Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 17, 2017;	2017_655679_0010 (A1)	019372-17	Resident Quality Inspection

Licensee/Titulaire de permis

AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
130 ELM STREET SUDBURY ON P3C 1T6

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

CEDARWOOD LODGE
860 GREAT NORTHERN ROAD SAULT STE. MARIE ON P6A 5K7

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

MICHELLE BERARDI (679) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested to have the order's compliance date amended to December 29, 2017. A review of the factors presented by the licensee was considered and as a result the compliance date requested was granted.

Issued on this 17 day of November 2017 (A1)

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

Original report signed by the inspector.

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MICHELLE BERARDI (679) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): September 18-22, and 25-29, 2017.

Additional logs inspected during this RQI included:

- One critical incident submitted to the Director related to an allegation of staff to resident neglect;

- Two critical incidents submitted to the Director related to resident to resident abuse;

- One critical incident submitted to the Director related to resident falls;

- One critical incident submitted to the Director related to improper care of a resident; and

- Four complaints submitted to the Director related to the care of residents.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Life Enrichment Manager, Dietary Services Manager, Registered Dietitian (RD), Physiotherapist, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Food Service Worker (FSW), family members and residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, staff personnel files and reviewed numerous licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

14 WN(s)
8 VPC(s)
5 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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. (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).

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 direction to staff and others who provided the direct care to the resident.

During the inspection, resident #009 was identified as experiencing a particular level of continence through a resident observation.

Inspector #613 reviewed the resident's current care plan which identified interventions under a specific focus as follows:
- provide reminders to the resident at specific times.
- a specific number of staff to assist the resident at specific times.

A further review of the care plan identified a contradicting intervention under a different focus as follows;
- a specific continence intervention to be completed at specific times.
- a specific number of staff to provide assistance.

During an interview on September 26, 2017, with PSW #102, they verified that

resident #009's care plan was unclear with respect to their interventions. One area of resident #009's care plan identified that they were to receive a specific continence intervention at certain times, whereas another area within the care plan identified to provide the intervention to the resident at different times. Additionally, one area of the care plan identified that the resident required assistance from a specific number of staff and another area identified that resident #009 required assistance from a different number of staff.

In an interview with RAI Coordinator #106 on September 26, 2017, they identified that the care plan for resident #009 should have provided more clear direction for the staff to follow, and that they were in the process of updating it to reflect the current needs of the resident.

During an interview on September 27, 2017, with the Administrator, they stated that all resident care plans should provide clear direction for staff to follow. The Administrator further indicated that all registered staff, including Registered Nurses (RN's), Registered Practical Nurses (RPN's) and the RAI Coordinator, could update a care plan on med e-care.

2. 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 was given the opportunity to participate fully in the development of the resident's plan of care.

Inspector #679 reviewed a complaint submitted to the Director on a particular date. The complaint alleged that resident #010 was started on a medication without the Substitute Decision Maker (SDM) being notified.

Inspector #679 reviewed the physician's orders for resident #010 and noted an order. The order provided directions for a number of medications. Inspector #679 reviewed the physicians order sheet and could not locate any indication that the family had been notified of the new medication orders.

Inspector #679 reviewed the electronic progress notes for resident #010 and could not identify any documentation to support that the SDM was made aware of the new medication order.

In an interview with the Administrator on September 27, 2017, they confirmed that it was the expectation of the home that a SDM would be notified of any changes to

a resident's medication.

3. 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 Critical Incident report was submitted to the Director on a particular date. The CI report alleged that a staff member improperly transferred residents #010 and #011.

A review of resident #010's electronic care plan, outlined that they required a specific transfer device with assistance from two staff members.

A review of the electronic care plan for resident #011, outlined that a specific transfer device was to be used with assistance from two staff members.

Inspector #679 reviewed the home's internal investigation which identified that on a particular date, PSW #111 told RN #112 that PSW #110 had completed two resident transfers alone utilizing a specific transfer device. A typed interview identified that PSW #110 admitted to using the transfer device alone on resident #010 and #011.

A review of the home's policy entitled "Zero Lift", last revised April 2012, identified that "All transfer lift devices will require two staff or more to be present during the lift".

In an interview with the DOC on September 26, 2017, they identified that all mechanical lift transfers were to be completed with two staff members. The DOC further identified that information regarding the transfer status was to be found in the resident's plan of care.

4. Inspector #679 reviewed two complaints submitted to the Director on two particular dates. The complaint indicated that a resident, suspected to be resident #009, wandered into resident #010's room, causing them to be afraid.

A review of the electronic care plan outlined that resident #010 was to have a specific intervention in place.

On September 26, 2017, and September 27, 2017, Inspector #679 observed resident #010 without the intervention in place.

In an interview with RN #112 on September 27, 2017, they identified that the intervention was to implemented at all times.

5. A Critical Incident (CI) report was submitted to the Director on a specific date, for an incident of abuse that occurred a number of days prior.

For further details refer to WN #3

On September 20, 2017, Inspector #542 reviewed resident #016's care plan. The care plan outlined a specific intervention for behaviours.

On September 26, 2017, Inspector #542 observed resident #016 without the specific intervention in place for a total of approximately 45 minutes.

On September 28, 2017, Inspector #679 observed resident #016 without the intervention in place for approximately 10 minutes.

On September 26, 2017, Inspector #542 interviewed PSW #113, who indicated that the resident had exhibited behaviours in the past and that there were specific interventions in place.

On September 27, 2017, Inspector #542 informed the Administrator that resident #016 was observed without their intervention in place. The Administrator acknowledged that the intervention was to be implemented for resident #016.

6. During a health care record review, it was identified that resident #009 had experienced a number of falls over a 19 day period.

A review of the care plan for resident #009 identified a focus of "falls" with an intervention to ensure that a specific device was in place at specific times.

On a specific date, Inspector #613 observed resident #009 without the device in place from 0900 hours to 1045 hours.

During an interview on September 25, 2017, with PSW #102, they stated that resident #009 was supposed to have the device in place at specific times. PSW #102 confirmed that the device was not implemented as per the care plan.

During an interview on September 27, 2017, with the Administrator, they confirmed that all staff should be following the resident's care plans.

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident or improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

In an interview with resident #008 on a specific date, they identified a concern that occurred a number of months ago in which a staff member refused to provide them assistance with a specific intervention.

On September 18, 2017, Inspector #679 brought forth resident #008's concerns to the DOC.

On September 27, 2017, Inspector #679 reviewed the Ministry of Health and Long-Term Care's (MOHLTC) online CI reporting system and was unable to locate that a CI report related to this allegation was submitted to the Director after being brought forward by Inspector #679.

A review of the policy entitled "Zero Tolerance to Resident Abuse and Neglect" last revised July 2017, outlined that an immediate report was to be made to the MOHLTC Director where there was a reasonable suspicion that the following incidents had occurred or may occur: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

In an interview with the Administrator on September 25, 2017, they identified that they did not have any prior knowledge of this occurrence. The Administrator identified that they did not complete an investigation into this allegation because the resident was unable to recall the date that it had occurred, the person that the resident had notified when it occurred, and that the staff member involved no longer worked in the home.

2. A Critical Incident (CI) report was submitted to the Director on a particular date, for an incident that had occurred a number of days prior. The CI report submitted under "Improper/ Incompetent treatment of a resident" alleged that a staff member improperly transferred residents #010 and #011.

A review of the homes policy entitled "Zero tolerance to resident abuse and neglect" last revised July, 2017, identified that where there was a reasonable suspicion that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident had occurred, an immediate report to the Director was to be made.

In an interview with Inspector #679, the homes Administrator identified that they attempted to submit the CI report, however, they encountered technical issues with the system. Inspector #679 requested to review documentation to support that the Administrator attempted to submit the report within the allotted time, however the Administrator was unable to provide any documentation. Further, the Administrator identified that it was the expectation of the home that any instances of improper or incompetent treatment or care of a resident, that resulted in harm or a risk of harm to the resident was reported to the Director immediately. [s. 24. (1)]

3. Inspector #542 reviewed a Critical Incident (CI) report that was submitted to the Director on a particular date, for an alleged incident of abuse that had occurred on a particular date. The CI report indicated that resident #016 performed an action towards another resident.

On September 20, 2017, Inspector #542 reviewed the electronic progress notes for resident #016 and noted that on a particular date, an incident of physical abuse had occurred. Inspector #542 was unable to locate any further information regarding the incident.

Inspector #679 reviewed the Ministry of Health and Long-Term Care's online reporting portal and did not identify a CI report related to this incident.

On September 28, 2017, Inspector #542 interviewed the Administrator who identified that the previous Administrator/Director of Care did not notify the Director of this incident by submitting a CI report. The Administrator further identified that they were unable to locate any documentation to indicate that an investigation into this incident was completed.

Additional Required Actions:

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

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 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 protected from abuse by anyone and that residents were not neglected by the licensee or staff.

A) According to the Long-Term Care Homes Act (LTCHA), 2007 O. Reg 79/10, sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member. According to the LTCHA, physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.

A Critical Incident (CI) report was submitted to the Director on a particular date, for an alleged incident of abuse that had occurred a number of days prior. The CI report indicated that resident #016 performed an action towards a co-resident. As per the CI report, the home documented that they had updated resident #016's care plan to indicate a specific intervention. Resident #016's family member was upset and indicated that they should have always been implementing that intervention. It was also documented in the CI report that there had not been any previous incidents in the past or since their admission.

Inspector #542 reviewed resident #016's admission documents which indicated that they were admitted to the home on a particular date. The admission documents contained documentation which identified that resident #016 had a history of behaviours.

Inspector #542 interviewed resident #016's POA on September 28, 2017. Resident #016's POA indicated that the home was made aware of the resident's history of behaviours on admission to the home, and that a particular intervention should have been been implemented. Inspector #542 asked the POA if they had been made aware of a altercation between resident #016 and a co-resident that had occurred on a particular date. The POA indicated that at that time they were made aware and reminded the staff member that a particular intervention should be implemented at all times.

On September 20, 2017, Inspector #542 reviewed resident #016's care plan that was in place prior to the submission of the CI report. The care plan did not include any information regarding resident #016's potential to exhibit behaviours.

On September 20, 2017, Inspector #542 reviewed resident #016's Resident Assessment Protocol (RAP) that was completed on a particular date (a number of days post admission to the home). It was documented that resident #016 had exhibited behaviours.

On September 20, 2017, Inspector #542 reviewed the progress notes for resident #016 and the following was documented regarding their behaviours:

On a particular date, resident #016 performed an inappropriate action towards co-residents.

On a particular date, a resident complained to a staff member that resident #016 was inappropriate towards them.

On a particular date, resident #016 was observed performing an inappropriate action towards a co-worker.

On a particular date, resident #016 was physically responsive to a co-resident.

B) According to the Long-Term Care Homes Act, 2007, section 6 (7), stipulated

that the licensee shall ensure the care set out in the plan of care is provided to the resident as specified in the plan.

On September 20, 2017, Inspector #542 reviewed resident #016's care plan. The care plan outlined a specific intervention that was to be implemented for resident #016.

See WN #1-5 for further details.

On September 26, 2017, Inspector #542 observed resident #016 without the specific intervention in place for a total of approximately 45 minutes.

On September 28, 2017, Inspector #679 observed resident #016 without the intervention in place for approximately 10 minutes.

C) According to the Long Term Care Homes Act, 2007, s. 24 (1) 2, stipulated that the licensee shall ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

See WN #2-3 for further details.

D) According to the Long Term Care Homes Act, 2007, r. 26. (3) 5, stipulated that the licensee shall ensure that a plan of care must be based on, at minimum, interdisciplinary assessments of the following with respect to the resident: Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

See WN #12 for further details.

On September 26, 2017, Inspector #542 interviewed PSW #113. They stated that the resident had exhibited inappropriate behaviours and that specific interventions were to be implemented.

On September 27, 2017, Inspector #542 interviewed the Resident Assessment Instrument (RAI) Coordinator who verified that when the RAP assessment was

completed on a specific date, for resident #016, that all of their behaviours should have been documented in the care plan. They acknowledged that the care plan was not updated to reflect resident #016's behaviours until after the incident occurred on a specific date.

On September 27, 2017, Inspector #542 interviewed the Administrator, who indicated that they were not aware on admission that resident #016 had exhibited behaviours prior to their admission to the home. Inspector #542 showed the Administrator the documents that came with the resident to the home on admission that outlined their past history of behaviours. Inspector #542 also informed the Administrator that the initial RAPS assessment that was completed on a particular date, outlined that there was a previous history. The Administrator acknowledged that this information should have been included in the care plan. The Administrator was also made aware that Inspector #542 observed resident #016 without their intervention in place on more than one occasion.

The home was provided with documentation that outlined that the resident had exhibited behaviours in the past. The home then failed to ensure that resident #016's care plan identified all of their behaviours even after the completion of a RAP assessment that outlined their behaviours on a particular date. The progress notes identified a number of other incidents, whereby the resident exhibited inappropriate behaviours, leading to a specific date when the CI report was submitted. The licensee then updated the care plan. The licensee has also failed to ensure that resident #016 was monitored as indicated on their plan of care.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 003

WN #4: 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 circumstance of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

During a staff interview, resident #005 was identified as having experienced a recent fall.

A health care record review was completed for a two month period, which identified that resident #005 had experienced a number of falls.

The Inspector reviewed the post falls assessments on MED e-care and was unable to locate post falls assessments for any of the resident's falls.

A review of the home's policy entitled "Falls" last reviewed February 2014, identified that a head to toe assessment (including Head injury routine for any un-witnessed falls and falls where resident reports that he/she hit their head during the fall) was to be completed after a resident experienced a fall.

During an interview on September 26, 2017, with the RAI Coordinator, they reviewed the post falls assessments and stated there were not any post falls on MED e-care.

During interviews on September 28, 2017, with RPN #121 and RN #112, they stated that registered staff were required to complete a post falls assessment on MED e-care within 24 hours after a resident had fallen.

During an interview on September 26, 2017, with the Administrator, they confirmed that there were no post falls assessments on MED e-care for the identified falls experienced by resident #005; registered staff should have completed the post falls assessments for all falls.

2. During a staff interview, resident #009 was identified as having experienced a recent fall.

A review of the health care record by Inspector #613 revealed that resident #009 had experienced a number falls over the period of 19 days.

Inspector #613 reviewed the post falls assessment section on MED e-care and was unable to locate a post falls assessments for any of the falls.

During an interview with the RAI Coordinator on September 27, 2017, they reviewed the post falls assessments section on MED e-care and informed the Inspector that a number of post falls assessments for some of the identified falls were started, but were incomplete, and that a number of post falls assessments for a number of the falls had not been completed.

During interviews with RPN #121 and RN #112 on September 28, 2017, they stated that registered staff were required to complete a post falls assessment on MED e-care within 24 hours after a resident had fallen.

During an interview on September 28, 2017, with the Administrator, they stated that post fall assessments were to be completed within 24 hours post fall, and that registered staff were to document in the progress notes for 72 hours following a fall.

A review of the post falls assessments on MED e-care on a specific date identified that all incomplete post falls assessments had been completed late past the 24 hour time frame; furthermore, a number of post falls assessments for the falls experienced by resident #009 remained unfinished.

3. Inspector #542 reviewed a complaint submitted to the Director on a specific date. The complaint identified that resident #015 experienced a fall on a specific date and that the complainant was concerned that the resident was not assessed immediately.

On September 21, 2017, Inspector #542 completed a health care record review for resident #015. The care plan included documentation to indicate that the resident was assessed for being at a specific risk level for falls. The care plan also outlined specific interventions to prevent or decrease resident #015 from falling. A review of the progress notes, described the fall that occurred on a specific date. Inspector #542 was unable to locate a post-falls assessment during the record review.

On September 26, 2017, Inspector #542 interviewed the Administrator. Inspector #542 informed the Administrator that they were unable to locate a post-falls assessment for resident #015. The Administrator identified that they were also unable to locate a post fall assessment. Subsequently, the Administrator identified that post fall assessments were to be completed 24 hours post fall and that registered staff were to document within the progress notes for 72 hours following a fall.

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

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

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirement was met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: staff apply the physical device in accordance the manufacturer's instruction.

During the inspection, resident #009 was identified as having a potential restraint which was applied incorrectly.

Inspector #613 observed the resident in their wheelchair with a specific device in place on a particular date.

A review of the physician's orders identified that the device was ordered a number of days prior.

A review of the plan of care, indicated that resident #009 required a specific device

for safety. The resident's care plan directed staff to check the resident and release the device as per protocol.

During various observations, Inspector #613 noted that resident #009 would perform an action which would modify the application of the device.

A review of the manufacturer's instruction for the specific device identified that when it was properly applied the device could not be modified.

A review of the electronic progress notes on MED e-care identified that resident #009 had fallen on a particular date, where they were found sitting on the floor in a specific location. RN #123 had documented that it appeared that resident #009 had slid under the device and onto the floor. The progress notes did not identify any further action taken by RN #123 on the shift that the incident had occurred or by the registered staff on the following shift, to ensure the resident's safety, despite being aware of the improper application of the device.

On a particular date, Inspector #613 went to speak with the Physiotherapist (PT) regarding the reassessment of resident #009's device for their mobility aid. During this time, Inspector #542 observed resident #009 sliding out of their mobility aid resulting in the device being positioned improperly.

Physiotherapist #122 assessed the mobility aid and noted that the device was not applied properly. This resulted in the device leaving enough of a gap for resident #009 to slide underneath it. PT #122 re-adjusted the device appropriately to prevent the resident from sliding underneath it. PT #122 initiated the request for the mobility aid technician to check the device for safety.

As the Physiotherapist was reassessing the device on a particular date, RPN #120 informed Inspector #613 that resident #009 had slid out of their mobility aid through the device and was found on the floor. RPN #120 indicated that they had called the Medical Director, who ordered an urgent reassessment of the device to prevent the resident sliding from their mobility aid; however, the RPN had not yet wrote the order or informed PT #122.

Inspector #613 interviewed PT #122, who stated that a referral was received from staff on a specific date, and that an assessment was completed. PT #122 stated that resident #009 currently used a mobility aid and they were unsure if the vendor or a staff member applied the device. PT #122 confirmed that the device had not

been applied appropriately. During the same interview, PT #122 stated that they had not received another referral to check the mobility aid or the device. PT #122 stated that staff should have completed a referral and that they could have asked a physiotherapy assistant who works in the home each morning to assess the device, as well as leave a note requesting that the Physiotherapist assess the mobility aid.

During an interview on September 27, 2017, with the Administrator, they confirmed that the registered staff should have taken action, such as calling the vendor or making a referral to physiotherapist, to prevent resident #009 from sliding out of their mobility aid to ensure their safety, as staff were aware of the improper fitting device. [s. 110. (1) 1.]

2. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were documented; all assessment, reassessment and monitoring, including the resident`s response.

During the inspection, resident #009 was identified as having a potential restraint that was applied incorrectly.

On September 19, 2017, Inspector #613 observed the resident using their mobility aid with a specific device in place.

A review of the physician's orders identified that a restraint was ordered on a specific date.

A review of the care plan specific to restraints, indicated that resident #009 required a specific device for safety while using their mobility aid.

Inspector #613 reviewed the home's "Restraint Monitoring Record" for resident #009 over the period of a number of days and identified that resident #009's condition was not reassessed, nor was the effectiveness of the device evaluated by a member of the registered nursing staff at least every eight hours on a number of dates.

During an interview with RN #112 on September 28, 2017, they stated that registered staff were to sign off on the Restraint Monitoring Record every eight

hours; RN #112 confirmed that this had not been done on a number of dates. RN #112 stated that the purpose of them signing was to ensure that the PSW's documented their hourly checks. If signatures from the PSW's were missing, they were responsible to notify the PSWs to complete their documentation on the sheet. RN #112 further stated that registered staff should have identified and documented what they had done with the device, such as assessing, reassessing and monitoring the use of the device.

During an interview on September 28, 2017, with the Director of Care, they confirmed that registered staff were required to document on the Restraint Monitoring Record that they had assessed, reassessed and were monitoring the resident. The Director of Care verified that the lack of documentation for resident #009 on the Restraint Monitoring Record was unacceptable. [s. 110. (7) 6.]

3. On September 21, 2017, Inspector #542 completed a health care record review for resident #015. The care plan included documentation to indicate that the resident was to have a specific device in place when using their mobility aid.

During observations on September 25 and 26, 2017, Inspector #542 observed resident #015 using their mobility aid with a specific device in place.

Inspector #542 reviewed the "Restraint Monitoring Record" over a period of a number of days and identified the following:

- On a particular date, the restraint was last checked at a certain time. There was no further documentation regarding the removal, releasing or repositioning until the following day.
- On a particular date, there was no documentation to indicate that a registered staff member had re-assessed the need for the restraint from a particular date until the following day.
- On a particular date, the documentation identified that the restraint was applied at a specific time. However, there was no further documentation until the following date.
- On a particular date, the record was missing documentation to support that the device was re-assessed by a member of the registered nursing staff.

On September 26, 2017, Inspector #542 reviewed the home's policy, titled, "Least Restraint Program" last reviewed June 2014. The policy indicated that the resident's condition was to be reassessed at least every eight hours by a member

of the registered nursing staff. The policy further indicated that the restraint monitoring record was to be completed on each shift to demonstrate when the restraint was applied, removed, when the resident was repositioned, and the effect it had on the resident. [s. 110. (7) 6.]

4. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that every release device and all repositioning was documented.

During the inspection, resident #009 was identified as having a potential restraint which was applied incorrectly.

On September 19, 2017, Inspector #613 observed the resident using their mobility aid with a specific device in place.

A review of the physician's orders identified that a restraint was ordered on a particular date.

A review of the care plan specific to restraints, indicated that resident #009 required a specific device for safety while using their mobility aid. The resident's care plan directed staff to check the resident and release the device as per protocol.

The Inspector reviewed the home's Restraint Monitoring Record for the resident over a period of days, and identified the following;
On a specific date: no hourly checks for 9 hours.
On a specific date: no hourly checks for 8 hours.
On a specific date: no hourly checks for 8 hours.
On a specific date: no hourly checks for 8 hours.

During an interview with PSW #102, they stated that they were required to document every hour when they applied, repositioned or removed the device.

During an interview with RN #112 on September 28, 2017, they stated that registered staff were to sign off on the Restraint Monitoring Record every eight hours. RN #112 stated that the purpose of them signing was to ensure that the PSW's documented their hourly checks. If signatures from the PSW's were missing, they were responsible to notify the PSW's to complete their

documentation on the sheet. RN #112 further stated that PSWs should have identified and documented what they had done with the device such as applying, monitoring and releasing.

During an interview with the Director of Care on September 28, 2017, they confirmed that staff should have identified and documented what they had done with the restraint, such as applying, positioning and releasing. The Director of Care verified that the lack of documentation for resident #009 on the Restraint Monitoring Record was unacceptable.

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 005

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 ensuring that when residents #009 and #015 are restrained by a physical device under section 31 of the Act that the following is documented: any assessment, reassessment and monitoring, including the residents response and every release of the device and all repositioning, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy promoting zero tolerance of abuse and neglect was complied with.

Inspector #679 reviewed a Critical Incident (CI) report submitted to the Director on a particular date. The CI report outlined an incident of alleged neglect towards resident #012, in which RN #108 failed to perform a specific intervention.

Neglect is defined within the Ontario Regulation 79/10 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 review of the CI report identified that on a particular date PSW #109 informed RN #108 that resident #012 required assistance with a specific wound care intervention. The CI report identified that the resident's wound care intervention had not been initiated for a specific amount of time.

Inspector #679 reviewed resident #012's medication record. The record identified that the resident's intervention was scheduled daily at a specific time and when required.

A review of a written statement dated a particular date, identified that at a certain time PSW #109 informed RN #108 that resident #012 needed assistance with an intervention. The letter further identified that a number of hours later, the intervention was not completed.

A review of a typed statement dated a particular date, identified that on a particular date, resident #012 was received in a condition which indicated that the intervention was not completed.

In an interview with Inspector #679 on September 27, 2017, RN #108 indicated that they could not recall the details of that shift, but that the intervention was not done.

b) Inspector #679 reviewed a hand written statement dated a particular date, included within the home's internal investigation. The statement identified that on a particular date, staff found resident #012 sitting in a unclean bed. The statement identified that resident #012 was upset stating that they required assistance and no one would help them. Furthermore, the letter identified that RN #108 commented to the staff that resident #012 was yelling the "entire time" and when approached to ask why the resident was left in that condition RN #108 stated "what did you want me to do about it?".

Inspector #679 reviewed a document dated on a particular date, which indicated that RN #108 was terminated from the home on specific grounds.

In an interview with the DOC on September 26, 2017, they indicated that the neglect was substantiated and that RN #108 was terminated from the home.

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 ensuring that the policy promoting zero tolerance of abuse and neglect is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the requirements were met with respect to every plan of care and that the care plan was based on at a minimum, interdisciplinary assessment of the following with respect to the resident: mood and behaviour patterns, including wandering, any identified responsive behaviours, and potential behavioural triggers and variations in resident functioning at different times of the day.

A CI report was submitted to the Director on a specific date, for an incident of abuse that occurred a number of days prior. The home documented that they had updated resident #016's care plan to indicate a specific intervention. Resident #016's family member was upset and stated that the intervention should have always been in place.

For further details refer to WN #3

Inspector #542 reviewed resident #016's admission documents which indicated that they were admitted to the home on a specific date. The document included a statement regarding the residents history of behaviours.

On September 20, 2017, Inspector #542 reviewed resident #016's care plan that was in place prior to the submission of the CI report. The care plan did not include any information regarding resident #016's potential to exhibit behaviours.

On September 20, 2017, Inspector #542 reviewed resident #016's Resident Assessment Protocol (RAP) that was completed on a specific date (a number of days post admission to the home). It was documented that resident #016 had exhibited specific behaviours.

Inspector #542 interviewed resident #016's POA on September 28, 2017. Resident #016's POA indicated that the home was made aware of the resident's history of behaviours on admission to the home.

On September 27, 2017, Inspector #542 interviewed the Resident Assessment Instrument (RAI) Coordinator who verified that when the RAP assessment was completed on a specific date, for resident #016, that all of their behaviours should have been documented in the care plan. They acknowledged that the care plan was not updated to reflect resident #016's behaviours until after the incident occurred on a specific date.

On September 27, 2017, Inspector #542 interviewed the Administrator, who indicated that they were not aware on admission that resident #016 had exhibited behaviours. Inspector #542 showed the Administrator the documents that came with the resident to the home on admission that outlined their history of behaviours. Inspector #542 also informed the Administrator that the initial RAPS assessment that was completed on a specific date, outlined that there was a previous incident involving resident #016. The Administrator acknowledged that this information should have been in the plan of care.

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 ensuring that resident #016's plan of care is based on at a minimum, an interdisciplinary assessment of the resident, with respect to their mood and behaviour patterns, including wandering, any identified responsive behaviours, and the potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining of a resident by a physical device was included in the plan of care only if the following requirement was satisfied: A physician, registered nurse in the extended class or other person provided for in the regulation has ordered or approved the restraining.

On September 21, 2017, Inspector #542 completed a health care record review for resident #015. The care plan included documentation to indicate that the resident was to have a specific device in place. Inspector #542 observed that the home had obtained a consent from the Power of Attorney.

Inspector #542 reviewed the resident's health care record and was unable to locate an order by either a physician or a registered nurse in the extended class for the use of the restraint.

Throughout the Inspection, Inspector #542 observed resident #015 with the specific device in place.

In interviews with Inspector #542 on September 29, 2017, PSW #109 and PSW #104 indicated that resident #015 used a specific device.

A review of the home's policy entitled, "Least Restraint Program" last reviewed June 2014, identified that staff were to apply the specific device once it had been ordered or approved by a physician or a registered nurse in the extended class.

On September 28, 2017, Inspector #542 interviewed the Administrator, regarding the use of the device without a physician's order. The Administrator and Inspector #542 reviewed the health care record and were unable to locate an order for the use of the device. The device was being applied without an order for a number of days.

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 ensuring that the restraining of a resident by a physical device is included in the plan of care only if the following requirement is satisfied: a physician, registered nurse in the extended class, or other person provided for in the regulation has ordered and approved the restraining, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items.

On September 18, 2017, Inspectors #613 and #679 observed the following used and unlabelled personal care items in the residents’ shared rooms or bathrooms: one comb and one bottle of hand cream.

On September 19, 2017, Inspectors #613 and #679 observed the following used and unlabelled personal care items in residents’ shared rooms or bathrooms:

- In a specific room, one bottle of body wash, one bottle of body lotion, three toothbrushes and two bars of soap;
- In a specific room, one hair comb and one tooth brush;
- In a specific room, one toothbrush, one comb and one toothbrush;
- In a specific room, one urinal, one toothbrush and one denture cup;
- In a specific room, one denture cup and a pair of eye glasses;
- In a specific room, one denture cup, two toothbrushes and two combs;
- In a specific room, one hair brush, one comb, one toothbrush and two denture cups; and
- In a specific room, one hairbrush, two toothbrushes.

A review of the home’s policy titled, "Personal Care - Resident Personal Items" implemented July 2010, identified that all personal items must be labelled within seven days of admission and when new items were received by the resident. The policy identified that the resident's name was to be on the personal items that the resident was using within his/her room.

During interviews on September 28, 2017, with the Administrator and Director of Care, they confirmed that all personal care items were to be labelled within 48 hours from admission and when acquiring new personal care items.

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 ensuring that each resident of the home has his or her personal belongings, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #10: 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.

Inspector #679 reviewed a CI report submitted to the Director on a specific date. The CI report outlined an incident of alleged neglect towards resident #012, in which RN #108 failed to perform a specific intervention.

A review of the care plan outlined that resident #012 began exhibiting altered skin integrity on a specific date, and was diagnosed with a condition a number of weeks after.

A review of the electronic wound assessments identified that wound assessments were completed for resident #012's altered skin integrity on a number of occasions. The wound assessments were each completed a number of weeks or days from the prior assessment.

Inspector #679 reviewed the home's policy entitled "Skin care program: assessment and care planning" last reviewed July 2017. The policy identified that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, a skin tear or a wound, was to receive a weekly skin assessment by a member of the registered nursing staff.

In an interview with the DOC on September 26, 2017, they identified to Inspector #679 that skin assessments were to be completed weekly, and that this did not occur for resident #012.

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 ensuring that any 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, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following was developed to meet the needs of residents with responsive behaviours: protocols for the referral of residents to specialized resources where required.

A Critical Incident (CI) report was submitted to the Director on a specific date, for an incident of abuse that occurred a number of days prior.

For further details refer to WN #3

On September 28, 2017, Inspector #542 reviewed the home's policies and procedures regarding responsive behaviours. Inspector #542 was unable to identify any documentation regarding protocols for the referral of residents to specialized resources.

On September 28, 2017, Inspector #542 interviewed the Administrator who identified that the home did not have any protocols for the referral of residents with responsive behaviours to specialized resources.

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 ensuring that protocols are developed for the referral of residents to specialized resources, to meet the needs of residents with responsive behaviours, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review, in order to reduce and prevent medication incidents/adverse drug reactions, that any changes and improvements identified in the review were implemented and that a written record was kept of everything provided in clause (a) and (b).

On September 21, 2017, Inspector #613 requested to view the home's quarterly medication review as part of a mandatory task for the resident quality inspection (RQI).

During an interview with the Director of Care on September 25, 2017, they confirmed that they did not have a quarterly review to provide to the Inspector at this time. The DOC indicated that they were working on completing the quarterly medication review. The DOC further informed Inspector #613 that the former Director of Care had not completed the quarterly review to analyze the trends for the medication errors from January to June 2017.

A review of policy titled, "Medication Management Committee" approved April 1, 2015 (no revision date), identified that the Medication Management Committee would meet at minimum quarterly to evaluate the effectiveness of the medication management system and implement changes identified in the quarterly evaluation. [s. 135. (3)]

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 ensuring that a quarterly review is undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review, in order to reduce and prevent medication incidents/adverse drug reactions, that any changes and improvements identified in the review are implemented and that a written record is kept of everything provide in clause (a) and (b), to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute-decision maker.

A) During a family interview with Inspector #679 on a particular date, resident #004's family member identified that they had only participated in a specific number of care conference since the resident was admitted to the home.

Inspector #679 reviewed the electronic progress notes and identified one note titled "care conference" documented on a specific date. The inspector did not locate any further documentation to identify that a care conference was held within six weeks of admission, or for 2017.

In an interview with the Administrator, they identified that the initial care conference record for resident #004 was likely completed on a paper record, and stored within the resident's thinned chart. The Administrator was unable to provide the Inspector with a record to indicate that the initial care conference was held for resident #004.

B) Inspector reviewed a complaint submitted to the Director on a specific date. The complaint identified that home had not reviewed the plan of care with resident #004's family.

Inspector #679 reviewed the electronic progress notes and was unable to locate any notes to identify that a care conference had been held since resident #004's admission to the home.

In an interview with the Administrator they identified that care conferences were held annually, and that no care conference had been held for resident #004.

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a Personal Assistance Services Device (PASD) had been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with the authority to give that consent.

During the inspection, resident #005 was identified as using a specific device through a resident observation.

Throughout the inspection, resident was observed with the specific device in place.

A review of resident #005's care plan identified that the device was used for comfort and that the resident was able to undo the device on command.

Inspector #613 reviewed resident #005's plan of care, which did not identify a consent for the use of the specific device.

During an interview with RPN # 117 on September 27, 2017, they confirmed that the device was used as a PASD. RPN #117 stated there should be a signed consent form in the resident's paper chart. RPN #117 reviewed the paper chart and confirmed there was no consent.

During an interview on September 28, 2017, with the Director of Care, they confirmed there should have been a signed consent form prior to the use of the PASD and the signed consent form should have been on the resident's paper chart.

Issued on this 17 day of November 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MICHELLE BERARDI (679) - (A1)

Inspection No. / No de l'inspection : 2017_655679_0010 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 019372-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Nov 17, 2017;(A1)

Licensee / Titulaire de permis : AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
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LTC Home / Foyer de SLD : CEDARWOOD LODGE
860 GREAT NORTHERN ROAD, SAULT STE. MARIE, ON, P6A-5K7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Crystal Morettin

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 AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan which will ensure that the care set out in the plan of care is provided to all residents as specified in their plan, specifically ensuring that:

a) The care set out in the care plan is provided to resident #009 as specified, in relation to fall prevention interventions;

b) The care set out in the care plan is provided to resident #010 as specified, in relation to the prevention of behaviours;

c) The care set out in the care plan is provided to resident #016 as specified, in relation to their behaviours;

d) The care set out in the care plan is provided to resident's #010 and #011 as specified, in relation to their transfer techniques.

The plan is due on November 7, 2017, and the order is to be complied by November 24, 2017.

Grounds / Motifs :

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

During a health care record review, it was identified that resident #009 had experienced a number of falls over a 19 day period.

A review of the care plan for resident #009 identified a focus of "falls" with an intervention to ensure that a specific device was in place at specific times.

On a specific date, Inspector #613 observed resident #009 without the device in place from 0900 hours to 1045 hours.

During an interview on September 25, 2017, with PSW #102, they stated that resident #009 was supposed to have the device in place at specific times. PSW #102 confirmed that the device was not implemented as per the care plan.

During an interview on September 27, 2017, with the Administrator, they confirmed that all staff should be following the resident's care plans. (613)

2. A Critical Incident (CI) report was submitted to the Director on a specific date, for an incident of abuse that occurred a number of days prior.

For further details refer to WN #3

On September 20, 2017, Inspector #542 reviewed resident #016's care plan. The care plan outlined a specific intervention for behaviours.

On September 26, 2017, Inspector #542 observed resident #016 without the specific intervention in place for a total of approximately 45 minutes.

On September 28, 2017, Inspector #679 observed resident #016 without the intervention in place for approximately 10 minutes.

On September 26, 2017, Inspector #542 interviewed PSW #113, who indicated that the resident had exhibited behaviours in the past and that there were specific interventions in place.

On September 27, 2017, Inspector #542 informed the Administrator that resident #016 was observed without their intervention in place. The Administrator acknowledged that the intervention was to be implemented for resident #016. (542)

3. Inspector #679 reviewed two complaints submitted to the Director on two particular dates. The complaint indicated that a resident, suspected to be resident #009, wandered into resident #010's room, causing them to be afraid.

A review of the electronic care plan outlined that resident #010 was to have a specific intervention in place.

On September 26, 2017, and September 27, 2017, Inspector #679 observed resident #010 without the intervention in place.

In an interview with RN #112 on September 27, 2017, they identified that the intervention was to implemented at all times. (679)

4. A Critical Incident report was submitted to the Director on a particular date. The CI report alleged that a staff member improperly transferred residents #010 and #011.

A review of resident #010's electronic care plan, outlined that they required a specific transfer device with assistance from two staff members.

A review of the electronic care plan for resident #011, outlined that a specific transfer device was to be used with assistance from two staff members.

Inspector #679 reviewed the home's internal investigation which identified that on a particular date, PSW #111 told RN #112 that PSW #110 had completed two resident transfers alone utilizing a specific transfer device. A typed interview identified that PSW #110 admitted to using the transfer device alone on resident #010 and #011.

A review of the home's policy entitled "Zero Lift", last revised April 2012, identified that "All transfer lift devices will require two staff or more to be present during the lift".

In an interview with the DOC on September 26, 2017, they identified that all mechanical lift transfers were to be completed with two staff members. The DOC further identified that information regarding the transfer status was to be found in the resident's plan of care.

The decision to issue this compliance order was based on the scope which was determined to be a pattern, having affected more than the fewest number of residents that were inspected, the severity, which indicated potential for actual harm, and the compliance history, which despite previous non-compliance issued, including five voluntary plans of correction (May 2016, report # 2016_339617_0019; January 2016, report # 2016_281542_0003; October 2015, report # 2015_281542_0021; August 2015, report # 2015_339617_0018; and July 2015, report # 2015_281542_0013) and one compliance order (October 2016, report #2016_395613_0019) noncompliance continued with this section of the legislation. (679)

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Dec 29, 2017(A1)

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

The licensee shall prepare, submit and implement a plan that ensures that any person who has reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director:

a) abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident;

B) improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The plan is due on November 7, 2017, and the order is to be complied by November 24, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident or improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Inspector #542 reviewed a Critical Incident (CI) report that was submitted to the Director on a particular date, for an alleged incident of abuse that had occurred on a particular date. The CI report indicated that resident #016 performed an action towards another resident.

On September 20, 2017, Inspector #542 reviewed the electronic progress notes for resident #016 and noted that on a particular date, an incident of physical abuse had occurred. Inspector #542 was unable to locate any further information regarding the incident.

Inspector #679 reviewed the Ministry of Health and Long-Term Care's online reporting portal and did not identify a CI report related to this incident.

On September 28, 2017, Inspector #542 interviewed the Administrator who identified that the previous Administrator/Director of Care did not notify the Director of this incident by submitting a CI report. The Administrator further identified that they were unable to locate any documentation to indicate that an investigation into this incident was completed. (542)

2. A Critical Incident (CI) report was submitted to the Director on a particular date, for an incident that had occurred a number of days prior. The CI report submitted under "Improper/ Incompetent treatment of a resident" alleged that a staff member improperly transferred residents #010 and #011.

A review of the homes policy entitled "Zero tolerance to resident abuse and neglect" last revised July, 2017, identified that where there was a reasonable suspicion that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident had occurred, an immediate report to the Director was to be made.

In an interview with Inspector #679, the homes Administrator identified that they attempted to submit the CI report, however, they encountered technical issues with the system. Inspector #679 requested to review documentation to support that the Administrator attempted to submit the report within the allotted time, however the Administrator was unable to provide any documentation. Further, the Administrator identified that it was the expectation of the home that any instances of improper or incompetent treatment or care of a resident, that resulted in harm or a risk of harm to the resident was reported to the Director immediately. (679)

3. In an interview with resident #008 on a specific date, they identified a concern that occurred a number of months ago in which a staff member refused to provide them assistance with a specific intervention.

On September 18, 2017, Inspector #679 brought forth resident #008's concerns to the DOC.

On September 27, 2017, Inspector #679 reviewed the Ministry of Health and Long-Term Care's (MOHLTC) online CI reporting system and was unable to locate that a CI report related to this allegation was submitted to the Director after being brought forward by Inspector #679.

A review of the policy entitled "Zero Tolerance to Resident Abuse and Neglect" last revised July 2017, outlined that an immediate report was to be made to the MOHLTC Director where there was a reasonable suspicion that the following incidents had occurred or may occur: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

In an interview with the Administrator on September 25, 2017, they identified that they did not have any prior knowledge of this occurrence. The Administrator identified that they did not complete an investigation into this allegation because the resident was unable to recall the date that it had occurred, the person that the resident had notified when it occurred, and that the staff member involved no longer worked in the home.

The decision to issue this compliance order was based on the scope which was determined to be a pattern, having affected more than the fewest number of residents that were inspected, the severity, which indicated potential for actual harm and actual harm, and the compliance history, which despite previous noncompliance issued, including, two voluntary plans of correction (December 2015, report #2015_395613_0022; and October 2015, report #2015_281542_0021), and two compliance orders (October 2016, report #2016_395613_0019; and May 2016, report #2016_463616_0013), noncompliance continued with this section of the legislation. (679)

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

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

Dec 29, 2017(A1)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan which ensures that residents are protected from abuse by anyone, specifically, ensuring that residents are protected from abuse by resident #016.

The plan is due on November 7, 2017, and the order is to be complied by November 24, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

A) According to the Long-Term Care Homes Act (LTCHA), 2007 O. Reg 79/10, sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member. According to the LTCHA, physical abuse is defined

as the use of physical force by a resident that causes physical injury to another resident.

A Critical Incident (CI) report was submitted to the Director on a particular date, for an alleged incident of abuse that had occurred a number of days prior. The CI report indicated that resident #016 performed an action towards a co-resident. As per the CI report, the home documented that they had updated resident #016's care plan to indicate a specific intervention. Resident #016's family member was upset and indicated that they should have always been implementing that intervention. It was also documented in the CI report that there had not been any previous incidents in the past or since their admission.

Inspector #542 reviewed resident #016's admission documents which indicated that they were admitted to the home on a particular date. The admission documents contained documentation which identified that resident #016 had a history of behaviours.

Inspector #542 interviewed resident #016's POA on September 28, 2017. Resident #016's POA indicated that the home was made aware of the resident's history of behaviours on admission to the home, and that a particular intervention should have been implemented. Inspector #542 asked the POA if they had been made aware of a altercation between resident #016 and a co-resident that had occurred on a particular date. The POA indicated that at that time they were made aware and reminded the staff member that a particular intervention should be implemented at all times.

On September 20, 2017, Inspector #542 reviewed resident #016's care plan that was in place prior to the submission of the CI report. The care plan did not include any information regarding resident #016's potential to exhibit behaviours.

On September 20, 2017, Inspector #542 reviewed resident #016's Resident Assessment Protocol (RAP) that was completed on a particular date (a number of days post admission to the home). It was documented that resident #016 had exhibited behaviours.

On September 20, 2017, Inspector #542 reviewed the progress notes for resident #016 and the following was documented regarding their behaviours:

On a particular date, resident #016 performed an inappropriate action towards co-

residents.

On a particular date, a resident complained to a staff member that resident #016 was inappropriate towards them.

On a particular date, resident #016 was observed performing an inappropriate action towards a co-worker.

On a particular date, resident #016 was physically responsive to a co-resident.

B) According to the Long-Term Care Homes Act, 2007, section 6 (7), stipulated that the licensee shall ensure the care set out in the plan of care is provided to the resident as specified in the plan.

On September 20, 2017, Inspector #542 reviewed resident #016's care plan. The care plan outlined a specific intervention that was to be implemented for resident #016.

See WN #1-5 for further details.

On September 26, 2017, Inspector #542 observed resident #016 without the specific intervention in place for a total of approximately 45 minutes.

On September 28, 2017, Inspector #679 observed resident #016 without the intervention in place for approximately 10 minutes.

C) According to the Long Term Care Homes Act, 2007, s. 24 (1) 2, stipulated that the licensee shall ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

See WN #2-3 for further details.

D) According to the Long Term Care Homes Act, 2007, r. 26. (3) 5, stipulated that the licensee shall ensure that a plan of care must be based on, at minimum, interdisciplinary assessments of the following with respect to the resident: Mood and

behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

See WN #12 for further details.

On September 26, 2017, Inspector #542 interviewed PSW #113. They stated that the resident had exhibited inappropriate behaviours and that specific interventions were to be implemented.

On September 27, 2017, Inspector #542 interviewed the Resident Assessment Instrument (RAI) Coordinator who verified that when the RAP assessment was completed on a specific date, for resident #016, that all of their behaviours should have been documented in the care plan. They acknowledged that the care plan was not updated to reflect resident #016's behaviours until after the incident occurred on a specific date.

On September 27, 2017, Inspector #542 interviewed the Administrator, who indicated that they were not aware on admission that resident #016 had exhibited behaviours prior to their admission to the home. Inspector #542 showed the Administrator the documents that came with the resident to the home on admission that outlined their past history of behaviours. Inspector #542 also informed the Administrator that the initial RAPS assessment that was completed on a particular date, outlined that there was a previous history. The Administrator acknowledged that this information should have been included in the care plan. The Administrator was also made aware that Inspector #542 observed resident #016 without their intervention in place on more than one occasion.

The home was provided with documentation that outlined that the resident had exhibited behaviours in the past. The home then failed to ensure that resident #016's care plan identified all of their behaviours even after the completion of a RAP assessment that outlined their behaviours on a particular date. The progress notes identified a number of other incidents, whereby the resident exhibited inappropriate behaviours, leading to a specific date when the CI report was submitted. The licensee then updated the care plan. The licensee has also failed to ensure that resident #016 was monitored as indicated on their plan of care.

The decision to issue this compliance order was based on the scope which was

determined to be isolated, having affected one or the fewest number of the population that were inspected, the severity, which indicated actual harm, and the compliance history, which despite previous non-compliance issued, including one voluntary plan of correction (December 2015, report #2015_395613_0022), one compliance order and directors referral (October 2016, report #2016_395613_0019) noncompliance continued with this section of the legislation. (542)

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

Dec 29, 2017(A1)

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

The licensee shall prepare, submit and implement a plan which ensures 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. This plan shall include but not limited to staff training and an auditing process.

The plan is due on November 7, 2017, and the order is to be complied by November 24, 2017.

Grounds / Motifs :

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

Inspector #542 reviewed a complaint submitted to the Director on a specific date. The complaint identified that resident #015 experienced a fall on a specific date and that the complainant was concerned that the resident was not assessed immediately.

On September 21, 2017, Inspector #542 completed a health care record review for resident #015. The care plan included documentation to indicate that the resident was assessed for being at a specific risk level for falls. The care plan also outlined specific interventions to prevent or decrease resident #015 from falling. A review of the progress notes, described the fall that occurred on a specific date. Inspector #542 was unable to locate a post-falls assessment during the record review.

On September 26, 2017, Inspector #542 interviewed the Administrator. Inspector #542 informed the Administrator that they were unable to locate a post-falls assessment for resident #015. The Administrator identified that they were also unable to locate a post fall assessment. Subsequently, the Administrator identified that post fall assessments were to be completed 24 hours post fall and that registered staff were to document within the progress notes for 72 hours following a fall. (542)

2. During a staff interview, resident #009 was identified as having experienced a recent fall.

A review of the health care record by Inspector #613 revealed that resident #009 had experienced a number falls over the period of 19 days.

Inspector #613 reviewed the post falls assessment section on MED e-care and was unable to locate a post falls assessments for any of the falls.

During an interview with the RAI Coordinator on September 27, 2017, they reviewed the post falls assessments section on MED e-care and informed the Inspector that a number of post falls assessments for some of the identified falls were started, but were incomplete, and that a number of post falls assessments for a number of the falls had not been completed.

During interviews with RPN #121 and RN #112 on September 28, 2017, they stated that registered staff were required to complete a post falls assessment on MED e-care within 24 hours after a resident had fallen.

During an interview on September 28, 2017, with the Administrator, they stated that post fall assessments were to be completed within 24 hours post fall, and that registered staff were to document in the progress notes for 72 hours following a fall.

A review of the post falls assessments on MED e-care on a specific date identified that all incomplete post falls assessments had been completed late past the 24 hour time frame; furthermore, a number of post falls assessments for the falls experienced by resident #009 remained unfinished. (613)

3. During a staff interview, resident #005 was identified as having experienced a recent fall.

A health care record review was completed for a two month period, which identified that resident #005 had experienced a number of falls.

The Inspector reviewed the post falls assessments on MED e-care and was unable to locate post falls assessments for any of the resident's falls.

A review of the home's policy entitled "Falls" last reviewed February 2014, identified that a head to toe assessment (including Head injury routine for any un-witnessed falls and falls where resident reports that he/she hit their head during the fall) was to be completed after a resident experienced a fall.

During an interview on September 26, 2017, with the RAI Coordinator, they reviewed the post falls assessments and stated there were not any post falls on MED e-care.

During interviews on September 28, 2017, with RPN #121 and RN #112, they stated that registered staff were required to complete a post falls assessment on MED e-care within 24 hours after a resident had fallen.

During an interview on September 26, 2017, with the Administrator, they confirmed that there were no post falls assessments on MED e-care for the identified falls experienced by resident #005; registered staff should have completed the post falls assessments for all falls.

The decision to issue this compliance order was based on the scope which was determined to be widespread, the severity, which indicated potential for actual harm, and the compliance history, which despite previous non-compliance issued, including, one written notification (July 2015, report #2015_395613_0012) and one VPC (December 2015, report #2015_395613_0022), noncompliance continued with this section of the legislation. (613)

This order must be complied with by /
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Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Dec 29, 2017(A1)

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan which ensures that when a resident is restrained by a physical device under section 31 or section 36 of the Act, that the physical device is applied in accordance with the manufacturer's instructions. This plan shall include but not limited to auditing all residents with a restraint order and ensuring proper application of the restraint in accordance with the manufacturers instructions.

The plan is due on November 7, 2017, and the order is to be complied by November 24, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the following requirement was met with

respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: staff apply the physical device in accordance the manufacturer's instruction.

During the inspection, resident #009 was identified as having a potential restraint which was applied incorrectly.

Inspector #613 observed the resident in their wheelchair with a specific device in place on a particular date.

A review of the physician's orders identified that the device was ordered a number of days prior.

A review of the plan of care, indicated that resident #009 required a specific device for safety. The resident's care plan directed staff to check the resident and release the device as per protocol.

During various observations, Inspector #613 noted that resident #009 would perform an action which would modify the application of the device.

A review of the manufacturer's instruction for the specific device identified that when it was properly applied the device could not be modified.

A review of the electronic progress notes on MED e-care identified that resident #009 had fallen on a particular date, where they were found sitting on the floor in a specific location. RN #123 had documented that it appeared that resident #009 had slid under the device and onto the floor. The progress notes did not identify any further action taken by RN #123 on the shift that the incident had occurred or by the registered staff on the following shift, to ensure the resident's safety, despite being aware of the improper application of the device.

On a particular date, Inspector #613 went to speak with the Physiotherapist (PT) regarding the reassessment of resident #009's device for their mobility aid. During this time, Inspector #542 observed resident #009 sliding out of their mobility aid resulting in the device being positioned improperly.

Physiotherapist #122 assessed the mobility aid and noted that the device was not applied properly. This resulted in the device leaving enough of a gap for resident

#009 to slide underneath it. PT #122 re-adjusted the device appropriately to prevent the resident from sliding underneath it. PT #122 initiated the request for the mobility aid technician to check the device for safety.

As the Physiotherapist was reassessing the device on a particular date, RPN #120 informed Inspector #613 that resident #009 had slid out of their mobility aid through the device and was found on the floor. RPN #120 indicated that they had called the Medical Director, who ordered an urgent reassessment of the device to prevent the resident sliding from their mobility aid; however, the RPN had not yet wrote the order or informed PT #122.

Inspector #613 interviewed PT #122, who stated that a referral was received from staff on a specific date, and that an assessment was completed. PT #122 stated that resident #009 currently used a mobility aid and they were unsure if the vendor or a staff member applied the device. PT #122 confirmed that the device had not been applied appropriately. During the same interview, PT #122 stated that they had not received another referral to check the mobility aid or the device. PT #122 stated that staff should have completed a referral and that they could have asked a physiotherapy assistant who works in the home each morning to assess the device, as well as leave a note requesting that the Physiotherapist assess the mobility aid.

During an interview on September 27, 2017, with the Administrator, they confirmed that the registered staff should have taken action, such as calling the vendor or making a referral to physiotherapist, to prevent resident #009 from sliding out of their mobility aid to ensure their safety, as staff were aware of the improper fitting device.

The decision to issue this compliance order was based on the scope which was determined to be isolated, having affected one or the fewest number of the population that were inspected, the severity, which indicated potential for actual harm, and the compliance history, which despite previous non-compliance issued, including one voluntary plan of correction (May 2015, report #2015_281542_0010) non-compliance continued with this section of the legislation. (613)

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

Dec 29, 2017(A1)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

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

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

Issued on this 17 day of November 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MICHELLE BERARDI - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : Sudbury