Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 11, 2018	2018_624196_0024	004107-18, 004442-18, 006176-18, 006841-18, 007020-18, 008080-18, 008350-18, 009001-18, 009103-18, 009210-18, 009617-18, 009632-18, 010751-18, 011280-18, 011548-18, 011698-18, 015556-18, 015707-18, 015906-18, 018097-18, 022163-18	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street P.O. Box 3251 THUNDER BAY ON P7B 5G7

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

Hogarth Riverview Manor
300 Lillie Street THUNDER BAY ON P7C 4Y7

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

LAUREN TENHUNEN (196), KATHERINE BARCA (625), MELISSA HAMILTON (693)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 27 to 31, and September 5 and 6, 2018.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:

- Four regarding infection prevention and control;
- Four regarding alleged staff to resident abuse/neglect;
- Two regarding resident falls;
- One regarding misappropriation of controlled substances;
- One regarding plan of care and medication administration; and
- Six regarding resident elopement.

The following intakes were not inspected during this CIS inspection:
- Three regarding responsive behaviours.

Complaint inspection #2018_624196_0023 and Follow Up inspection #2018_624196_0022 were conducted concurrently with this Critical Incident System (CIS) inspection.

Non-compliance pursuant to the LTCHA, 2007, S.O. 2007, c.8, s. 6 (7), identified from the concurrent CIS inspection will be issued in the Follow Up inspection report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Clinical Managers (CMs), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Infection Prevention and Control IPAC) Facilitator, Resident Assessment Instrument (RAI) Coordinators, Physiotherapist Assistant (PTA), Staff Educator, Staffing Coordinator, Dietary Manager, Dietary Aides, Resident Home Workers (RHWs), family members and residents.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, home's internal investigation notes and complaints, staff education records, as well as reviewed numerous licensee policies, procedure and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 VPC(s)**
- **3 CO(s)**
- **1 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.O. 2007, c.8, 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 written policy to promote zero tolerance of

abuse and neglect of residents was complied with.

The home submitted a CIS report to the Director in 2018, which outlined allegations of a type of abuse by Dietary Aide (DA) #105 towards resident #018. The allegations described DA #105's conduct with resident #018.

O. Reg. 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that were performed by anyone other than a resident.

Inspector #687 reviewed the home’s policy titled “Zero Tolerance of Resident Abuse and Neglect Program” last revised April 2016, which indicated that any form of abuse or neglect by any person, whether through deliberate acts or negligence will not be tolerated.

A record review of the home’s internal investigation notes by Inspector #687, identified that DA #105 received discipline for abuse towards resident #018.

In an interview with DA #105, they stated that they were made aware of the alleged abuse allegation towards resident #018.

During an interview conducted by Inspector #687 with Staffing Clerk #103, they stated that on a specific date in 2018, they were asked to work as a Resident Home Worker (RHW) which included assisting residents with meal service, portering residents to and from an area and making residents' beds. The Staffing Clerk further stated that they were assisting in the dining room and resident #018 was observed to exhibit a specific behaviour. The resident made some statements towards the Staffing Clerk, PSW #108 and DA #105. The DA responded to resident #018, with a statement and the resident and DA exchanged dialogue. The Staffing Clerk further stated that they had sent a detailed email to the Director of Care (DOC) about this incident.

In an interview conducted by Inspector #687 with the DOC, they stated that the reason behind their decision to categorize this incident as one type of abuse rather than another type of abuse was due to the definition of emotional abuse in the legislation. The DOC further stated that they decided this incident was an emotional abuse incident by DA #105 towards resident #018 due to the specific response from the DA towards the resident. [s. 20. (1)]

2. The home submitted a CIS report to the Director, which outlined allegations of neglect by PSW #122 towards resident #019 on a date in 2018.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

Inspector #687 conducted a record review of the home's internal investigation notes, which identified PSW #122 was assigned to provide care to resident #019 on a specific date in 2018. The notes further identified that PSW #122 failed to provide care for resident #019 during the afternoon of that day, and the PSW failed to check the resident's continence product. As a result, the resident sustained an area of impaired skin integrity. Through the home's internal investigation, PSW #122 was found to be neglectful in providing appropriate care to resident #019.

In an interview conducted by Inspector #687 with the CM #130, they stated that they initiated the CIS report when it was reported by RN #116. The CM stated that PSW #122 was scheduled to work on a specific date in 2018, and was assigned to care for resident #019. According to CM #130, the PSW did not check the continence product of the resident after lunch time. The CM further stated that, due to this incident, the resident was found saturated with urine later that evening and was found with an area of impaired skin integrity. The CM stated that the outcome of the internal investigation report was that PSW #122 was neglectful towards the care of resident #019 and therefore received discipline. [s. 20. (1)]

3. The home submitted a CIS report to the Director, which outlined allegations of neglect by staff to multiple residents on a specific date in 2018.

During an interview conducted by Inspector #687 with PSW #112, #113, and #114, they verified that they were working on a specific date in 2018, on one of the units, and they noted that most of the residents’ continence products were completely saturated with urine including their clothing and bedding. PSW #112, #113, and #114 reported this incident to RPN #111 as they all stated that this incident constituted neglect to the majority of the residents on the unit.

During an interview with RPN #111, they verified that PSW #112, #113 and #114

this incident to RN #127. The RPN noted that the staff from the previous shift neglected their duties to provide care for the residents on the unit.

In an interview with the DOC, they verified that PSW #110 was working on the specific date in 2018, and should have led, "the brief rounds" to ensure that all residents that required continence products, were changed on their shift. The DOC further verified that based on their internal investigation, there was an element of neglect on the part of PSW #110; and therefore, they received a particular discipline. [s. 20. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CIS report was submitted to the Director for a fall sustained by resident #025 on a date in 2018, for which the resident was taken to the hospital and that resulted in a significant change in the resident's health status.

Inspector #625 reviewed the home's policy "Falls Prevention and Management Program – RC-15-01-01" last updated February 2017, which identified that a post-fall assessment was to be completed as soon as possible following a fall and referred to the Post-Fall Assessment Tool, Appendix 11. The Inspector reviewed the attached blank "Post-Fall Assessment Tool – Appendix 11" last updated February 2017, which contained assessment for resident's injury, potential contributing factors to the fall, the main root cause of the fall, possible prevention strategies, follow-up, recommendations and falls prevention interventions in place.

Inspector #625 reviewed resident #025's health care record and was not able to locate a completed post-fall assessment, in either an electronic or a hard copy format, for the fall that occurred.

During an interview with RN #171, they stated that a Post-Fall Assessment Tool was required to be completed after a fall. They were not able to locate a Post-Fall Assessment Tool for the fall that occurred on a specific date in 2018, that involved resident #025.

During an interview with RN #155, they acknowledged that a Post-Fall Assessment Tool should have been completed for resident #025 after their fall, which had resulted in a significant injury to the resident. The RN was not able to locate an electronic or a hard copy of the Post-Fall Assessment Tool completed for resident#025's fall on the specific date in 2018.

During an interview with Inspector #625, CM #106, stated that staff should have completed a post-fall assessment for resident #025's fall that occurred on the specific date in 2018. The CM was unable to locate a post-fall assessment completed for the fall, in either the resident's electronic or hard copy health care records. [s. 49. (2)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted to the Director for a fall sustained by resident #025 on a specific date in 2018, for which the resident was taken to the hospital and that resulted in a significant change in the resident's health status.

(a) On two dates in 2018, Inspector #625 observed resident #025 utilizing a safety device.

Inspector #625 reviewed resident #025's health care record including:
- a physician's order dated for a specific date in 2018, for a particular type of safety device. On another date, an undated notation on the order read "added to emar, CP updated". In addition, two nurses' signatures had been entered to signify the processing of the order;
- the electronic Medication/Treatment Administration Record (eMAR/eTAR) which identified that five out of seven, or 71 per cent (%), of the signed shiftly entries for the specific type of safety device were signed as "given";
- the care plan in effect, which did not list the use of a specific type of safety device; and
- the electronic Personal Support Worker (PSW) Flow Sheet for a particular month in 2018, which did not contain entries for the use of a particular type of safety device.

During an interview with resident #025's family member, they stated that the resident used a specific type of safety device.

During the inspection, PSW #151 acknowledged that resident #025 used a specific type of safety device.

During the inspection, PSWs #152 and #153 stated that resident #025 used a specific type of safety device. Both PSWs acknowledged that the use of a specific type of safety device should be included in a resident's care plan.

During an interview with RPN #154, they acknowledged that the use of a specific type of safety device was not listed on resident #025's care plan, although the corresponding physician's order was signed off by two nurses to indicate that the order had been processed and checked.

During an interview with RN #155, they stated that the use of a specific type of safety device was not listed on resident #025's care plan. The RN acknowledged that the use of specific type of safety device listed on the eMAR/eTAR had been signed as given on five out of seven entries, but that staff could not have applied the specific type of safety device if it had not been installed on the resident's mobility aid. The RN stated that RPNs were required to sign for the use of the specific type of safety device as a restraint shiftly on the eMAR/eTAR and PSWs were required to sign for its use hourly on the Flow

Sheets, on which it should be listed. The RN acknowledged that resident #025's care plan did not provide clear direction to staff on the use of the specific type of safety device.

During an interview with Clinical Manager (CM) #106, they acknowledged that the use of a specific type of safety device was not included in resident #025's care plan, that PSWs would be required to sign for their use, and that registered nursing staff could not sign that a specific type of safety device had been "given" if it had not yet been applied to the resident's mobility aid. The CM acknowledged that the plan of care did not provide clear direction to staff regarding resident #025's use of a specific type of safety device.

(b) On two consecutive dates during the inspection, Inspector #625 observed resident #025 laying in bed with a specific PASD in use.

Inspector #625 reviewed resident #025's health care record including:
- the PSW Flow Sheets which listed the specified PASD as an Assistive Device/PASD signed as having been used on 12 out of 30 day, 12 out of 30 evenings and 12 out of 31 night shifts. The day and evening shift entries identified that the resident had used this PASD and the night shift entries identified the resident had used this PASD in a different manor; and
- the current care plan which, under the focus of "Bed Mobility", identified that the resident required particular staff assistance or the use of a transfer aid for all bed mobility due to their medical condition, and indicated the resident utilize the PASD as staff assist them to turn over. The Inspector was unable to locate any further information related to the resident's use of the specified PASD such as when the PASD was/were to be used, and the specification of the PASD, including the number, type and position.

During an interview with RAI Coordinator #156, they acknowledged that resident #025's care plan did not identify the type of PASD used by the resident; they further indicated, knowing that information would be helpful to staff, and the plan of care was not clear as to how the resident moved in bed. [s. 6. (1) (c)]

2. A CIS report was submitted to the Director for a fall experienced by resident #026, for which the resident was taken to the hospital and that resulted in a significant change in the resident's health status.

a) A review of resident #026's current care plan by Inspector #625 identified that:
- under the focus of "Aids to Daily Living/PASD" the resident used a mobility aid with a

specific type of safety device; and
- under the focus of "Restraints" the resident had a specific type of safety device on their mobility aid and that staff were to document on the Restraint Monitoring Tool hourly.

During an interview with RAI Coordinator #156, they stated that resident #026's care plan was confusing to staff as the resident's use of a specific type of safety device listed under the "Restraints" section of their care plan should be listed under the section for PASDs, as the care plan currently reflected that the specific type of safety device was used as a restraint; which, it was not.

During an interview with CM #130, they acknowledged that resident #026's current care plan was unclear as to whether the specific type of safety device used by the resident functioned as a restraint or not.

b) Resident #026's current care plan identified that the resident would be able to transfer safely with a specific number of staff and specified the transfer method.

During an interview with PSW #157, they stated that resident #026 no longer required this number of staff to assist with transfers, but transferred with the assistance of only one staff.

During an interview with Physiotherapy Assistant (PTA) #158, they stated that they transferred resident #026 alone, not using two staff, and described the way the resident transferred.

During an interview with RPN #160, they stated that resident #026's care plan was not clear with respect to the number of staff required to assist the resident to transfer, that it was not clear why the number of staff were listed and believed it was a mistake.

During an interview with CM #130, they stated that resident #026's care plan was not clear as to whether the resident required two staff to transfer or whether they transferred with the assistance of one staff person using a type of transfer.

c) Resident #026's current care plan identified, under the focus of "Restraints" that staff were to use a specific restraint for a particular purpose and that specific fall prevention devices were to be used. The care plan also identified, under the focus of "Sleep and Rest", specifics of sleep location and arrangements.

A review of the resident's Flow Sheet for a particular month in 2018, under the "Assistive Devices Used/PASD [Personal Assistance Services Device]" section, the use of a specific intervention was documented to have occurred on 17 out of 30 day shifts, on 17 out of 30 evening shifts, and on 10 out of 31 night shifts. Each entry documented identified that a specific PASD had been used. The use of another type of safety device was documented to have occurred on three out of 30 day shifts and on eight out of 31 night shifts.

During an interview with co-resident #030, they stated that both residents had a particular sleeping arrangement. When the Inspector approached resident #030's bed with the residents, resident #030 stated that they did not know why the falls prevention device was positioned in a certain way.

During an interview with PSW #159, they stated that resident #026 had particular sleeping arrangements so the safety device would be put down on whatever side of the bed the resident slept on.

During an interview with RPN #160, they stated that resident #026 had particular sleeping arrangements and could not answer why the resident's care plan listed a specific intervention be used while the use of another intervention was documented on the Flow Sheet. The RPN acknowledged that the resident's care plan did not identify how the bed that resident #026 used during particular sleeping arrangements was to be set up to accommodate this arrangement.

During an interview with PTA #158, they stated that resident #026's care plan did not identify how their fall prevention device and a specific intervention would be implemented when they had particular sleeping arrangements.

During an interview with RAI Coordinator #156, they stated that the current care plan was confusing to staff with respect to the resident's use of a specific intervention. The RAI Coordinator acknowledged that the care plan did not specify how the intervention was used, and that some staff may think that the intervention was a restraint as it was listed under the "restraints" heading, when it was a PASD. They also stated that the location of the intervention in the care plan should "be a clue to staff", if the intervention was listed under the PASD heading, it would be a specific intervention and if it was listed under the "restraints" heading, it would be a different intervention [Although resident #026's safety device was listed under the "restraints" heading in their care plan.] [s. 6. (1) (c)]

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

A CIS report was submitted to the Director for a fall sustained by resident #025 on a specific date, for which the resident was taken to the hospital and that resulted in a significant change in the resident's health status.

Inspector #625 reviewed resident #025's health care record including:
- a physician's order dated on a specific date, for a specific type of safety device. Two nurses' signatures, had been entered to signify the processing of the order;
- the electronic Medication/Treatment Administration Record (eMAR/eTAR) which identified that five out of seven, or 71 per cent (%), of the signed shiftly entries for the specific type of safety device were signed as "given";
- a progress note that identified the specific type of safety device had not been administered as it was not yet on [the mobility aid].

The Inspector also reviewed a Motion Specialties log binder which contained an entry which identified that resident #025 required a specific type of safety device. The entry was checked marked in the area titled "done" with an undated note that read "Please Contact OT [Occupational Therapy] to have order put through".

During an interview with Inspector #625, the Manager of Motion Specialties #161, stated that an Occupational Therapist (OT) would have to prescribe the specific type of safety device if it was to be installed on a mobility aid supplied by that vendor. They stated that they did not know if anyone from the home looked at the notes the vendor left in the log binder, for example, if a mobility aid was from a different vendor or needed other follow-up. They said they were not sure if anyone knew that the specific type of safety device had not been applied and required an OT referral. They stated that checking off "done" was the means their employee used to indicate the entry was addressed, but that it did not indicate that a specific type of safety device had been applied to the mobility aid.

During an interview with RN #155, they stated that, to process to physician's order for a specific type of safety device, an email would need to be send to the OT. The RN stated that, even if it was put in the Motions Specialties log binder, it would not be addressed until the vendor received contact from the OT. The RN identified that an email had not been sent to the OT, so the OT would not be aware that the specific type of safety device

had been required. The RN acknowledged that the Motion Specialties log binder contained an entry that indicated staff were to contact OT to have the order put through and that the use of a specific safety device listed on the eMAR/eTAR, although documented as given on five out of seven, or 71 %, of entries, could not have been applied if the safety device had not been installed on the resident's mobility aid.

During an interview with CM #106, they stated the installation of a specific type of safety device would require a referral to OT as part of processing the order. The CM also stated that sometimes Motion Specialties employees would tell the staff on the floor if they needed to do something, but that sometimes Motion Specialties staff would just write it in the binder. They further stated that, if they did not know that they needed to check the binder for communication, it would be missed. The CM acknowledged that the staff could not sign that the specific type of safety device was given if it was not yet installed. [s. 6. (4) (b)]

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

A CIS report was submitted to the Director for a fall sustained by resident #025 on a specific date in 2018, for which the resident was taken to the hospital and that resulted in a significant change in the residents' health status.

On two particular dates, during the inspection, Inspector #625 observed resident #025 laying in bed with specific types of safety devices in place.

Inspector #625 reviewed resident #025's health care record including the PSW Flow Sheet for a particular month in 2018, which indicated the resident had used two specific types of safety devices and a specific type of bed.

Further analysis of the Flow Sheet by Inspector #625, identified:
- the use of one type of safety device had not been documented for 18 out of 30 day shifts, 18 out of 30 evening shifts and 19 out of 31 night shifts, or 60 % of the shifts;
- the use of another type of safety device had not been documented for 16 out of 30 day shifts, 14 out of 30 evening shifts and 20 out of 31 nights shifts, or 55 % of the shifts; and
- the use of the specific type of bed had not been documented for 12 out of 30 day shifts, 11 out of 30 evening shifts and 19 out of 31 night shifts, or 46 % of the shifts.

The Inspector noted that the resident's use of one of the specific types of safety devices

on a date during the inspection, observed by the Inspector, was not documented on the PSW Flow Sheet.

In addition, the Inspector noted that the Flow Sheet contained inconsistencies in the documentation of the interventions used. On seven dates in a particular month in 2018, the Flow Sheet identified that the resident had used one type of safety device but not another type of safety device. On 13 dates in another month in 2018, the Flow Sheet identified that the resident used one type of safety device but not another type of safety device.

During an interview with PSW #151, they stated that all residents had a specific type of bed and staff should document the use of the bed on each shift it was used. The PSW stated that resident #025 did not get up before 0700 hours and did not stay up after 2300 hours, so the use of the specific type of bed for the resident should be documented on each shift [during the day, evening and night shifts]. The PSW stated the other specific safety device should also be documented on the Flow Sheets, but identified they only documented the use of this safety device if the resident used a certain type.

During an interview with PSW #168, they stated that PSWs should document the use of any safety device, even certain types, on the Flow Sheets, and that all residents had a specific type of bed so their use should be documented, and the use of another specific safety device in use, each shift the resident was in bed.

During an interview with PSW #169, they stated they did not document if a certain type of specific safety device were used, but would document if a different type of safety device were used. The PSW then said they second guessed if they were required to document the use of a certain type of safety device. The PSW identified that the use of a specific type of safety device and specific type of bed should be documented every shift if a resident was in bed after 0700 hours and before 2300 hours.

During an interview with RPN #154, they acknowledged that resident #025 did not get up before 0700 hours and did not stay up after 2300 hours, and the use of their specific type of bed should be documented, with the use of a specific safety device, each shift on the Flow Sheets.

During an interview with RPN #170. they stated that PSWs were always required to document the use of a specific safety device and a specific type of bed, and that the documentation should reflect their use on every shift, if a resident remained in bed after

0700 hours and went to bed before 2300 hours. The RPN stated they were not sure if PSWs were required to document the use of a certain type of safety device.

During an interview with RAI Coordinator #156, they stated that the Flow Sheet should have all items documented when used under the PASD heading, such as a specific type of bed and safety devices. The RAI Coordinator stated that all residents had specific type of beds so they should be signed each shift the resident was in bed. They acknowledged that resident #025's Flow Sheet for a particular month in 2018, was missing documentation which should have been completed.

During an interview with CM #130, they stated that staff were required to document the use of a specific type of safety device and the specific type of beds on the Flow Sheets. The CM identified that a certain type of safety devices were classified as PASDs and would need to be documented on the Flow Sheets under the PASD section. [s. 6. (9) 1.]

5. A CIS report was submitted to the Director for a fall experienced by resident #026, for which the resident was taken to the hospital and that resulted in a significant change in the resident's health status.

A review of resident #026's care plan identified that the resident used a mobility aid for locomotion; used a specific type of safety device; had a specific type of bed; went to bed around a particular time; woke up around a particular time and had a particular sleeping arrangement.

Inspector #625 reviewed resident #026's health care record including the PSW Flow Sheet for a particular month in 2018, which indicated the resident had used a specific mobility aid, a specific safety device and a specific type of bed, during that month.

Further analysis of this Flow Sheet by Inspector #625 identified:
- the use of a mobility aid had not been documented for 6 out of 30 day shifts, 5 out of 30 evening shifts, or 18 % of the shifts;
- the use of a specific safety device had not been documented for 13 out of 30 day shifts, 13 out of 30 evening shifts, and 20 out of 31 night shifts, or 51 % of the shifts; and
- the use of a specific type of bed had not been documented for 16 out of 30 day shifts, 13 out of 30 evening shifts and 22 out of 31 night shifts, or 56 % of the shifts.

In addition, the Inspector noted documentation inconsistencies on the Flow Sheet. On four dates in a particular month in 2018, the Flow Sheet identified that the resident had

used a specific type of bed but not the specific safety device. On seven other dates, the Flow Sheet identified that the resident used a specific safety device but not a specific type of bed. Also, the absent documentation for the resident's mobility aid use did not correspond to the preceding day shift or following evening shift as, for all 11 times the mobility aid use had not been documented, the corresponding day or evening shift identified the mobility aid was used.

During an interview with PSW #151, they stated that all residents had a specific type of bed and staff should document the use of the bed on each shift it was used.

During an interview with PSW #168, they stated that PSWs should document the use of any specific safety devices, even a certain type of safety device, on the Flow Sheets, and that all residents had a specific type of bed, so their use should be documented, each shift the resident was in bed.

During an interview with PSW #169, they stated they did not document if a certain type of safety device were used, but would document if a different type of safety device were used. The PSW then said they second guessed if they were required to document the use of a specific type of safety device. The PSW identified that a specific type of bed should be documented every shift a resident was in bed.

During an interview with RPN #170, they stated that PSWs were always required to document the use of a specific type of bed, and that the documentation should reflect their use on every shift, if a resident remained in bed after 0700 hours and went to bed before 2300 hours. The RPN stated they were not sure if PSWs were required to document the use of a certain type of safety device.

During an interview with RAI Coordinator #156, they stated that the Flow Sheet should have all items documented when used under the PASD heading, such as a specific type of bed and safety device. The RAI Coordinator stated that all residents had a specific type of bed, so they should be signed each shift the resident used it.

During an interview with CM #130, they indicated that staff were required to document resident #026's use of a specific type of safety device, the specific type of bed and mobility aid on the Flow Sheets. The Manager identified that the care provided to resident #026, with respect to the specific type of safety device, the specific type of bed and mobility aid use, had not been documented as required, on the Flow Sheets. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures there is a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident and ensures that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent and complemented each other, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate action was taken in response to every such incident.

The home submitted a CIS report to the Director, which outlined allegations of neglect by

staff to multiple residents on a specific date in 2018.

Inspector #687 reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program" last revised April 2016, which indicated that "All homes will implement a comprehensive zero tolerance to resident abuse and neglect program" including measures to promptly and thoroughly investigate all alleged or reported incidents in a fair and transparent manner.

During an interview conducted by Inspector #687 with PSW #112, they verified that they worked on the specific date in 2018, and noted that residents #022, #023, and #024 were completely saturated with urine which included their continence products, clothing and their bedding. The PSW reported this incident to RPN #111 due to a clear indication that the previous shift neglected the care of the residents. The PSW further verified that the management did not speak to them about this alleged care neglect of the resident #022, #023 and #024. The PSW also stated that they were not asked to provide a written statement of the incident.

During an interview with the DOC, they stated that they did not interview PSW #112 as when they initiated their investigation about this alleged staff to resident care neglect incidents the PSW was not working that day. The DOC further stated that they had interviewed other staff members involved in the alleged neglect incidents and had all the information needed to proceed with the internal investigation; therefore, they did not interview PSW #112. The DOC acknowledged that based on their policy for the Zero Tolerance of Resident Abuse and Neglect Program, which indicated that the home would promptly and thoroughly investigate all alleged or reported incidents in a fair and transparent manner, they should have interviewed all the staff involved including PSW #112. [s. 23. (1) (b)]

2. The home submitted a CIS report to the Director, which outlined allegations of verbal abuse by Dietary Aide #105 toward resident #018 on a specific date in 2018.

Please refer to WN #1, finding 1., for details of the allegation of verbal abuse.

In an interview with the Dietary Manager #128, they verified that in the investigation notes DA #105 was interviewed but Staffing Clerk #103 was not interviewed in relation to the details of the alleged abuse by the DA towards resident #018. Therefore, as per the home's Zero Tolerance of resident Abuse and Neglect Program, insufficient action was taken in response to this incident as all staff that were involved were not interviewed. [s.

23. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that appropriate action is taken in response to every such incident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to make a report in writing to the Director setting out the following with respect to the incident: actions taken in response to the incident, including what care was given or action taken as a result of the incident.

Critical Incident System (CIS) reports were submitted to the Director related to outbreaks in the home.

Inspector #625 reviewed CIS reports related to:
- an outbreak, detailed in CIS a report to have occurred in the winter of 2018;
- an outbreak, detailed in CIS a report to have occurred in the winter of 2018; and
- an outbreak, detailed in CIS a report to have occurred in late winter of 2018.

The CIS reports contained an area to check off the measures the home had put into place to control or manage the outbreak, as well as an area where the home was required to "describe any other measure put in place to control or manage the outbreak if not indicated above".

a) Inspector #625 reviewed the home's outbreak file for an outbreak, which included Client/Resident: Respiratory Outbreak Line Listing Forms that identified swabs were collected from a specific number of residents and a specific number of residents had been placed in isolation during the outbreak.

Inspector #625 noted that the corresponding CIS report did not contain any information in the area the home was required to describe additional measures put in place to control or manage the outbreak, if it had not been indicated above.

During an interview with Infection Prevention and Control (IPAC) Facilitator #172, they stated that they had not included the collection and testing of swabs and the isolation of residents in the report to the Director.

b) Inspector #625 reviewed the home's outbreak file for an outbreak, which included a Respiratory Outbreak Line Listing – Resident Data form which identified swabs were collected from a specific number of residents, a specific number of residents were ordered antibiotics and a specific number of residents had been placed in isolation during the outbreak.

The Inspector also noted that the corresponding CIS report did not identify that swabs had been collected, antibiotics had been ordered or residents had been isolated during the outbreak. The area where the home was to describe any other measures put in place to control or manage the outbreak, if not indicated above, contained information that the outbreak had been identified on a weekend and that the staff had contacted the MOHLTC.

During an interview with IPAC Facilitator #172, they acknowledged that they had not

included the swab testing, antibiotic use or the isolation of residents, in the report.

c) Inspector #625 reviewed the home's outbreak file for an outbreak, which included Client/Resident: Gastrointestinal Outbreak Line Listing Forms that identified specimens were collected from a specific number of residents and a specific number of residents had been placed in isolation during the outbreak.

Inspector #625 noted that the corresponding CIS report did not identify that specimens had been collected or tested or that residents had been isolated during the outbreak. The area where the home was to describe any other measures put in place to control or manage the outbreak, if not indicated above, contained information about the location of the outbreak and operational staffing resources.

During an interview with IPAC Facilitator #172, they stated that they had not included the specimen collection and testing, or the isolation of residents in the report to the Director, although they would have been appropriate to include. [s. 107. (4) 3. i.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures a report in writing is made to the Director setting out the following with respect to the incident: actions taken in response to the incident, including what care was given or action taken as a result of the incident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that, on every shift, the symptoms indicating the presence of infection in residents were recorded.

Inspector #625 reviewed CIS reports related to an outbreak detailed in a CIS report to have occurred in winter 2018; and an outbreak detailed in another CIS report to have occurred in early spring 2018.

Inspector #625 reviewed the home's document titled "HRM Outbreak Procedure Daily Responsibilities", last updated June 18, 2018, and in place at the time of both outbreaks. The documents identified that the registered nursing staff had the following responsibilities:
- Pre-outbreak the RN was to ensure documentation every shift of symptomatic residents within e-notes. The RPN was to complete, chart and sign the 24 Hour Symptom Surveillance Form every shift to track symptoms of acute illness;
- During declaration of an outbreak over a weekend the RN was to maintain…the documentation of illness per shift while resident remained on the line list; and
- Daily, during an outbreak, the RN was to ensure e-notes were created for symptomatic residents on the line list every shift. The RPN was to chart resident symptoms every shifts, and interventions provided for the residents remaining in additional precautions due to line list criteria.

a) Inspector #625 reviewed a Respiratory Outbreak Line Listing – Resident Data document for one outbreak which identified that resident #031 experienced an onset of symptoms on a specific date in 2018, had an antibiotic ordered the following day, was started on isolation two days later and that symptoms were resolved approximately one week later.

The Inspector reviewed electronic progress notes for resident #031. The progress notes identified the onset of symptoms on a particular date, the progression of symptoms and initiation of an antibiotic on the following day, and continued symptoms exhibited up to approximately one week later. The progress notes did not include documentation recording the symptoms indicating the presence of infection of the resident over an approximate 36 hour period; then again over another approximate 22 hour period; and over another approximate 24 hour time period.

During an interview with Inspector #693, RN #133 stated that, once residents were listed on the line list, they needed to be charted on once per shift on the computer e-notes. The RN also identified that the Daily 24-Hour Symptom Surveillance Form was completed

every shift and was to be reviewed by management, or the RN on the weekends.

During an interview with the IPAC Facilitator #172, they stated that staff were required to record the symptoms of infection in residents every shift on the Daily 24-Hour Symptom Surveillance Form and monitor infection in residents daily in the electronic nurses' notes. The IPAC Facilitator informed the Inspector that they had shredded the Daily 24-Hour Symptom Surveillance Forms prior to a specific date in early spring 2018 and were not able to recall if any symptoms indicating the presence of infection were recorded on the forms for resident #031.

During an interview with CM #106, they reviewed the electronic progress notes for resident #031 and indicated that shiftly recording of the residents symptoms of infection had not been documented for multiple shifts.

b) Inspector #625 reviewed a Respiratory Outbreak Line Listing – Resident Data document for an outbreak which identified that resident #032 experienced an onset of symptoms on a particular date in 2018, and was started on isolation that same day.

The Inspector reviewed electronic progress notes for resident #032. The progress notes identified the onset of symptoms on a specific date, the progression and continuation of symptoms exhibited up to six days later, and the discontinuation of isolation precautions the following day. The progress notes did not include documentation recording the symptoms indicating the presence of infection of the resident over an approximate 48 hour time period; then again over an approximate 24 hour time period; an again over another 24 hour approximate time period; and lastly another 24 hour approximate time period.

During an interview with the IPAC Facilitator #172, they stated that staff had not recorded the symptoms indicating the presence of infection for resident #032 on the Daily 24-Hour Symptom Surveillance Form on the day shifts of two specific dates in 2018.

During an interview with CM #106, they reviewed the electronic progress notes for resident #032 and indicated that shiftly recording of the resident's symptoms of infection had not been documented for multiple shifts. [s. 229. (5) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that on every shift, the symptoms indicating the presence of infection in residents are recorded, to be implemented voluntarily.

Issued on this 19th day of October, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196), KATHERINE BARCA (625), MELISSA HAMILTON (693)
Inspection No. / No de l'inspection :	2018_624196_0024
Log No. / No de registre :	004107-18, 004442-18, 006176-18, 006841-18, 007020-18, 008080-18, 008350-18, 009001-18, 009103-18, 009210-18, 009617-18, 009632-18, 010751-18, 011280-18, 011548-18, 011698-18, 015556-18, 015707-18, 015906-18, 018097-18, 022163-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 11, 2018
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, P.O. Box 3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	Hogarth Riverview Manor 300 Lillie Street, THUNDER BAY, ON, P7C-4Y7
	Lina Johnson

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

To St. Joseph's Care Group, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 20 of the LTCHA.

Specifically, the licensee must:
a) Ensure residents #018 and #019, and all other residents, are protected from abuse and neglect by staff.
b) Ensure Dietary Aide #105, PSW #110 and PSW #122, review the home's policy entitled "Zero Tolerance of Resident abuse and Neglect Program", and maintain written records of this review.

Grounds / Motifs :

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

The home submitted a CIS report to the Director in 2018, which outlined allegations of a type of abuse by Dietary Aide (DA) #105 towards resident #018. The allegations described DA #105's conduct with resident #018.

O. Reg. 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that were performed by anyone other than a resident.

Inspector #687 reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program" last revised April 2016, which indicated that any form of abuse or neglect by any person, whether through deliberate acts or

negligence will not be tolerated.

A record review of the home's internal investigation notes by Inspector #687, identified that DA #105 received discipline for abuse towards resident #018.

In an interview with DA #105, they stated that they were made aware of the alleged abuse allegation towards resident #018.

During an interview conducted by Inspector #687 with Staffing Clerk #103, they stated that on a specific date in 2018, they were asked to work as a Resident Home Worker (RHW) which included assisting residents with meal service, portering residents to and from an area and making residents' beds. The Staffing Clerk further stated that they were assisting in the dining room and resident #018 was observed to exhibit a specific behaviour. The resident made some statements towards the Staffing Clerk, PSW #108 and DA #105. The DA responded to resident #018, with a statement and the resident and DA exchanged dialogue. The Staffing Clerk further stated that they had sent a detailed email to the Director of Care (DOC) about this incident.

In an interview conducted by Inspector #687 with the DOC, they stated that the reason behind their decision to categorize this incident as one type of abuse rather than another type of abuse was due to the definition of emotional abuse in the legislation. The DOC further stated that they decided this incident was an emotional abuse incident by DA #105 towards resident #018 due to the specific response from the DA towards the resident. (196)

2. The home submitted a CIS report to the Director, which outlined allegations of neglect by PSW #122 towards resident #019 on a date in 2018.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

Inspector #687 conducted a record review of the home's internal investigation notes, which identified PSW #122 was assigned to provide care to resident #019 on a specific date in 2018. The notes further identified that PSW #122 failed to provide care for resident #019 during the afternoon of that day, and the PSW failed to check the resident's continence product. As a result, the resident

sustained an area of impaired skin integrity. Through the home's internal investigation, PSW #122 was found to be neglectful in providing appropriate care to resident #019.

In an interview conducted by Inspector #687 with the CM #130, they stated that they initiated the CIS report when it was reported by RN #116. The CM stated that PSW #122 was scheduled to work on a specific date in 2018, and was assigned to care for resident #019. According to CM #130, the PSW did not check the continence product of the resident after lunch time. The CM further stated that, due to this incident, the resident was found saturated with urine later that evening and was found with an area of impaired skin integrity. The CM stated that the outcome of the internal investigation report was that PSW #122 was neglectful towards the care of resident #019 and therefore received discipline. (196)

3. The home submitted a CIS report to the Director, which outlined allegations of neglect by staff to multiple residents on a specific date in 2018.

During an interview conducted by Inspector #687 with PSW #112, #113, and #114, they verified that they were working on a specific date in 2018, on one of the units, and they noted that most of the residents' continence products were completely saturated with urine including their clothing and bedding. PSW #112, #113, and #114 reported this incident to RPN #111 as they all stated that this incident constituted neglect to the majority of the residents on the unit.

During an interview with RPN #111, they verified that PSW #112, #113 and #114 reported this incident to RN #127. The RPN noted that the staff from the previous shift neglected their duties to provide care for the residents on the unit.

In an interview with the DOC, they verified that PSW #110 was working on the specific date in 2018, and should have led, "the brief rounds" to ensure that all residents that required continence products, were changed on their shift. The DOC further verified that based on their internal investigation, there was an element of neglect on the part of PSW #110; and therefore, they received a particular discipline.

The decision to issue a Compliance Order (CO) was based on the home's ongoing non-compliance with this section of the legislation, the severity was actual harm/risk to the residents, and the scope was widespread. The home has

a history of non-compliance in this area of the legislation as follows:
- a written notification (WN) was issued from the Resident Quality Inspection (RQI) #2018_333577_0006, on June 1, 2018;
- a CO was issued from a Complaint inspection #2018_655679_0005, on March 22, 2018;
- a written notification (WN) was issued from a Critical Incident System (CIS) inspection #2018_657681_0001, on February 2, 2018;
- a Voluntary Plan of Correction (VPC) was issued from a Complaint inspection #2017_509617_0020, on November 14, 2017;
- a WN was issued from a CIS inspection #2017_509617_0017, on October 11, 2017;
- a Director Referral (DR) was from a Follow Up inspection #2016_391603_0024, on November 7, 2016;
- a VPC was issued from a RQI #2016_435621_0012, on October 11, 2016;
- a CO was issued from a Follow Up inspection #2016_333577_0010, on July 6, 2016;
- a VPC was issued from a Follow Up inspection #2016_246196_0006, on May 12, 2016; and
- a CO was issued from a Follow Up inspection # 2015_435621_0012, on February 16, 2016. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 19, 2018

Order # / Ordre no : 002

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

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 :

The licensee must be compliant with O. Reg. 79/10, s. 49 (2).

Specifically the licensee must;
a) Ensure resident #025, and all residents, that are assessed and where the condition or circumstances of the residents require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.
b) Develop, implement, and document an auditing process which ensures staff are conducting post fall assessments when required.
c) The documentation of the auditing process shall include actions taken when deficiencies are identified.

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 circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CIS report was submitted to the Director for a fall sustained by resident #025 on a date in 2018, for which the resident was taken to the hospital and that resulted in a significant change in the resident's health status.

Inspector #625 reviewed the home's policy "Falls Prevention and Management Program – RC-15-01-01" last updated February 2017, which identified that a post-fall assessment was to be completed as soon as possible following a fall

and referred to the Post-Fall Assessment Tool, Appendix 11. The Inspector reviewed the attached blank "Post-Fall Assessment Tool – Appendix 11" last updated February 2017, which contained assessment for resident's injury, potential contributing factors to the fall, the main root cause of the fall, possible prevention strategies, follow-up, recommendations and falls prevention interventions in place.

Inspector #625 reviewed resident #025's health care record and was not able to locate a completed post-fall assessment, in either an electronic or a hard copy format, for the fall that occurred.

During an interview with RN #171, they stated that a Post-Fall Assessment Tool was required to be completed after a fall. They were not able to locate a Post-Fall Assessment Tool for the fall that occurred on a specific date in 2018, that involved resident #025.

During an interview with RN #155, they acknowledged that a Post-Fall Assessment Tool should have been completed for resident #025 after their fall, which had resulted in a significant injury to the resident. The RN was not able to locate an electronic or a hard copy of the Post-Fall Assessment Tool completed for resident #025's fall on the specific date in 2018.

During an interview with Inspector #625, CM #106, stated that staff should have completed a post-fall assessment for resident #025's fall that occurred on the specific date in 2018. The CM was unable to locate a post-fall assessment completed for the fall, in either the resident's electronic or hard copy health care records. [s. 49. (2)]

The decision to issue a Compliance Order (CO) was based on the home's ongoing non-compliance with this section of the legislation, the severity was minimal harm or potential for actual harm, and the scope was isolated. The home has a history of non-compliance in this area of the legislation as follows:
- a CO was issued from a Critical Incident System (CIS) inspection #2017_509617_0017, on October 11, 2017;
- a Written Notification (WN) was issued from a Resident Quality Inspection (RQI) #2017_624196_0005, on May 16, 2017;
- a CO was issued from a Follow Up inspection #2017_616542_0002, on February 28, 2017;
- a CO was issued from a Follow Up inspection #2016_391603_0024, on

November 7, 2016;
- a Voluntary Plan of Correction (VPC) was issued from a RQI #2016_435621_0012, on October 11, 2016; and
- a CO was issued from a Complaint inspection #2016_333577_0011, on July 6, 2016. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 19, 2018

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6. (9) of the LTCHA.

Specifically, the licensee must:
a) Ensure the provision of the care set out in the plan of care for resident #025, specific to fall prevention interventions, is documented.
b) Ensure the provision of the care set out in the plan of care for resident #026, specific to fall prevention interventions and the use of Personal Assistance Service Devices (PASDs) is documented.
c) Conduct weekly audits of a sample of residents' health care records from each home area to ensure the provision of the care set out in the plan of care is documented.
d) Maintain written documentation of the weekly audits.

Grounds / Motifs :

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

A CIS report was submitted to the Director for a fall sustained by resident #025 on a specific date in 2018, for which the resident was taken to the hospital and that resulted in a significant change in the residents' health status.

On two particular dates, during the inspection, Inspector #625 observed resident #025 laying in bed with specific types of safety devices in place.

Inspector #625 reviewed resident #025's health care record including the PSW Flow Sheet for a particular month in 2018, which indicated the resident had used two specific types of safety devices and a specific type of bed.

Further analysis of the Flow Sheet by Inspector #625, identified:
- the use of one type of safety device had not been documented for 18 out of 30 day shifts, 18 out of 30 evening shifts and 19 out of 31 night shifts, or 60 % of the shifts;
- the use of another type of safety device had not been documented for 16 out of 30 day shifts, 14 out of 30 evening shifts and 20 out of 31 nights shifts, or 55 % of the shifts; and
- the use of the specific type of bed had not been documented for 12 out of 30 day shifts, 11 out of 30 evening shifts and 19 out of 31 night shifts, or 46 % of the shifts.

The Inspector noted that the resident's use of one of the specific types of safety devices on a date during the inspection, observed by the Inspector, was not documented on the PSW Flow Sheet.

In addition, the Inspector noted that the Flow Sheet contained inconsistencies in the documentation of the interventions used. On seven dates in a particular month in 2018, the Flow Sheet identified that the resident had used one type of safety device but not another type of safety device. On 13 dates in another month in 2018, the Flow Sheet identified that the resident used one type of safety device but not another type of safety device.

During an interview with PSW #151, they stated that all residents had a specific type of bed and staff should document the use of the bed on each shift it was used. The PSW stated that resident #025 did not get up before 0700 hours and did not stay up after 2300 hours, so the use of the specific type of bed for the resident should be documented on each shift [during the day, evening and night shifts]. The PSW stated the other specific safety device should also be documented on the Flow Sheets, but identified they only documented the use of this safety device if the resident used a certain type.

During an interview with PSW #168, they stated that PSWs should document the use of any safety device, even certain types, on the Flow Sheets, and that all residents had a specific type of bed so their use should be documented, and the use of another specific safety device in use, each shift the resident was in bed.

During an interview with PSW #169, they stated they did not document if a certain type of specific safety device were used, but would document if a different type of safety device were used. The PSW then said they second guessed if they were required to document the use of a certain type of safety device. The PSW identified that the use of a specific type of safety device and specific type of bed should be documented every shift if a resident was in bed after 0700 hours and before 2300 hours.

During an interview with RPN #154, they acknowledged that resident #025 did not get up before 0700 hours and did not stay up after 2300 hours, and the use of their specific type of bed should be documented, with the use of a specific safety device, each shift on the Flow Sheets.

During an interview with RPN #170. they stated that PSWs were always required to document the use of a specific safety device and a specific type of bed, and that the documentation should reflect their use on every shift, if a resident remained in bed after 0700 hours and went to bed before 2300 hours. The RPN stated they were not sure if PSWs were required to document the use of a certain type of safety device.

During an interview with RAI Coordinator #156, they stated that the Flow Sheet should have all items documented when used under the PASD heading, such as a specific type of bed and safety devices. The RAI Coordinator stated that all residents had specific type of beds so they should be signed each shift the resident was in bed. They acknowledged that resident #025's Flow Sheet for a particular month in 2018, was missing documentation which should have been completed.

During an interview with CM #130, they stated that staff were required to document the use of a specific type of safety device and the specific type of beds on the Flow Sheets. The CM identified that a certain type of safety devices were classified as PASDs and would need to be documented on the Flow Sheets under the PASD section. (625)

2. A CIS report was submitted to the Director for a fall experienced by resident #026, for which the resident was taken to the hospital and that resulted in a significant change in the resident's health status.

A review of resident #026's care plan identified that the resident used a mobility aid for locomotion; used a specific type of safety device; had a specific type of bed; went to bed around a particular time; woke up around a particular time and had a particular sleeping arrangement.

Inspector #625 reviewed resident #026's health care record including the PSW Flow Sheet for a particular month in 2018, which indicated the resident had used a specific mobility aid, a specific safety device and a specific type of bed, during that month.

Further analysis of this Flow Sheet by Inspector #625 identified:
- the use of a mobility aid had not been documented for 6 out of 30 day shifts, 5 out of 30 evening shifts, or 18 % of the shifts;
- the use of a specific safety device had not been documented for 13 out of 30 day shifts, 13 out of 30 evening shifts, and 20 out of 31 night shifts, or 51 % of the shifts; and
- the use of a specific type of bed had not been documented for 16 out of 30 day shifts, 13 out of 30 evening shifts and 22 out of 31 night shifts, or 56 % of the shifts.

In addition, the Inspector noted documentation inconsistencies on the Flow Sheet. On four dates in a particular month in 2018, the Flow Sheet identified that the resident had used a specific type of bed but not the specific safety device. On seven other dates, the Flow Sheet identified that the resident used a specific safety device but not a specific type of bed. Also, the absent documentation for the resident's mobility aid use did not correspond to the preceding day shift or following evening shift as, for all 11 times the mobility aid use had not been documented, the corresponding day or evening shift identified the mobility aid was used.

During an interview with PSW #151, they stated that all residents had a specific type of bed and staff should document the use of the bed on each shift it was used.

During an interview with PSW #168, they stated that PSWs should document the use of any specific safety devices, even a certain type of safety device, on the Flow Sheets, and that all residents had a specific type of bed, so their use should be documented, each shift the resident was in bed.

During an interview with PSW #169, they stated they did not document if a certain type of safety device were used, but would document if a different type of safety device were used. The PSW then said they second guessed if they were required to document the use of a specific type of safety device. The PSW identified that a specific type of bed should be documented every shift a resident was in bed.

During an interview with RPN #170, they stated that PSWs were always required to document the use of a specific type of bed, and that the documentation should reflect their use on every shift, if a resident remained in bed after 0700 hours and went to bed before 2300 hours. The RPN stated they were not sure if PSWs were required to document the use of a certain type of safety device.

During an interview with RAI Coordinator #156, they stated that the Flow Sheet should have all items documented when used under the PASD heading, such as a specific type of bed and safety device. The RAI Coordinator stated that all residents had a specific type of bed, so they should be signed each shift the resident used it.

During an interview with CM #130, they indicated that staff were required to document resident #026's use of a specific type of safety device, the specific type of bed and mobility aid on the Flow Sheets. The Manager identified that the care provided to resident #026, with respect to the specific type of safety device, the specific type of bed and mobility aid use, had not been documented as required, on the Flow Sheets.

The decision to issue a Compliance Order (CO) was based on the home's ongoing non-compliance with this section of the legislation, the severity was minimal risk, and the scope was a pattern of two residents that have been affected by repeated occurrences. The home has a history of non-compliance in this area of the legislation as follows:
- a Voluntary Plan of Correction (VPC) was issued from a Complaint inspection #2018_740621_0014, on May 18, 2018;
- a VPC was issued from a Resident Quality Inspection (RQI) #2017_624196_0005, on May 16, 2017;
- a VPC was issued from a Complaint inspection #2016_391603_0023, on November 3, 2016;
- a VPC was issued from a RQI inspection #2016_435621_0012, on October 11,

2016;
- a VPC was issued from a Complaint inspection #2016_246196_0005, on May 12, 2016; and
- a Written Notification (WN) was issued from a Complaint inspection #2016_264609_0006, on March 7, 2016.
(625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 19, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 11th day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Ministére 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

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

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