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 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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 14, 2019	2018_703625_0026 (A2)	024553-18, 026835-18, 031324-18	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 9) GP Inc. as general partner of CVH (No. 9) LP
766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Southbridge Pinewood
2625 Walsh Street East THUNDER BAY ON P7E 2E5

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

Amended by SHELLEY MURPHY (684) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee requires further time to ensure sustained compliance with this provision.

Issued on this 14th day of March, 2019 (A2)

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

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

Amended by SHELLEY MURPHY (684) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 11, 12, 13, 14 and 17, 2018.

The following intakes were completed during this inspection:

- logs #024553-18 and #031324-18, related to Critical Incident System (CIS) reports submitted for falls resulting in significant changes in the health status of two residents; and

- log #026835-18 related to a complaint forwarded by the home regarding medication administration, pain management and potential abuse/neglect of one resident.

During the course of the inspection, the inspector(s) spoke with residents, family members, substitute decision-makers (SDMs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), a Housekeeper, the Resident Assessment Instrument (RAI)/Documentation Coordinator, Associate Directors of Care (ADOCs), the Director of Care (DOC) and the Executive Director (ED).

The Inspector also conducted observations of the care and services provided to residents, of resident to resident interactions and of staff to resident interactions. The Inspector reviewed resident health care records (progress notes, assessments, electronic Treatment Administration Records (eTARs), electronic Medication Administration Records (eMARs), medical doctor's (MD's) orders and notations, hospital consultation notes, archived health care documents, etc.), staff schedules, text messages, relevant policies and programs, a home's investigation file, relevant portions of employee personnel files and CIS reports.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

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

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

Specifically failed to comply with the following:

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

s. 6. (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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted to the Director for a fall sustained by resident #003 in the fall of 2018, following which the resident

sustained injuries and was transferred to hospital, and which resulted in a significant change in the resident's health status.

(a) During an interview with RN #105, regarding resident #003's fall, they stated that the resident would have required a Clinical Monitoring Record be completed, either electronically or on paper.

Inspector #625 reviewed a memo dated in the fall of 2018, addressed to registered staff titled *NEW* Falls Protocol. The memo identified that the home would revert to paper charting for vital signs on all witnessed and unwitnessed falls, effective that date. The memo referred to an attached Clinical Monitoring Record.

The Inspector reviewed the Clinical Monitoring Record which identified that, if a fall was unwitnessed or a head injury was suspected, staff would monitor the resident for specific criteria, including neurological vital signs, every hour for four hours, then every eight hours for 72 hours. The record also identified that an unwitnessed fall would require a head injury routine to be completed every four hours [not hourly as previously identified on the record] and then every eight hours.

During an interview with ADOC #103, they acknowledged that the Clinical Monitoring Record was unclear as it identified that initial monitoring for an unwitnessed fall was to occur every hour and every four hours, referring to the same initial monitoring period.

During an interview with the DOC, they stated that, as a result of resident #003's fall in the fall of 2018, the home had implemented the Clinical Monitoring Record on paper. The DOC stated that, as of a date in the fall of 2018, staff were required to complete the paper copy instead of an electronic version to ensure that the monitoring was completed from shift to shift. The DOC acknowledged that the Clinical Monitoring Record was not clear with respect to the monitoring frequency of residents, as it indicated monitoring was to occur every hour for four hours and every four hours [for the same initial monitoring period].

(b) The Inspector reviewed the home's policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, which identified that staff were to record the treatment regimen on the electronic Treatment Administration Record (eTAR), monitor the resident's skin condition

with each dressing change, and re-assess at minimum weekly.

Inspector #625 reviewed resident #003's health care record including eTARs for two months in 2018, which contained entries directing staff to complete one activity at a specific frequency, complete an action at a specific time, and complete a second activity at a different frequency than the first activity. The Inspector was not able to distinguish if the signed entries reflected that the first or the second activity had been completed.

The Inspector then reviewed multiple Weekly Impaired Skin Integrity Assessments for altered skin integrity, which had been completed at different frequencies.

During an interview with RPN #111, they stated that the eTAR should have listed specific dates for the second activity to be completed on. The RPN stated that, if second activity wasn't listed as a separate intervention from the the first activity, which was required at a different frequency, staff wouldn't know which shift was to do the second activity, if it had already been done, or if it needed to be done. The RPN said that staff would have to check additional components of the resident's health care record to see if it needed to be done because it wasn't clear to staff when to do it or when it was done.

During an interview with the DOC, they stated that the second activity should have been scheduled on the eTAR as a separate entry from the first activity, which was required at a different frequency, as it was not clear to staff which of the activities had been completed. The DOC indicated that the second activity had not been completed at the frequency it should have been, as part of the problem was they had not been scheduled in the eTAR with clearly identified dates for staff to adhere to.

(c) The Inspector reviewed resident #003's referral to the Wound Care Champion for altered skin integiry. On a date in the fall of 2018, RPN #113, documented that staff were to follow the treatment orders from the hospital for the altered skin integrity.

Inspector #625 reviewed a document from the Thunder Bay Regional Health Sciences Centre (TBRHSC), dated in the fall of 2018, that identified instructions for the care of resident #003's altered skin integrity, including the completion of one treatment at a specific frequency.

Inspector #625 reviewed the home's policy titled "Skin and Wound Care Program: Wound Care Management – RC-23-01-02", last updated February 2017, that identified staff were to record the treatment regimen on the eMAR or eTAR.

The Inspector noted two of resident #003's 2018 eTARs contained entries for staff to follow related to the altered skin integrity. The eTAR did not contain any information related to the completion of the treatment identified in the TBRHSC document, to be completed at the frequency in the document, or at any frequency.

The Inspector reviewed resident #003's progress notes and identified that the resident had returned to the home on a date in the fall of 2018; had the treatment completed on a certain date in 2018, in response to the condition of the altered skin integrity, and that the treatment was no longer required at a later date in 2018 . The progress notes contained no other entries related to the treatment being provided to resident #003 during the time it was required.

During an interview with RPN #112, they stated that the eTAR entry was "definitely confusing" and was unclear; if the hospital ordered the treatment complete at a specific frequency, and Wound Care Champion/RPN #113 said to follow the hospital document, the hospital order should have been entered into the eTAR, but the eTAR didn't list to complete the treatment at the specified frequency. The RPN stated that, if the hospital wanted the the treatment completed at a specific frequency, that should have been followed, and that is what the eTAR should have listed.

During an interview with the DOC, they reviewed resident #003's health care record and confirmed that the TBRHSC document had indicated the resident's treatment was to be completed at a specific frequency, that the Wound Care Champion had documented to follow the orders from the hospital, that the eTARs did not identify that the resident's treatment was to be completed at the specific frequency, and that the only documentation of the treatment being provided was recorded in the progress notes on a date in fall of 2018. [s. 6. (1) (c)]

2. A CIS report was submitted to the Director for a fall experienced by resident #001 during the summer of 2018, during which the resident sustained an injury and was transferred to hospital. The report identified the resident's mobility had changed after the fall and they they required a mobility aid when they returned to the home.

(a) Inspector #625 reviewed resident #001's current care plan, last review completed in the fall of 2018, which identified the resident required assistance provided by staff for mobility. The same care plan identified that resident #001 exhibited responsive behaviours including a behaviour that was not consistent with the type of mobility assistance the care plan stated the resident required from staff.

Inspector #625 observed resident #001 during consecutive dates of the inspection and did not observe the resident to exhibit the responsive behaviour.

During an interview with PSW #126, they stated that resident #001 never exhibited the behaviour since their fall. The PSW elaborated that the care plan was not consistent when it identified that the resident exhibited the behaviour and also needed a particular level of assistance from staff for mobility.

During an interview with RPN #125, they stated that resident #001 no longer exhibited the behaviour since their fall and resulting use of a mobility aid, that staff currently provide the resident with a certain level of assistance with mobility. The RPN reviewed the resident's care plan and confirmed that it stated the resident exhibited the behaviour as well as required staff assistance for mobility. The RPN stated the care plan would not be clear to staff about the resident's mobility.

During an interview with RN #117, they reviewed resident #001's current care plan and acknowledged that it listed the resident required assistance by staff with mobility, as well as exhibited a behaviour. The RN elaborated that the resident used to exhibit the behaviour, before they fell, and since the fall, the resident no longer exhibited the behaviour. The RN stated the care plan did not provide clear direction to staff about the resident in this area and that the behaviour should have been revised when the rest of the care plan was.

During an interview with ADOC #103, they reviewed resident #001's current care plan and acknowledged that it was unclear with respect to the resident requiring assistance from with mobility and also exhibiting a mobility related behaviour. The ADOC stated it would be unclear to staff as the care plan listed two different items related to mobility that were not the same.

During an interview with the DOC, they reviewed resident #001's current care plan and indicated that it identified the resident required assistance by staff with

locomotion, as well as exhibited a particular behaviour. The DOC stated the care plan was not clear as to whether the resident exhibited the behaviour or required staff assistance. The DOC indicated that the resident exhibited the behaviour before they fell and that portion of the care plan should have been changed.

(b) The CIS report submitted to the Director for resident #001's fall, in the summer of 2018, was amended days later to include information on the resident's altered skin integrity. Weeks later, the report was further amended and indicated a change in the status of the altered skin integrity following an action taken by the staff days earlier.

A review by Inspector #625 of a Skin - Weekly Impaired Skin Integrity Assessment dated the summer of 2018, identified multiple areas of altered skin integrity on multiple locations of resident #001's body.

Inspector #625 reviewed resident #001's health care record with a focus on the plan of care related to the altered skin integrity and identified:
- a care plan that listed interventions to be performed on a specific date to one area of altered skin integrity on the resident's body, and referred staff to the eTAR for directions on treatment of the altered skin integrity. The care plan did not reference the resident's altered skin integrity on the other location(s) of the resident's body, or that there were multiple sites of altered skin integrity on the area listed.
- eTARs for multiple months in 2018, that referred to a weekly skin assessment of the altered skin integrity on one area of the resident's body; and an action required by staff to one area of altered skin integrity to be completed on a specific date. The eTARs did not contain the treatment referred to in the care plan for the resident's area of altered skin integrity, did not identify the number of sites of altered skin integrity in that area, and did not include any reference to the altered skin integrity on another area on the resident's body, including care required for a treatment, weekly assessments or an action required to be completed by staff.
- eMARs for multiple months 2018, which each contained one entry that combined the directions for care for multiple treatments to multiple locations of altered skin integrity on the resident's body. The eMARs did not identify the number of sites of altered skin integrity on the areas of the resident's body.
- a document from the TBRHSC which identified staff were to complete an activity which involved the areas of altered skin integrity, within a specific time frame, on a specific date.
- a progress note entered by RPN #127, that identified the activity identified in the

TBRHSC document had occurred to one area of altered skin integrity on the resident's body.
- a progress note entered days after the activity was completed by RPN #127, and outside of the time frame listed on the TBRHSC document, that identified RN #117, had completed the activity to another area of altered skin integrity on the resident.

During an interview with RPN #125, they stated that they had only been aware of the resident's altered skin integrity on one area of their body from reading the eMARs and eTARs but saw the other area of altered skin integrity on the resident's body when they were completing a treatment on the first area, in the presence of the resident. The RPN stated they probably should have gone in and added the other sites as it was not clear to people that they were there and needed interventions. The RPN stated that, if the eMAR and eTAR did not contain directions for staff to follow, the plan of care had not been clear with respect to the resident's second location of altered skin integrity, including the treatment needed or the date of the activity staff were required to perform.

During an interview with RN #117, they stated that they had reviewed resident #001's health care record and recalled completing a required activity on a second location on the resident's body, as they had noticed the activity had not been completed when they had provided care to the resident. The RN had been aware that the activity had occurred to one area on the resident's body on the date identified in the TBRHSC document, when, at that time, it had not been clear to staff that the resident's had a second area on their body to which the activity was required. The RN stated that it had not been clear to staff to complete a procedure on the second area of altered skin integrity, or complete weekly assessments on that area so it looked like those items were not being done.

During an interview with ADOC #103, they reviewed resident #001's health care record and acknowledged that the care plan had listed the resident had an area of altered skin integrity to one location on their body but did not identify the resident also had altered skin integrity on another location of the resident's body. The ADOC commented that the care plan referred staff to the eTARS for direction related to a treatment for the altered skin integrity on the first area, when the interventions were not listed on the eTARs, but were listed on the eMARS. The ADOC stated that the care plan did not provide clear directions to staff with respect to the resident's treatment, the number of areas of altered skin integrity, the location of the altered skin integrity and where to find instructions on how to

care for the altered skin integrity. The ADOC acknowledged that the eTAR listed a weekly skin assessment for one area of altered skin integrity, but did not include information on completing an associated treatment. The ADOC also acknowledged the eMAR did not list the individual locations of the altered skin integrity that required treatment, but had one entry for multiple treatment areas, although additional areas of altered skin integrity were listed on the assessment completed in the summer of 2018. The ADOC stated that each of the treatments required for the areas of altered skin integrity should have been listed separately on the eTAR [not on the eMAR].

During an interview with the DOC, they stated that the treatment listed should have been entered on the eTAR, not on the eMAR, and that each location on each area of altered skin integrity should have been entered separately as it was not clear to staff, based on the eMAR, that there were multiple distinct areas of altered skin integrity. The DOC acknowledged that the care plan listed the altered skin integrity to one area on the resident as resolved but did not identify the second area; referred staff to the eTAR for information related to treatments that had been entered on the eMAR; and did not provide clear direction to staff with respect to the resident's treatments, the number of locations of altered skin integrity, the areas of altered skin integrity and where to find instructions for care. [s. 6. (1) (c)]

3. 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 assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A CIS report was submitted to the Director for a fall experienced by resident #003 in the fall of 2018, following which the resident sustained injuries and was transferred to hospital.

Inspector #625 reviewed resident #003's health care record, with a focus on one area of altered skin integrity, which included:
- a Head to Toe Skin Assessment note and a Referral to the home's Wound Care Champion completed by RPN #106 on a date in the fall of 2018, which identified altered skin integrity in one area to be a specific measurement;
- a Weekly Impaired Skin Integrity Assessment completed by RPN #106 on the same date as the previous assessment, which identified the area of altered skin integrity to be a measurement that was more than twice the first documented

measurement;
- a Weekly Impaired Skin Integrity Assessment completed by RPN #114 on another date in the fall of 2018, which identified altered skin integrity in one area to be a specific measurement; and
- a Weekly Impaired Skin Integrity Assessment completed by RN #105 on the day after the previous assessment, which identified the area of altered skin integrity to be more than triple the previous documented measurement.

During a review of electronic progress notes, the Inspector also noted entries which listed inconsistent assessment of the status of a treatment to an area of altered skin integrity as follows:
- on one date in the fall of 2018, RPN #111, documented the status of the treatment to be in one state;
- on the same date as the previous progress note, RPN #115 documented that the treatment was in a second state that differed from the previously documented state. There were no entries that identified the treatment had been performed and if the state of the treatment had been changed within the 12 hours in between the notes;
- on the following date, approximately 12 hours after the previous note, RPN #114 identified that the treatment to be in the same state as was initially documented by RPN #111;
- on the following date, RN #105 identified the treatment to be in the same state initially documented; and
- on the following date, RPN #111, also identified the treatment to be in the same state initially documented.

During an interview with RPN #111, they stated that they had performed a treatment related activity at a specific frequency and verified the state of the treatment as documented in the progress note they had entered.

During an interview with ADOC #103, they stated that the staff involved in the care of resident #003 had not collaborated with each so that their assessments of the resident were integrated, consistent and complemented each other.

During an interview with the DOC, they acknowledged that the assessments of the resident's altered skin integrity completed by multiple staff were not consistent with each other. The DOC specifically acknowledged that the Head to Toe Skin Assessment and the Weekly Impaired Skin Integrity Assessments listed inconsistent measurements of altered skin integrity [s. 6. (4) (a)]

4. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other person designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A CIS report was submitted to the Director for a fall experienced by resident #001 in the summer of 2018, during which the resident sustained an injury and was transferred to hospital.

The home's policy titled "Falls Prevention and Management Program – RC-15-01-01", last updated February 2017, directed staff to notify a resident's "POA/SDM/family" after a fall and update the "POA/SDM/family" with resident status changes as required. The programs also identified that staff were to document the fall and actions taken during the 72 hours post fall follow-up. In addition, the "Post Fall Clinical Pathway – Appendix 9", last updated February 2017, directed staff to notify a resident's family of a fall after providing first aid and comfort measures to the resident.

Inspector #625 reviewed resident #001's progress notes, including a note dated the spring of 2018 which identified the resident experienced a fall. Substitute decision-maker (SDM) notification was documented in a subsequent entry on the same date. On the following date a fall was documented and the note identified read that the family would be informed the following date. The Inspector was not able to locate a subsequent note that identified the resident's SDM had been informed of the second fall. The progress notes also identified that resident #001 fell on a date in the fall of 2018, and that this was the next fall the resident experienced after the fall they had in the summer of 2018, when they had sustained an injury and were transferred to hospital. The Inspector was unable to locate a note detailing SDM notification of the fall that occurred in the fall of 2018.

During an interview with RPN #125 they reviewed resident #001's health care record and stated that there was no documentation that resident #001's SDMs had been notified of either fall that had occurred in the spring or the fall of 2018. The RPN indicated that the resident's family would definitely want to know about all falls the resident experienced and that the home's falls prevention and management program required staff to notify a resident's SDM after a fall.

During an interview with RN #117, they stated that staff were required to notify

residents' families of falls and make a progress note entry documenting the notification. The RN reviewed resident #001's health care record and stated that the note dated the spring of 2018, identified the resident fell and staff would inform the family the following date, but the progress notes did not identify that the SDM was notified. The RN also identified that there was no progress note that indicated the resident's SDM was notified of the fall on the date in the fall of 2018.

During an interview with ADOC #103, they reviewed resident #001's progress notes and acknowledged that the progress notes contained no record that resident's SDM was notified of the falls that occurred on either the date in the spring or the fall of 2018. The ADOC acknowledged that the family would have wanted to be notified of the resident's falls. The ADOC stated that the family should have been notified and the notification should have been documented in the progress notes.

During interviews with the DOC, they reviewed resident #001's health care record and identified that SDM notification of the resident's falls on specific dates in the spring and fall of 2018, was not documented in the progress notes. The DOC stated that the resident's SDM should have been contacted for all falls and that the contact should have been documented, as detailed in the falls program. The DOC was not able to locate any internal documents that identified resident #001's SDM had been notified of either of the falls. [s. 6. (5)]

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

A CIS report was submitted to the Director for a fall experienced by resident #003 on a date in the fall of 2018, following which the resident sustained injuries and was transferred to hospital. The report identified that, after the fall, the resident had been transferred in a specific manner by a PSW.

Inspector #625 reviewed resident #003's care plan in effect at the time of their fall which identified the resident required specific staff assistance for all types of care. The care plan cautioned staff to be aware that a factor influencing the specific level of care the resident required could occur at any time.

The Inspector also reviewed the home's investigation file which included notes from interviews with:
- PSW #107, who the notes identified had provided personal care to resident

#003 after their fall. The notes detailed the PSW stated the resident communicated in a particular verbal manner at that time but the PSW concluded that was normal behaviour for the resident. The notes further indicated that the PSW assisted the resident to transfer; and
- RPN #106, who the notes indicated shared that PSW #107 had informed them that assisted resident #003 to transfer after their fall.

During an interview with PSW #107, they stated that they had responded to resident #003 and had discovered the resident had fallen and required personal care. The PSW stated that they provided personal care to the resident in a manner that was not in accordance with the resident's care plan. The PSW remarked that the resident had stated they wanted to get up and that they then assisted the resident to transfer in a manner that was not in accordance with the resident's care plan.

During an interview with the DOC, they stated that PSW #107 had informed them that they had found resident #003 after their fall, they had provided personal care to the resident in a manner that was not in accordance with their care plan; the resident verbally communicated an injury but that the PSW said they believed the resident usually communicated in that manner; and they had assisted the resident to transfer. The DOC acknowledged that PSW #107 had not transferred resident #003 in the manner detailed in their plan of care in place at the time of the fall. [s. 6. (7)]

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

A CIS report was submitted to the Director for a fall experienced by resident #003 on a date in the fall of 2018, following which the resident sustained injuries and was transferred to hospital.

(a) Inspector #625 reviewed resident #003's health care record including eTARs for months in 2018, which contained entries directing staff to perform multiple treatment and assessment interventions related to altered skin integrity at specific frequencies. The Inspector noted that 50 per cent of the entries in one month; and 10 per cent of the entries in another month were not signed indicating completion.

Inspector #625 then reviewed resident #003's progress notes which included no documentation related to the resident's altered skin integrity on any of dates

which had not been signed for on the eTAR.

During an interview with RPN #110 they stated that they had completed a component of the eTAR entry to resident #003's altered skin integrity on multiple consecutive shifts they had worked but had failed to document that it was completed.

During an interview with RPN #111, they stated that they had always completed a component of the eTAR entry to resident #003's altered skin integrity and had completed it during the date that it was unsigned for on the eTARs. The RPN acknowledged that they had forgotten to sign for the activity that they had completed.

During an interview with RPN #112, they stated that they had completed a component of the eTAR entry to resident #003's altered skin integrity several times on one shift, when they went in to help the resident. The RPN stated they forgot to sign that they had completed that activity on the eTAR, although it had been done.

During an interview with the DOC, they reviewed the eTARs and acknowledged that multiple shifts had not been signed to identify that a component of the eTAR entry had been completed.

(b) The CIS report submitted to the Director for resident #003's fall on a date in the fall of 2018, indicated MD #116 had advised the staff to provide a specific treatment to a part of the resident's body.

Inspector #625 reviewed resident #003's health care record with a focus on the specific treatment and identified one progress note related to the treatment post-fall, dated the same day as the fall, by RN #105, that identified "MD advised writer to [complete a specific treatment to a location on the resident's body]". The Inspector was not able to locate documentation that identified the treatment had been completed in the resident's progress notes or on their eTARs.

During an interview with PSW #107, they stated that they were told to perform a different treatment to the resident after their fall, and explained how they had completed the different treatment to the resident.

During an interview with RN #105, they stated that MD #116 had ordered staff to

perform a specific treatment to a location on the resident's body, and the RN recalled bringing supplies up for that treatment, as well as supplies for a different treatment. The RN stated the staff completed one treatment ordered by the MD and then the other treatment. The RN showed Inspector a text dated the date of the fall, from MD #116, that instructed staff to complete a specific treatment to an area on the resident's body.

During interviews with the DOC, they reviewed resident #003's health care record and acknowledged there was no documentation to indicate that either the treatment ordered by the MD or the second treatment initiated by the RN had occurred, although the DOC had been informed that staff had completed the treatment initiated by the RN during their own interviews with staff. [s. 6. (9) 1.]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by the

licensee or staff.

Ontario Regulation 79/10 defines neglect as 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.

A CIS report was submitted to the Director for a fall experienced by resident #003 on a date in the fall of 2018, following which the resident sustained injuries and was transferred to hospital. The CIS report initially indicated that the resident had a fall of a particular characteristic at a specific time, described the details and mechanism of the fall, identified that a post-fall assessment had been completed by an RPN and identified a method of transfer used with the resident after the fall.

The CIS report was amended multiple weeks later to inform the Director that the information initially reported to the Director related to the circumstances of the fall had been incorrect as follows:
- the fall was not of a characteristic reported and did not occur at the time reported;
- the mechanism of the fall differed from what was initially reported;
- a post-fall assessment of the resident had not been completed;
- the resident was not transferred in the manner reported;
- post-fall monitoring of the resident had not occurred;
- incorrect information had been reported which was subsequently communicated to the physician;
- the physician determined the resident's care and treatment needs based on false information; and
- the resident's SDM was provided with inaccurate information regarding the circumstances of the fall.

The licensee failed to provide the resident with the treatment, care, services or assistance required for health, safety or well-being, which included inaction or a pattern of inaction that jeopardized the health, safety or well-being of the resident as follows:

(a) After discovering resident #003 had fallen, PSW #107 failed to notify a member of the registered nursing staff of the resident's fall so that the resident could be assessed for injury. Instead the PSW proceeded to provide care to the resident in a manner that was not in accordance with their plan of care. During the

care, according to the PSW, the resident was verbally communicating an injury which the PSW concluded was the resident's normal behaviour. The PSW then transferred the resident in a manner that was not in accordance with the resident's plan of care.

Refer to WN #1, finding #5 for further details.

(b) The RPN who had been initially informed of the resident's fall, RPN #106, was notified, by PSW #107, that the fall had been of a particular characteristic and that the resident had been transferred in a particular manner, without being assessed by a member of the registered nursing staff first, and that the resident had an injury. Knowing factual information about the fall, the RPN failed to accurately document the information and failed to communicate the accurate information to the RN, including that the particular characteristic of the fall, the specific mechanism of the fall, the absence of an assessment of the resident prior to the resident being moved, and the method of transfer of the resident after the fall.

The RN then communicated the inaccurate information to MD #116 who considered the information to be accurate when determining that a particular type of injury was not likely due to the mechanism of the fall, and deciding the resident's treatment, which included an optional component.

During an interview with Inspector #625, SDM #109 stated their follow-up actions were based on the inaccurate information and the MD's subsequent impression of the resident's injury, which resulted in a delay in the resident receiving a diagnostic test and discovery of the resident's injuries.

The resident experienced injuries after their fall, but did not receive appropriate care and treatment as the circumstances of the fall were not accurately communicated to staff and others involved in the resident's care. Progress notes identified the resident received prn (pro re nata or as needed) analgesic medication on multiple occasions between the fall, and their admission to hospital days later, in addition to the scheduled analgesic medication ordered. The notes also contained entries that outlined the resident had experienced an injury beginning on the date of the fall. The notes were consistent in the documentation that the resident stated and complained of an injury in a specific location multiple times; displayed signs of an injury during transfers on subsequent dates; remained in bed with visible injuries to to a specific location on subsequent dates; the injury affected the provision of care to the resident; and had a diagnostic test

performed multiple days after the fall that determined the resident had a significant injury.

Refer to WN #3, finding #1 for further details.

(c) The registered nursing staff failed to provide the resident with appropriate clinical monitoring, as required by the licensee. Although the resident's fall was of a particular characteristic, which was known to responding RPN #106, they failed to initiate a Clinical Monitoring Record, which was required in accordance with the home's Falls Prevention and Management Program, which indicated, for a fall of that characteristic, the resident was to be monitored at specific frequencies, for a specific duration. Further, the program indicated that a fall of another characteristic required monitoring at a different frequency, for a specific duration. The monitoring included vital signs, pain assessment and neurological assessment. The home's staff completed no Clinical Monitoring Records for resident #003's fall, whether the staff believed it to be of either characteristic. In addition, the home's staff failed to document any monitoring or assessment of the resident for multiple hours, encompassing the entire shift following the fall.

Refer to WN #3, finding #1 for further details.

(d) Upon return from hospital, the resident had altered skin integrity to an area on their body which required appropriate treatment and monitoring. A document from the TBRHSC identified that the resident's treatment was to occur at a specific frequency until the status of the altered skin integrity met specific criteria. From the date the resident returned from hospital to the date the treatment was no longer required, documentation identified the treatment had not occurred at the required frequency.

The required Weekly Impaired Skin Integrity Assessments were not completed at the required frequency, and contained significant inconsistencies in the assessment criteria. In addition, other assessments and documentation listed inconsistencies in the assessment of the altered skin integrity.

Finally, the home's staff failed to document that the altered skin integrity had resolved, and the last documentation of the altered skin integrity was related to a procedure performed by the home's staff to the area of altered skin integrity.

Refer to WN #1, findings #1 and #3, and WN #3, finding #1 for further details.

(e) Upon return from hospital, the resident experienced an injury that required monitoring and assessment. The home's Pain Identification and Management policy identified three monitoring and assessment documents that were to be completed; a Pain Flow Note, a Pain Flow Record and a Pain Assessment. Although the resident met criteria for the completion of the documents, none of the documents had been completed for the resident.

Refer to WN #3, finding #1 for further details.

In summary, resident #003 was not provided with the treatment, care, services or assistance required for their health, safety or well-being, in areas related to required programs, specifically regarding falls prevention and management, skin and wound care and pain management. [s. 19. (1)]

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, where the LTCHA, 2007 or Ontario Regulation 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

Ontario Regulation 79/10, r. 30 (1) requires the licensee to ensure that, for each of the interdisciplinary programs required under section 48 of the regulation, there is a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Ontario Regulation 79/10, r. 48 (1) 1. identifies that every licensee of a long-term care home shall ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury is developed and implemented in the home.

A CIS report was submitted to the Director for a fall experienced by resident #003 in the fall of 2018, following which the resident sustained injuries and was transferred to hospital. The report identified that, after the fall, the resident had been transferred in a particular manner by a PSW.

(a) Inspector #625 reviewed the home's "Falls Prevention and Management Program – RC-15-01-01" last updated February 2017, which identified that post fall management included implementing the Post-Fall Clinical Pathway, Appendix 9.

The Inspector reviewed the referenced "Post Fall Clinical Pathway, Appendix 9" last updated February 2017, which identified that a focused assessment by the first registered staff person on the scene was required after a resident's fall; followed by a clinical decision by registered staff to not move the resident, to move the resident, or to have the resident get up independently. If it was decided to move the resident, or if the resident got up independently, staff were to reassess the resident for possible injury and pain and provide first aid.

A review of the home's investigation file included notes from interviews with PSW #107 and RPN #106, and identified that PSW #106 had assisted resident #003 following their fall, without an assessment of the resident by registered staff prior to doing so.

During an interview with PSW #107, they stated to the Inspector that they had assisted resident #003 transfer after their fall, prior to notifying registered staff of the resident's fall.

During an interview with the home's DOC, they stated that PSW #107 had not complied with the home's Falls Prevention and Management Program which required an assessment of resident #003 by registered staff prior to moving the resident.

(b) The home's "Falls Prevention and Management Program – RC-15-01-01" last updated February 2017, identified that staff were required to notify the POA/SDM/family as required.

The "Post Fall Clinical Pathway, Appendix 9" last updated February 2017, also identified that staff were to notify family of the fall, after providing first aid and comfort measures.

A progress note dated the date of the fall identified that RPN #106 attempted to call resident #003's substitute decision-maker (SDM) but was unable to leave a message.

A progress note entered 17 hours after the previous note, identified that RPN #108 had contacted resident #003's SDM to communicate information from the physician regarding taking the resident for a diagnostic test. The note indicated that the SDM had not been aware of the resident's fall, and was notified of the fall during that call.

During an interview with SDM #109, they stated that they were contacted the day following resident #003's fall, and that the nurse who had called was surprised that the SDM had not been notified of the fall the prior day when it had occurred.

During an interview with RPN #108, they stated that their phone call to resident #003's SDM the day after the fall, was the first time the SDM had been informed of the fall. The RPN explained that they had called the SDM to discuss sending the resident for a diagnostic test, to which the SDM asked "For what?". The RPN stated that the SDM hadn't even been aware of the fall, so the RPN explained everything to them.

During an interview with the DOC, they stated that RPN #106 had acknowledged that they had not left communication for the following day shift to inform the SDM of the fall the next day and that, as a result, the fall that occurred was not communicated to the SDM until the next day [when RPN #108 phoned the SDM and learned that the SDM had not been previously notified of the fall].

(c) Inspector #625 reviewed the home's "Falls Prevention and Management Program – RC-15-01-01" last updated February 2017. The policy identified that:
- Post fall management included implementing the Post-Fall Clinical Pathway, Appendix 9;
- If a resident hit their head or was suspected of hitting their head (e.g. unwitnessed fall), staff were to complete a Clinical Monitoring Record, Appendix 10; and
- For 72 hours post-fall staff were to assess the following at each shift: pain, bruising, change in functional status, change in cognitive status and changes in range of motion. Staff were also to document the fall and results of all assessments and actions taken during the 72 hours post-fall follow-up.

The "Post Fall Clinical Pathway, Appendix 9" last updated February 2017, identified that if the fall was unwitnessed, staff were to complete clinical monitoring.

The Inspector reviewed the referenced "Clinical Monitoring Record-Appendix 10" which identified that an unwitnessed fall required hourly monitoring every hour for four hours, then every eight hours for 72 hours, and a witnessed fall required monitoring every shift for 72 hours. The monitoring included vital signs, pain assessment and neurological assessment.

A review of the home's investigation file included notes from interviews with PSW #107 and RPN #106 which identified that resident #003's fall on a date in the fall of 2018, had been of a particular characteristic and the resident was discovered to have fallen by PSW #107.

The Inspector was not able to locate any Clinical Monitoring Records for the monitoring of resident #003 after the fall that occurred. Further, a review of progress notes identified no documentation of the resident for hours, which reflected an absence of documentation of the resident's status on the shift following their fall.

During an interview with RN #105, they stated that Clinical Monitoring Records should have been completed for resident #003's fall, but they could not locate an electronic Clinical Monitoring Record and stated that one had not been initiated electronically on Point Click Care (PCC) for the resident.

During an interview with the DOC, they acknowledged that staff were required to complete a Clinical Monitoring Record for resident falls, which included monitoring of residents after falls of a particular characteristic hourly for four hours, followed by every eight hours for 72 hours. The DOC acknowledged that, as a result of resident #003's fall, to ensure that the monitoring was done as required from shift to shift, the home had moved to a paper Clinical Monitoring Record.

(d) Ontario Regulation 79/10, r. 48 (1) 2. requires the licensee to ensure that a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions, was developed and implemented in the home.

Inspector #625 reviewed the home's policy titled "Skin and Wound Care Program: Wound Care Management – RC-23-01-02", last updated February 2017, that identified staff were to document the resolution of skin integrity issues in the interdisciplinary progress notes.

The Inspector reviewed resident #003's progress notes and identified the most recent progress note related to the incision, dated the fall of 2018, which identified staff had performed a procedure related to the altered skin integrity, that the area was healing and that the plan was to "continue to monitor". The Inspector was not able to locate any subsequent progress notes related to the altered skin integrity.

During an interview with the DOC, they acknowledged that there was no documentation that identified the altered skin integrity had resolved, although the home's skin and wound care program indicated such documentation was required. The DOC confirmed that the last documented progress note related to the altered skin integrity was entered when staff performed the procedure and identified that the altered skin integrity was healing.

(e) Ontario Regulation 79/10, s. 48 (1) 4. requires every licensee of a long-term care home to ensure that a pain management program to identify pain in residents and manage pain is developed and implemented in the home.

Inspector #625 reviewed the home's policy "Pain Identification and Management – RC-19-01-01", last updated February 2017, which indicated:
- staff were to assess residents for pain using the Pain Flow Note in PCC, and complete a pain flow note on all residents who had any change in condition that had the potential to impact the resident's pain level;
- staff were to initiate the Pain Flow Record for 72 hours if the resident had prn (pro re nata, or as needed) pain medication used for three consecutive days; and
- after 72 hours, if further information was required to manage the resident's pain, a Pain Assessment was to be completed.

The Inspector reviewed resident #003 's health care record including:
- electronic progress notes that identified the resident had fallen, sustained injuries, and experienced related pain;
- eMAR medication administration notes that identified the resident received prn analgesic medication on multiple dates following the fall, including some dates where multiple does were administered, and including the documentation that the analgesic had not always been effective.

Although the resident had experienced a change in condition that impacted their pain level, the Inspector could not locate a Pain Flow Note completed for the resident.

Although the resident had received prn pain medication for multiple consecutive days, the Inspector did not locate a Pain Flow Record completed for the resident.

Inspector #625 noted that the resident's prn pain medication dose had changed on one date and, the following date, the new dose was documented as ineffective

in managing the resident's pain. In addition, on that date, the resident required the prn medication at a greater frequency than any other date the prn medication had been administered during that period of time. However, the Inspector could not locate a Pain Assessment completed for the resident.

During an interview with ADOC #103, they acknowledged that the home's Pain Identification and Management policy had not been complied with, with respect to resident #003 upon return from hospital as: a Pain Flow Note had not been completed when the resident had a change in condition that had the potential to impact their pain level; a Pain Flow Record had not been completed when the resident used prn pain medication for multiple consecutive dates; and a Pain Assessment had not been completed when the resident's prn pain medication had been ineffective. [s. 8. (1) (b)]

2. Ontario Regulation 79/10, r. 48 (1) 2. requires the licensee to ensure that a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions, was developed and implemented in the home.

A CIS report was submitted to the Director for a fall experienced by resident #001 in the summer of 2018, during which the resident sustained an injury and was transferred to hospital. Days later, the report was amended and identified that the resident had altered skin integrity in two areas, including an area with multiple sites of altered skin integrity. Weeks later the report was further amended and indicated staff had performed a procedure as scheduled and one area of altered skin integrity was resolving.

Inspector #625 reviewed the home's policy titled "Skin and Wound Care Program: Wound Care Management – RC-23-01-02", last updated February 2017, that identified:
- a nurse was to reassess altered skin integrity at least weekly, if clinically indicated;
- staff were to use the Impaired Skin Integrity Assessment for skin impairments excluding ulcers;
- residents were to receive specified care as set out in the plan of care; and
- staff were to document the resolution of skin integrity issues in the interdisciplinary progress notes.

(a) Nursing staff failed to reassess resident #001's multiple sites of altered skin

integrity in one area, and multiple sites of skin integrity in another area, weekly, and failed to use the Impaired Skin Integrity Assessment to assess resident #001's altered skin integrity. The only weekly assessment completed for the resident's altered skin integrity was completed on the assessment intended for use with ulcers.

See finding WN #4, finding #1 for details.

(b) The Inspector could not locate a progress note identifying the resolution of resident #001's altered skin integrity on the second area on their body.

During an interview with ADOC #103, they stated that a progress note had not been entered indicating resident #001's altered skin integrity had resolved.

During an interview with the DOC, they stated that staff were required to document the resolution of skin integrity issues in interdisciplinary notes, but that the resolution of resident #001's altered skin integrity on the second area of the body had not been documented in the notes as required. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that, where the LTCHA, 2007, or Ontario Regulation 79/10 requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, specifically the home's falls prevention and management, skin and wound care and pain management programs, are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A CIS report was submitted to the Director for a fall experienced by resident #001 in the summer of 2018, during which the resident sustained an injury and was transferred to hospital. Days later, the report was amended and identified that the resident had altered skin integrity in two areas, including an area with multiple sites of altered skin integrity. Weeks later the report was further amended and indicated staff had performed a procedure as scheduled and one area of altered skin integrity was resolving.

The Inspector reviewed the home's policy titled "Skin and Wound Care Program – Wound Care Management – RC-23-01-02", last updated February 2017. The policy identified that a nurse was required to assess a resident exhibiting altered skin integrity using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, and a nurse was to

complete a reassessment at least weekly, if clinically indicated. The policy identified the Impaired Skin Integrity Assessment was to be used for skin impairments other than pressure ulcers, venous status ulcers, or any type of ulcer, as the ulcers would be assessed using the Bates Jensen Wound Assessment Tool.

The Inspector reviewed resident #001's health care record with a focus on the altered skin integrity related to the resident's injury and assessment of the areas of altered skin integrity including:
- a progress note dated the summer of 2018, that identified the resident returned to the home and that multiple areas of altered skin integrity were present, including multiple sites within one area;
- eMARs for multiple months in 2018, which contained one entry each month directing staff to perform multiple treatments to multiple areas;
- eTARs for multiple months in 2018, which listed one entry for weekly skin assessments due for altered skin integrity to one area on the resident's body. The eTARs did not identify that the resident had more than one site to be assessed or that sites were located on multiple distinct areas. The eTARs were checked off as completed on multiple dates. Two entries were coded as "Other / See Progress Note".

The Inspector then reviewed completed assessments of the altered skin integrity:
- on the date the resident returned to the home, a Skin – Weekly Impaired Skin Integrity Assessment was completed for the one site of altered skin integrity in one area, but the measurement field was left blank;
- on the day following the resident's return from hospital, a Skin - Weekly Impaired Skin Integrity Assessment identified multiple areas, which each contained multiple sites, of altered skin integrity; and
- on the week following the resident's return from hospital, a Skin - Weekly Wound Assessment - includes Bates-Jensen Wound Assessment was completed, with a summary note related to one site in one area of altered skin integrity.

Although the assessment completed the date following the resident's return to the home, identified multiple ares each with multiple sites of altered skin integrity, the Inspector was not able to locate subsequent weekly assessments of the sites, except for the assessment intended for use with ulcers completed the week following the resident's return from hospital.

Inspector #625 reviewed an eMAR medication administration note corresponding

to a date in the summer of 2018, when one of the weekly skin assessments was due for one site in one area of altered skin integrity. It identified a change in treatment of the area and that the site was resolved. It did not include any information related to the weekly skin assessment that was due that date but not completed.

The Inspector reviewed a progress note corresponding to a date in the fall of 2018 , entered by the RPN, who documented that they had completed the weekly skin assessment for sites of altered skin integrity in one area, but for which no weekly assessment had been completed. The note identified that a treatment was performed on one area of the resident's body and listed the size of one component of the altered skin integrity.

During an interview with RPN #125, they stated that all weekly wound assessments were to be completed electronically and, if resident #001 only had a few assessment present, those were the only assessments that were completed, "what's there, is what was done".

During an interview with ADOC #103, they acknowledged that a specific number of separate sites of altered skin integrity were listed on resident #001's wound assessment completed the date after they returned from hospital, and the eMARs listed a different number of treatments were required. The ADOC acknowledged that resident #001 had not had any of the weekly impaired skin integrity assessments completed as required [as detailed in the home's policy], as the first two assessments, were actually the initial wound assessments for the resident, and staff picked the incorrect type of assessment to complete when they identified the assessments as weekly assessments. The ADOC also acknowledged that the assessment completed the week after the resident returned from hospital was the one intended for use with ulcers and that multiple sites of altered skin integrity were included in one assessment, when each site should have had a separate assessment using the correct weekly impaired skin integrity assessment.

During an interview with the DOC, they acknowledged that the first two assessments titled "weekly" assessments, were actually "initial" assessments of the altered skin integrity sites, and that the assessment completed the week after the resident's return to the home was intended for use with ulcers; the employee had picked the incorrect assessment and the employee should have had one assessment completed for each altered skin integrity site and not combined them all together on one. [s. 50. (2) (b) (iv)]

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 that ensures that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CIS report was submitted to the Director for a fall experienced by resident #001 on a date in the summer of 2018, during which the resident sustained an injury and was transferred to hospital.

Inspector #625 reviewed resident #001's progress notes, which were consistent

with the information provided in the CIS report related to the resident's fall. The progress notes also identified that the resident fell on two dates in the spring of 2018, and one date in the fall of 2018.

The Inspector was not able to locate Post-Fall Assessments for the four falls that occurred in the spring, summer and fall of 2018.

The Inspector reviewed the home's policy titled "Falls Prevention and Management Program – RC-15-01-01", last updated February 2017, directed staff to complete a Post-Fall Assessment as soon as possible after a fall.

During an interview with RPN #125, they reviewed resident #001's health care record and acknowledged that, although the progress notes identified the resident fell on the four dates in the spring, summer and fall of 2018, Post-Falls Assessments had not been completed for any of these falls.

During an interview with RN #117, they reviewed resident #001's health care record and confirmed that the resident fell on the four dates in the spring, summer and fall of 2018. The RN stated that Post-Falls Assessments had not been completed for these falls.

During an interview with ADOC #103, they reviewed resident #001's health care record and identified that the resident fell on the four dates in the spring, summer and fall of 2018. The ADOC stated that Post-Fall Assessments were required after each of these falls, and that this requirement was identified in the home's policy, but that the Post-Fall Assessments had not been completed.

During an interview with the DOC, they confirmed that resident #001 fell on four dates in the spring, summer and fall of 2018, as detailed in their progress notes. The DOC stated that Post-Falls Assessments were required after each of these falls but that none had been completed. [s. 49. (2)]

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 sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 14th day of March, 2019 (A2)

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SHELLEY MURPHY (684) - (A2)
Inspection No. / No de l'inspection :	2018_703625_0026 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	024553-18, 026835-18, 031324-18 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 14, 2019(A2)
Licensee / Titulaire de permis :	CVH (No. 9) GP Inc. as general partner of CVH (No. 9) LP 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Southbridge Pinewood 2625 Walsh Street East, THUNDER BAY, ON, P7E-2E5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jonathon Riabov

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

To CVH (No. 9) GP Inc. as general partner of CVH (No. 9) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(a) the planned care for the resident;

(b) the goals the care is intended to achieve; and

(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with s. 6 (1) of the LTCHA, 2007.

The licensee shall ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Specifically, the licensee must:
a) Review and update, as required, resident #001's and resident #003's written plans of care to ensure the written plans set out clear directions to staff and others who provide direct care to the residents.
b) Maintain written records of the reviews including the dates of the reviews, the documents updated and any changes made.
c) Review and update, as required, the home's post fall clinical monitoring documents, including any electronic documents in use, to ensure they provide clear directions to staff with respect to post-fall clinical monitoring requirements.
d) Maintain written copies of any documents that were reviewed or updated, including the dates of the reviews, the documents updated and any changes made.
e) Develop and implement a written procedure for staff to adhere to when making changes to residents' plans of care, with a focus on skin and wound care. The procedure shall include direction on where the information is to be located, what information should be included and how staff are to update the plans of care for residents with multiple wounds and/or multiple treatments.
f) Maintain a written record of the procedure and any supporting documentation related to implementation of the procedure in the home.
g) Conduct routine audits in the home to determine if staff are adhering to the procedure implemented and take corrective action when deficiencies are noted.
h) Maintain records of the audits including, but not limited to, the dates of the audits, the findings and any actions taken as a result of the audits.

Grounds / Motifs :

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

A Critical Incident System (CIS) report was submitted to the Director for a fall sustained by resident #003 in the fall of 2018, following which the resident sustained injuries and was transferred to hospital, and which resulted in a significant change in the resident's health status.

(a) During an interview with RN #105, regarding resident #003's fall, they stated that the resident would have required a Clinical Monitoring Record be completed, either electronically or on paper.

Inspector #625 reviewed a memo dated in the fall of 2018, addressed to registered staff titled *NEW* Falls Protocol. The memo identified that the home would revert to paper charting for vital signs on all witnessed and unwitnessed falls, effective that date. The memo referred to an attached Clinical Monitoring Record.

The Inspector reviewed the Clinical Monitoring Record which identified that, if a fall was unwitnessed or a head injury was suspected, staff would monitor the resident for specific criteria, including neurological vital signs, every hour for four hours, then every eight hours for 72 hours. The record also identified that an unwitnessed fall would require a head injury routine to be completed every four hours [not hourly as previously identified on the record] and then every eight hours.

During an interview with ADOC #103, they acknowledged that the Clinical Monitoring Record was unclear as it identified that initial monitoring for an unwitnessed fall was to occur every hour and every four hours, referring to the same initial monitoring period.

During an interview with the DOC, they stated that, as a result of resident #003's fall in the fall of 2018, the home had implemented the Clinical Monitoring Record on paper. The DOC stated that, as of a date in the fall of 2018, staff were required to complete the paper copy instead of an electronic version to ensure that the monitoring was completed from shift to shift. The DOC acknowledged that the Clinical Monitoring Record was not clear with respect to the monitoring frequency of residents, as it indicated monitoring was to occur every hour for four hours and every four hours [for the same initial monitoring period].

(b) The Inspector reviewed the home's policy titled "Skin and Wound Program: Wound Care Management – RC-23-01-02", last updated February 2017, which

identified that staff were to record the treatment regimen on the electronic Treatment Administration Record (eTAR), monitor the resident's skin condition with each dressing change, and re-assess at minimum weekly.

Inspector #625 reviewed resident #003's health care record including eTARs for two months in 2018, which contained entries directing staff to complete one activity at a specific frequency, complete an action at a specific time, and complete a second activity at a different frequency than the first activity. The Inspector was not able to distinguish if the signed entries reflected that the first or the second activity had been completed.

The Inspector then reviewed multiple Weekly Impaired Skin Integrity Assessments for altered skin integrity, which had been completed at different frequencies.

During an interview with RPN #111, they stated that the eTAR should have listed specific dates for the second activity to be completed on. The RPN stated that, if second activity wasn't listed as a separate intervention from the the first activity, which was required at a different frequency, staff wouldn't know which shift was to do the second activity, if it had already been done, or if it needed to be done. The RPN said that staff would have to check additional components of the resident's health care record to see if it needed to be done because it wasn't clear to staff when to do it or when it was done.

During an interview with the DOC, they stated that the second activity should have been scheduled on the eTAR as a separate entry from the first activity, which was required at a different frequency, as it was not clear to staff which of the activities had been completed. The DOC indicated that the second activity had not been completed at the frequency it should have been, as part of the problem was they had not been scheduled in the eTAR with clearly identified dates for staff to adhere to.

(c) The Inspector reviewed resident #003's referral to the Wound Care Champion for altered skin integiry. On a date in the fall of 2018, RPN #113, documented that staff were to follow the treatment orders from the hospital for the altered skin integrity.

Inspector #625 reviewed a document from the Thunder Bay Regional Health Sciences Centre (TBRHSC), dated in the fall of 2018, that identified instructions for the care of resident #003's altered skin integrity, including the completion of one

treatment at a specific frequency.

Inspector #625 reviewed the home's policy titled "Skin and Wound Care Program: Wound Care Management – RC-23-01-02", last updated February 2017, that identified staff were to record the treatment regimen on the eMAR or eTAR.

The Inspector noted two of resident #003's 2018 eTARs contained entries for staff to follow related to the altered skin integrity. The eTAR did not contain any information related to the completion of the treatment identified in the TBRHSC document, to be completed at the frequency in the document, or at any frequency.

The Inspector reviewed resident #003's progress notes and identified that the resident had returned to the home on a date in the fall of 2018; had the treatment completed on a certain date in 2018, in response to the condition of the altered skin integrity, and that the treatment was no longer required at a later date in 2018. The progress notes contained no other entries related to the treatment being provided to resident #003 during the time it was required.

During an interview with RPN #112, they stated that the eTAR entry was "definitely confusing" and was unclear; if the hospital ordered the treatment complete at a specific frequency, and Wound Care Champion/RPN #113 said to follow the hospital document, the hospital order should have been entered into the eTAR, but the eTAR didn't list to complete the treatment at the specified frequency. The RPN stated that, if the hospital wanted the the treatment completed at a specific frequency, that should have been followed, and that is what the eTAR should have listed.

During an interview with the DOC, they reviewed resident #003's health care record and confirmed that the TBRHSC document had indicated the resident's treatment was to be completed at a specific frequency, that the Wound Care Champion had documented to follow the orders from the hospital, that the eTARs did not identify that the resident's treatment was to be completed at the specific frequency, and that the only documentation of the treatment being provided was recorded in the progress notes on a date in fall of 2018. (625)

2. A CIS report was submitted to the Director for a fall experienced by resident #001 during the summer of 2018, during which the resident sustained an injury and was transferred to hospital. The report identified the resident's mobility had changed after the fall and they they required a mobility aid when they returned to the home.

(a) Inspector #625 reviewed resident #001's current care plan, last review completed in the fall of 2018, which identified the resident required assistance provided by staff for mobility. The same care plan identified that resident #001 exhibited responsive behaviours including a behaviour that was not consistent with the type of mobility assistance the care plan stated the resident required from staff.

Inspector #625 observed resident #001 during consecutive dates of the inspection and did not observe the resident to exhibit the responsive behaviour.

During an interview with PSW #126, they stated that resident #001 never exhibited the behaviour since their fall. The PSW elaborated that the care plan was not consistent when it identified that the resident exhibited the behaviour and also needed a particular level of assistance from staff for mobility.

During an interview with RPN #125, they stated that resident #001 no longer exhibited the behaviour since their fall and resulting use of a mobility aid, that staff currently provide the resident with a certain level of assistance with mobility. The RPN reviewed the resident's care plan and confirmed that it stated the resident exhibited the behaviour as well as required staff assistance for mobility. The RPN stated the care plan would not be clear to staff about the resident's mobility.

During an interview with RN #117, they reviewed resident #001's current care plan and acknowledged that it listed the resident required assistance by staff with mobility, as well as exhibited a behaviour. The RN elaborated that the resident used to exhibit the behaviour, before they fell, and since the fall, the resident no longer exhibited the behaviour. The RN stated the care plan did not provide clear direction to staff about the resident in this area and that the behaviour should have been revised when the rest of the care plan was.

During an interview with ADOC #103, they reviewed resident #001's current care plan and acknowledged that it was unclear with respect to the resident requiring assistance from with mobility and also exhibiting a mobility related behaviour. The ADOC stated it would be unclear to staff as the care plan listed two different items related to mobility that were not the same.

During an interview with the DOC, they reviewed resident #001's current care plan

and indicated that it identified the resident required assistance by staff with locomotion, as well as exhibited a particular behaviour. The DOC stated the care plan was not clear as to whether the resident exhibited the behaviour or required staff assistance. The DOC indicated that the resident exhibited the behaviour before they fell and that portion of the care plan should have been changed.

(b) The CIS report submitted to the Director for resident #001's fall, in the summer of 2018, was amended days later to include information on the resident's altered skin integrity. Weeks later, the report was further amended and indicated a change in the status of the altered skin integrity following an action taken by the staff days earlier.

A review by Inspector #625 of a Skin - Weekly Impaired Skin Integrity Assessment dated the summer of 2018, identified multiple areas of altered skin integrity on multiple locations of resident #001's body.

Inspector #625 reviewed resident #001's health care record with a focus on the plan of care related to the altered skin integrity and identified:
- a care plan that listed interventions to be performed on a specific date to one area of altered skin integrity on the resident's body, and referred staff to the eTAR for directions on treatment of the altered skin integrity. The care plan did not reference the resident's altered skin integrity on the other location(s) of the resident's body, or that there were multiple sites of altered skin integrity on the area listed.
- eTARs for multiple months in 2018, that referred to a weekly skin assessment of the altered skin integrity on one area of the resident's body; and an action required by staff to one area of altered skin integrity to be completed on a specific date. The eTARs did not contain the treatment referred to in the care plan for the resident's area of altered skin integrity, did not identify the number of sites of altered skin integrity in that area, and did not include any reference to the altered skin integrity on another area on the resident's body, including care required for a treatment, weekly assessments or an action required to be completed by staff.
- eMARs for multiple months 2018, which each contained one entry that combined the directions for care for multiple treatments to multiple locations of altered skin integrity on the resident's body. The eMARs did not identify the number of sites of altered skin integrity on the areas of the resident's body.
- a document from the TBRHSC which identified staff were to complete an activity which involved the areas of altered skin integrity, within a specific time frame, on a specific date.

- a progress note entered by RPN #127, that identified the activity identified in the TBRHSC document had occurred to one area of altered skin integrity on the resident's body.
- a progress note entered days after the activity was completed by RPN #127, and outside of the time frame listed on the TBRHSC document, that identified RN #117, had completed the activity to another area of altered skin integrity on the resident.

During an interview with RPN #125, they stated that they had only been aware of the resident's altered skin integrity on one area of their body from reading the eMARs and eTARs but saw the other area of altered skin integrity on the resident's body when they were completing a treatment on the first area, in the presence of the resident. The RPN stated they probably should have gone in and added the other sites as it was not clear to people that they were there and needed interventions. The RPN stated that, if the eMAR and eTAR did not contain directions for staff to follow, the plan of care had not been clear with respect to the resident's second location of altered skin integrity, including the treatment needed or the date of the activity staff were required to perform.

During an interview with RN #117, they stated that they had reviewed resident #001's health care record and recalled completing a required activity on a second location on the resident's body, as they had noticed the activity had not been completed when they had provided care to the resident. The RN had been aware that the activity had occurred to one area on the resident's body on the date identified in the TBRHSC document, when, at that time, it had not been clear to staff that the resident's had a second area on their body to which the activity was required. The RN stated that it had not been clear to staff to complete a procedure on the second area of altered skin integrity, or complete weekly assessments on that area so it looked like those items were not being done.

During an interview with ADOC #103, they reviewed resident #001's health care record and acknowledged that the care plan had listed the resident had an area of altered skin integrity to one location on their body but did not identify the resident also had altered skin integrity on another location of the resident's body. The ADOC commented that the care plan referred staff to the eTARS for direction related to a treatment for the altered skin integrity on the first area, when the interventions were not listed on the eTARs, but were listed on the eMARS. The ADOC stated that the care plan did not provide clear directions to staff with respect to the resident's

treatment, the number of areas of altered skin integrity, the location of the altered skin integrity and where to find instructions on how to care for the altered skin integrity. The ADOC acknowledged that the eTAR listed a weekly skin assessment for one area of altered skin integrity, but did not include information on completing an associated treatment. The ADOC also acknowledged the eMAR did not list the individual locations of the altered skin integrity that required treatment, but had one entry for multiple treatment areas, although additional areas of altered skin integrity were listed on the assessment completed in the summer of 2018. The ADOC stated that each of the treatments required for the areas of altered skin integrity should have been listed separately on the eTAR [not on the eMAR].

During an interview with the DOC, they stated that the treatment listed should have been entered on the eTAR, not on the eMAR, and that each location on each area of altered skin integrity should have been entered separately as it was not clear to staff, based on the eMAR, that there were multiple distinct areas of altered skin integrity. The DOC acknowledged that the care plan listed the altered skin integrity to one area on the resident as resolved but did not identify the second area; referred staff to the eTAR for information related to treatments that had been entered on the eMAR; and did not provide clear direction to staff with respect to the resident's treatments, the number of locations of altered skin integrity, the areas of altered skin integrity and where to find instructions for care.

The decision to issue a compliance order was based on the severity, which was determined to be a level 2, as there was the potential for actual harm to occur to the residents. The scope was a level 2, as the home demonstrated a pattern of occurrence involving two residents. The home had a level 2 compliance history, as it consists of non-compliance issued in one or more unrelated areas of the legislation. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2019(A2)

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 :

The licensee must be compliant with s. 19 (1) of the LTCHA, 2007.

The licensee shall ensure that residents are protected from abuse by anyone and are not neglected by the licensee or staff.

Specifically, the licensee must:
a) Ensure resident #003 is provided the treatment, care, services and assistance they require for health, safety or well-being, with a focus on falls prevention and management, skin and wound care and pain management.
b) Ensure that all residents who require treatment, care, services and assistance for health, safety or well-being, are provided the treatment, care, services and assistance required, with an emphasis on falls prevention and management, skin and wound care and pain management.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Ontario Regulation 79/10 defines neglect as 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.

A CIS report was submitted to the Director for a fall experienced by resident #003 on a date in the fall of 2018, following which the resident sustained injuries and was

transferred to hospital. The CIS report initially indicated that the resident had a fall of a particular characteristic at a specific time, described the details and mechanism of the fall, identified that a post-fall assessment had been completed by an RPN and identified a method of transfer used with the resident after the fall.

The CIS report was amended multiple weeks later to inform the Director that the information initially reported to the Director related to the circumstances of the fall had been incorrect as follows:
- the fall was not of a characteristic reported and did not occur at the time reported;
- the mechanism of the fall differed from what was initially reported;
- a post-fall assessment of the resident had not been completed;
- the resident was not transferred in the manner reported;
- post-fall monitoring of the resident had not occurred;
- incorrect information had been reported which was subsequently communicated to the physician;
- the physician determined the resident's care and treatment needs based on false information; and
- the resident's SDM was provided with inaccurate information regarding the circumstances of the fall.

The licensee failed to provide the resident with the treatment, care, services or assistance required for health, safety or well-being, which included inaction or a pattern of inaction that jeopardized the health, safety or well-being of the resident as follows:

(a) After discovering resident #003 had fallen, PSW #107 failed to notify a member of the registered nursing staff of the resident's fall so that the resident could be assessed for injury. Instead the PSW proceeded to provide care to the resident in a manner that was not in accordance with their plan of care. During the care, according to the PSW, the resident was verbally communicating an injury which the PSW concluded was the resident's normal behaviour. The PSW then transferred the resident in a manner that was not in accordance with the resident's plan of care.

Refer to WN #1, finding #5 for further details.

(b) The RPN who had been initially informed of the resident's fall, RPN #106, was notified, by PSW #107, that the fall had been of a particular characteristic and that

the resident had been transferred in a particular manner, without being assessed by a member of the registered nursing staff first, and that the resident had an injury. Knowing factual information about the fall, the RPN failed to accurately document the information and failed to communicate the accurate information to the RN, including that the particular characteristic of the fall, the specific mechanism of the fall, the absence of an assessment of the resident prior to the resident being moved, and the method of transfer of the resident after the fall.

The RN then communicated the inaccurate information to MD #116 who considered the information to be accurate when determining that a particular type of injury was not likely due to the mechanism of the fall, and deciding the resident's treatment, which included an optional component.

During an interview with Inspector #625, SDM #109 stated their follow-up actions were based on the inaccurate information and the MD's subsequent impression of the resident's injury, which resulted in a delay in the resident receiving a diagnostic test and discovery of the resident's injuries.

The resident experienced injuries after their fall, but did not receive appropriate care and treatment as the circumstances of the fall were not accurately communicated to staff and others involved in the resident's care. Progress notes identified the resident received prn (pro re nata or as needed) analgesic medication on multiple occasions between the fall, and their admission to hospital days later, in addition to the scheduled analgesic medication ordered. The notes also contained entries that outlined the resident had experienced an injury beginning on the date of the fall. The notes were consistent in the documentation that the resident stated and complained of an injury in a specific location multiple times; displayed signs of an injury during transfers on subsequent dates; remained in bed with visible injuries to to a specific location on subsequent dates; the injury affected the provision of care to the resident; and had a diagnostic test performed multiple days after the fall that determined the resident had a significant injury.

Refer to WN #3, finding #1 for further details.

(c) The registered nursing staff failed to provide the resident with appropriate clinical monitoring, as required by the licensee. Although the resident's fall was of a particular characteristic, which was known to responding RPN #106, they failed to

initiate a Clinical Monitoring Record, which was required in accordance with the home's Falls Prevention and Management Program, which indicated, for a fall of that characteristic, the resident was to be monitored at specific frequencies, for a specific duration. Further, the program indicated that a fall of another characteristic required monitoring at a different frequency, for a specific duration. The monitoring included vital signs, pain assessment and neurological assessment. The home's staff completed no Clinical Monitoring Records for resident #003's fall, whether the staff believed it to be of either characteristic. In addition, the home's staff failed to document any monitoring or assessment of the resident for multiple hours, encompassing the entire shift following the fall.

Refer to WN #3, finding #1 for further details.

(d) Upon return from hospital, the resident had altered skin integrity to an area on their body which required appropriate treatment and monitoring. A document from the TBRHSC identified that the resident's treatment was to occur at a specific frequency until the status of the altered skin integrity met specific criteria. From the date the resident returned from hospital to the date the treatment was no longer required, documentation identified the treatment had not occurred at the required frequency.

The required Weekly Impaired Skin Integrity Assessments were not completed at the required frequency, and contained significant inconsistencies in the assessment criteria. In addition, other assessments and documentation listed inconsistencies in the assessment of the altered skin integrity.

Finally, the home's staff failed to document that the altered skin integrity had resolved, and the last documentation of the altered skin integrity was related to a procedure performed by the home's staff to the area of altered skin integrity.

Refer to WN #1, findings #1 and #3, and WN #3, finding #1 for further details.

(e) Upon return from hospital, the resident experienced an injury that required monitoring and assessment. The home's Pain Identification and Management policy identified three monitoring and assessment documents that were to be completed; a Pain Flow Note, a Pain Flow Record and a Pain Assessment. Although the resident met criteria for the completion of the documents, none of the documents had been

completed for the resident.

Refer to WN #3, finding #1 for further details.

In summary, resident #003 was not provided with the treatment, care, services or assistance required for their health, safety or well-being, in areas related to required programs, specifically regarding falls prevention and management, skin and wound care and pain management.

The decision to issue a compliance order was based on the severity, which was determined to be a level 3, as actual harm occurred to the resident. The scope was a level 2, as the home demonstrated a pattern of occurrence where resident #003 repeatedly did not receive the treatment, care, services or assistance they required in multiple areas. The home had a level 2 compliance history, as it consists of non-compliance issued in one or more unrelated areas of the legislation. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2019(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, 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:

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 14th day of March, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by SHELLEY MURPHY (684) - (A2)

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

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