s. 19. (1)]

A Compliance Order is warranted due to the actual harm sustained by resident #001. The scope is isolated. The licensee has a history of non-compliance with LTCHA 2007 S.O. 2007, c.8, s. 19(1). Most recently, a Compliance Order was issued on June 2, 2016 as a result of inspection #2016-200148-0011. Prior to this a Compliance Order was issued to the licensee on April 7, 2015 as a result of inspection #2015-2865-0002.

(161)

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

Dec 01, 2017(A1)

Order # /
Ordre no : 002

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

(A1)
This plan must be submitted in writing by September 15, 2017 to Kathleen Smid, LTCH Inspector Nursing at 347 Preston Street, 4th floor, Ottawa Ontario K1S 3J4 OR by fax at 613-569-9670.

At a minimum, the licensee shall ensure that the plan includes:

1. the development and implementation of an ongoing monitoring process to ensure that for each resident who has been identified at risk for falls, that the fall interventions as set out in their plan of care, is provided. The licensee shall ensure that a documented record of the ongoing monitoring process is kept in the home that includes:
- the name of the staff member conducting the resident specific review, the date and time of the review, resident's name, room number, and the improvements made in response to any discrepancies found between the provision of the resident's care and their plan of care to minimize the resident's risk of falls.

2. the development and implementation an ongoing monitoring process to ensure that the care, for each resident who has been identified as requiring a mechanical lift for transfers, as set out in their plan of care to promote safe transfers, is provided. The licensee shall ensure that a documented record of the ongoing monitoring process is kept in the home that includes: - the name of the staff member conducting the resident specific review, the date and time of the review, resident's name, room number, and the improvements made in response to any discrepancies found between the provision of the resident??s care and their plan of care to promote safe transfers.

3. The plan must include target dates, person responsible for ensuring completion of each item listed above, immediate actions taken to prevent recurrence and the long-term actions planned to correct any discrepancies and prevent recurrences.

Grounds / Motifs :

1. The licensee failed to ensure that resident #001 was provided care interventions to minimize her/his risk of falls and safe transfers, as specified in the plan.

On January 5, 2017 the licensee submitted a CIR to the Director. This CIR indicated that resident #001 was found in bed, in the early morning on an identified date in December 2016 with facial injuries; the cause of the resident's injuries were unknown.

On February 2, 2017 the Ministry of Health and Long-Term Care Infoline received a complaint from resident #001's SDM expressing concerns regarding the unexplained facial injuries to the resident that were discovered in the early morning on the identified date in December 2016.

Resident #001 was admitted to the home in October 2015 with multiple medical diagnoses. Due to the degree of cognitive impairment coupled with her/his physical limitations, resident #001 was dependent on staff to anticipate her/his needs and provide assistance with all her/his activities of daily living. Resident #001 was transferred from bed to chair with the assistance of two people and a mechanical lift. Resident #001 was at high risk for falls and required the use of physical restraints, bedrails and frequent monitoring.

According to resident #001's plan of care dated three days before the identified date in December 2016, interventions to minimize the risk of falls included: (1) a lap belt with 14 pound pressure release when the resident was seated in a wheelchair; (2) a table top with a rear closure when the resident was seated in a wheelchair; (3) two full bedrails in the upright position when the resident was in bed and (4) assistance of two people with a mechanical lift for transfers.

On an identified date in December 2016, PSW #112 and PSW #113 worked the night shift from 2300 hours to 0700 hours the following morning. They were assigned to the provision of care and services to resident #001. As previously indicated in Written Notification #1, during the early morning of the day after the identified date in December 2016 at approximately 0500 hours, PSW #112 and PSW #113 went into resident #001's room to change the resident's continence product. When PSW #112 and PSW #113 turned resident #001 over onto her/his back, they observed that the resident had facial injuries. PSW #112 and PSW #113 immediately alerted RPN #105 who assessed resident #001's vital signs, level of pain and initiated the home's head injury assessment and neurological status procedures.

On the identified date in December 2016, RPN #108 asked the PSW's coming on duty for the evening shift, if they had any information regarding the unexplained facial

injuries discovered during the previous night on resident #001. PSW #104 indicated to RPN #108 that he had worked the previous evening shift from 1500 hours to 2300 hours and was assigned to the provision of care and services to resident #001. On March 2, 2017 during an interview, RPN #108 indicated to Inspector #161 that on the identified date in December 2016, PSW #104 told him that at approximately 1800 hours the evening before, he had removed the tabletop restraint from resident #001's wheelchair which caused resident #001 to fall and sustain facial injuries.

According to the licensee's investigation notes, on an identified date in January 2017, PSW #104 told the PMORC #106 that he found resident #001 on the floor with facial injuries. PSW #104 indicated that he panicked and didn't tell anyone about the incident. On an identified date in January 2017, it was documented in the licensee's investigation notes that PSW #104 told the licensee's investigators, that resident #001 was sitting in her/his wheelchair in her/his room and that he was preparing the resident for bed. PSW #104 removed resident #001's lap belt restraint, wheelchair foot pedals, table top restraint and the resident's shirt. He placed a fresh shirt on resident #001 for sleeping. PSW #104 was unsure if he had reapplied the table top restraint before he left the resident's room to assist another staff member. When PSW #104 returned to resident #001's room, the resident was on the floor. PSW #104 picked up resident #001 and placed her/him in bed. PSW #104 indicated to PMORC #106 that although he knew that he was supposed to transfer resident #001 with a mechanical lift, he chose not to. The resident was making sounds of distress. PSW #104 observed that resident #001 had facial injuries and there was blood on the bed sheets. PSW #104 washed resident #001's face and changed the bed sheets. PSW #104 indicated that he checked on resident #001 frequently and that he had applied ice to the resident #001's eye.

On an identified date in December 2016, PSW #104 did not provide care to resident #001 as set out in the planned care related to minimization of the risk of falls and safe transfers. PSW #104 removed both the lap belt and table top restraints from resident #001 while the resident was sitting in her/his wheelchair and left the resident alone in her/his room. When PSW #104 returned to resident #001's room, he found the resident lying on the floor with facial injuries. PSW #104 picked resident #001 up from the floor and transferred the resident to bed without the assistance of two people and a mechanical lift. [s. 6. (7)]

A Compliance Order is warranted due to the actual harm sustained by resident #001.

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

The scope is isolated. The licensee has a history of non-compliance with LTCHA 2007 S.O. 2007, c.8, s.6(7). Most recently, a Written Notification was issued on October 17, 2016 as a result of Inspection No, 2016_286547_0024. Prior to this, there has been non-compliance issued to the licensee on the following dates: one Written Notification was issued on July 13, 2016 as a result of Inspection No. 2016_285126_0013; one Written Notification was issued on July 13, 2016 as a result of Inspection No. 2016_285126_0012; one Written Notification was issued on June 2, 2016 as a result of Inspection No. 2016_200148_0011; one Written Notification was issued on February 11, 2016 as a result of Inspection No. 2016_287548_0002; one Voluntary Plan of Corrective Action was issued on June 18, 2015 as a result of Inspection No. 2015_362138_0017; one Voluntary Plan of Corrective Action was issued on April 7, 2015 as a result of Inspection No. 2015_286547_0002. (161)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Dec 01, 2017(A1)

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 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 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

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

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection 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

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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection 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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9 day of August 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LINDA HARKINS - (A1)

Service Area Office /
Bureau régional de services : Ottawa