Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 28, 2020	2020_768693_0013 (A1)	023069-19, 023859-19, 000362-20, 001220-20, 001221-20, 001369-20, 001530-20, 003301-20, 003303-20, 003588-20, 003602-20, 003640-20, 003790-20, 003917-20, 004212-20, 004271-20, 005624-20, 006300-20, 006745-20, 006821-20, 007397-20, 007438-20, 007590-20, 007938-20, 008097-20, 008843-20, 008939-20, 009484-20, 009707-20, 009792-20, 010318-20, 010387-20, 010434-20, 010923-20, 010925-20, 010945-20, 011471-20, 011811-20, 011813-20, 011991-20, 012251-20, 013037-20, 013198-20, 013417-20, 013674-20, 013745-20, 013821-20, 013981-20, 014078-20, 014107-20	Critical Incident System

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Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street 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

Amended by MELISSA HAMILTON (693) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Issued on this 28th day of September, 2020 (A1)

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

Original report signed by the inspector.

Ontario

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Ministère des Soins de longue durée

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009707-20,
009792-20,
010318-20,
010387-20,
010434-20,
010923-20,
010925-20,
010945-20,
011471-20,
011811-20,
011813-20,
011991-20,
012251-20,
013037-20,
013198-20,
013417-20,
013674-20,
013745-20,
013821-20,
013981-20,
014078-20,
014107-20

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300 Lillie Street THUNDER BAY ON P7C 4Y7

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

Amended by MELISSA HAMILTON (693) - (A1)

Amended Inspection Summary/Résumé de l’inspection

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

This inspection was conducted on the following date(s): July 6 to 10, 13 to 17, and 20 to 24, 27, and August 4, 2020.

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

-five intakes, regarding alleged incompetent or improper care of residents;

-18 intakes, regarding alleged resident to resident abuse;

-11 intakes, regarding alleged staff to resident abuse or neglect;

-14 intakes, regarding resident falls; and

-two intakes, regarding resident elopement.

Follow Up inspection #2020_768693_0011, Complaint inspection #2020_768693_0012, and CIS inspection #2020_768693_0014, were conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Managers (CM), Registered Nurses (RNs), Resident Assessment Instrument Coordinators (RAI Coordinators), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, Resident Home Workers (RHW), residents, and their family members.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **9 WN(s)**
- **3 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

A Critical Incident System (CIS) report was received by the Director on an identified date, related to staff to resident neglect. The CIS report indicated that the family member of resident #002 had found the resident in an identified condition, as they needed an identified Activity of Daily Living (ADL) to be completed and staff had not answered their call bell.

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

A review of the home's policy, "Zero Tolerance of Resident Abuse and Neglect Program, LRC-02-01-01", last updated in October, 2019, indicated that the home was committed to have provided a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times. They had zero tolerance for abuse and neglect and any form of abuse or neglect by any person, whether through deliberate acts or negligence, would not be tolerated.

A review of the home's internal investigation notes by Inspector #577, identified that PSW #143 had attended to resident #002, attached an identified assistive device, activated their call bell, and waited an identified number of minutes. PSW #143 reported that staff had not answered their call bell, they realized it was an identified time, so they removed the assistive device from the resident; they told the resident that they would tell the oncoming staff to assist them with an identified ADL and they left the resident.

A review of resident #002's care plan at the time of the incident indicated that resident #002 required the assistance of an identified device for a specified ADL.

During an interview with PSW #143, they advised Inspector #577 that resident #002 needed to be assisted with an identified ADL, they attached an identified assistive device for another identified device and called for assistance on the call bell; when staff had not answered the call bell, and realized staff were in report, they removed the identified device and communicated to the oncoming staff that resident #002 required assistance with the identified ADL.

During an interview with CM #117, they advised Inspector #577 that PSW #143 had provided incompetent care to resident #002 when they had not completed the care for the resident, left them and had not waited for assistance. [s. 20. (1)]

2. A CIS report was received by the Director on an identified date, related to staff to resident neglect of residents #005 and #006. The report alleged that resident #005 was found in a particular condition, without specified care complete, at an identified time. Similarly, resident #006 was found in a particular condition and had not been provided with specified care, at an identified time.

A review of the home's policy, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting - RC-02-01-02", revised June 2019, which indicated that anyone who witnessed or suspected abuse or neglect by another resident, staff or other person must notify management immediately; any employee or person who became aware of an alleged, suspected or witnessed resident incident of abuse or neglect would report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior supervisor on shift at the time; the person reporting the suspected abuse would follow the home's reporting process and provincial requirements to ensure the information was provided to the home Administrator/designate immediately.

A review of the home's policy, titled, "Care and Comfort Rounds, LRC-12-01-06", last updated on December 18, 2019, indicated that the home would schedule regular care and comfort rounds at set intervals to proactively anticipate resident needs related to pain, positioning, prompted toileting, proximity to personal items and other comfort and safety issues; comfort rounds were scheduled every hour to proactively address pain, position, prompted toileting and possessions.

a) A review of resident #005's care plan at the time of the incident indicated that

the resident required an identified level of assistance for an identified ADL and utilized a specific product, at all times.

A review of the investigation file included the following documentation:

-PSW #139 provided morning care and did not provide the resident with an identified product and only assisted them with an identified ADL at a specified time, on an identified date;
-PSW #137 found the resident in an identified condition, at an identified time, without the utilization of a specified product; their ambulation device was described as being a certain condition; they informed RPN #138; and
-RPN #138 was informed of alleged neglect and had not immediately informed the RN; they indicated that a discussion with the PSWs was sufficient.

b) A review of resident #006's care plan at the time of the incident indicated that the resident required an identified product.

A review of the investigation file included the following:

- PSW #139 provided morning care and did not provide the resident with identified interventions after an identified time on an identified date;
- the resident was not checked at change of shift; PSW #144 found them in an identified condition at an identified time;
-an identified document, from an identified date, from CM #100 to PSW #139, which indicated that they had worked a specified shift on identified dates, where they had not provided care to two residents at an identified time and had not completed the care as required;
-an identified document, from an identified date, from CM #100 to PSW #136, which indicated they had not immediately reported alleged neglect/incompetent care to a registered staff member or CM, but had reported it to the Manager two days later via email;
-an identified document, from an identified date, from CM #100 to PSW #137, which indicated that the care of a resident was not provided until a specified time and was reported as incompetent care. It was determined that they did not complete care as documented; it was expected that they check all the residents assigned to them and all care provided was documented; and
-an identified document, from an identified date, from CM #100 to RPN #138, which indicated that a staff member had brought concerns to them of alleged neglect towards a resident, and they had not reported it to the RN or Manager

immediately, but felt that a discussion with the PSWs was sufficient.

A review of an email from PSW #136 to CM #100, sent two days after the incident, indicated that PSW #137 had reported to them that they found resident #005 in a particular condition and without the use of an identified product; it was the second occurrence with a different staff; believed that the resident did not accept care from identified staff; and an incident from the day before where PSW #137 reported to them that they found resident #006 in their ambulation device in a particular condition.

During an interview with RPN #138, they advised Inspector #577 that PSW #137 informed them about care concerns related to resident #005 and #006, and they didn’t report it.

During an interview with PSW #137, they advised Inspector #577 that they had not checked resident #006 after shift change, and their co-worker found the resident to be in a particular condition, at a certain time. They found resident #005 to be in a particular condition and not utilizing an identified product, when they checked them at an identified time.They further reported that they informed RPN #138.

During an interview with PSW #136, they advised Inspector #577 that PSW #137 had reported to them that they found resident #005 in an identified condition, without the use of an identified product and resident #006 was found in a particular condition; PSW #137 reported to them that resident #005 doesn't like identified PSWs and had noticed that when identified staff members offered them care, they would refuse to use a required product and would be found in an identified condition. PSW #136 indicated that they were advised that PSW #137 didn't report these incidents to the RPN, so they sent an email to the CM, as for two consecutive days, PSW #139 left two residents in an identified condition.

During an interview with PSW #139, they advised Inspector #577 that they provided care to resident #005 and they had refused to use an identified product. They reported that they don’t recall whether resident #005 and #006 were checked every hour or assisted with a specified ADL at an identified time.

During an interview with CM #100, they advised the Inspector, that PSW #139 neglected to have provided specified care for resident #005 and #006, as they weren’t assisted with an identified ADL or provided with identified interventions, at

a specific time; identified care wasn't provided to resident #006 until the an identified; resident #005 wasn't provided with an identified product (refused) and wasn't provided specific interventions at an identified time. The CM indicated that resident #005 was checked at an identified time, and found to be in a particular condition without the use of an identified product. The CM advised that the residents should have been checked at an identified time. In addition, the CM indicated that PSW #144 found resident #006 in a particular condition and they reported it to PSW #137, who then reported both resident incidents to RPN #138. CM #100 indicated that RPN #138 didn't report the incidents. CM #100 advised that PSW #139 failed to follow the care plans, failed to provide identified care at an identified time (both residents) and should have checked resident #006 and #005 at an identified time; as well, the staff should have been checking the resident's every hour, and at identified times. Further, PSW #136 and RPN #138 had not immediately reported alleged neglect. [s. 20. (1)]

3. A CIS report was submitted to the Director on an identified date, for an incident of staff to resident verbal abuse that had occurred on an identified date. The report identified that PSW #135 had sworn at resident #026.

The LTCHA 2007 defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

The home's investigation records were reviewed and included an identified document addressed to PSW #135 that read, "your actions constitute verbal abuse of a resident…".

In an interview, PSW #134 described the incident in which PSW #135 had exhibited an identified behaviour and said [expletive] to the resident.

In an interview, CM #109 acknowledged that the home's policy on and zero tolerance of abuse had not been complied with, as verbal abuse had occurred when PSW #135 had sworn at resident #026. [s. 20. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CIS report was received by the Director on an identified date, related to staff to resident neglect. The CIS report indicated that the family member of resident #002 had found the resident in an identified condition, as they needed an identified Activity of Daily Living (ADL) to be completed and staff had not answered their call bell.

A review of home's policy, "Mechanical Lifts Procedure, LLP-01-01-03", last updated on January 22, 2020, indicated that two people were required when positioning a sling on a resident.

A review of the home's internal investigation notes by Inspector #577, identified that PSW #143 had attended to resident #002, and attached their transfer sling while they waited for further staff assistance.

During an interview with PSW #143, they advised Inspector #577 that resident #002 needed assistance with an ADL and they attached an assistive device for

another device and called for assistance on the call bell; when staff had not answered the call bell, they removed the device and communicated to the on coming staff that resident #002 required assistance with an identified ADL.

During an interview with CM #117, they advised Inspector #577 that PSW #143 had not followed the home's "Safe Lifting with Care" policy when they had attached the assisitive device onto resident #002 without a second staff member. [s. 36.]

2. A CIS report was submitted to the director on an identified device, for the improper and incompetent treatment of resident #028. The CIS report indicated that PSW #104, reported to CM #100, that on an identified device, during care, resident #028 required an identified level of assistance to transfer, using an identified assisitive device, but was transferred improperly by PSW #103, by means of a transfer with an identified level of assistance.

Inspector #693 reviewed resident #028's care plan that was current on an identified date. The care plan, last updated on a specified date, identified that resident #028 would transfer safely with an identified level of assistance, using an identified assisitive device.

During an interview with PSW #106, they indicated that it was the home's policy, to always have an identified number of staff members participate in an identified type of transfer of a resident.

Inspector #693 reviewed the home's investigation notes. The investigation notes identified that during an interview with Interim Clinical Manager #102, PSW #103 indicated that they completed an identified type of transfer for resident #028, on an identified date, as they thought the resident was going to fall and wanted to prevent an injury. The investigation notes further indicated that during an interview with Interim Clinical Manager #102, PSW #104 stated that they offered to help PSW #103 multiple times with the transfer, but PSW #103 was adamant that they would do the transfer alone. The home's investigation file contained an identified document, written to PSW #103, from Interim Clinical Manager #102. The letter indicated on an identified date, it was reported that PSW #103 transferred a resident by an identified means, when the resident required a different identified method and mechanism to transfer. The letter further indicated that it's purpose was to bring attention to PSW #103, the appropriate safety precautions that should be exercised when operating a mechanical lift and expectations to follow

the home’s policy.

Inspector #693 reviewed the home’s policy, titled, "Mechanical Lifts, LLP-01-01-02", last updated January 22, 2020. The policy indicated that two trained staff were always required when a transfer was performed, using a mechanical lift.

During an interview with Interim Clinical Manager #102, they stated that resident #028 was to be transferred, using an identified device, with an identified number of staff members participating in the lift, as well that the home's policy required two staff members for all mechanical lift transfers. The Interim Clinical Manager indicated that PSW #103 completed an improper transfer of resident #028. [s. 36.]

3. A CIS report was submitted to the Director on an identified date, for the improper and incompetent treatment of resident #035. The CIS report indicated that RPN #142, reported to CM #100, that on an identified date, resident #035 had been transferred by PSW #105, while assisting with an identified ADL, and the resident required assistance from an identified number of staff members, utilizing an identified device.

Inspector #693 reviewed resident #035’s care plan that was current on an identified date. The care plan, last updated on an identified date, indicated that resident #035 would transfer safely with the assistance of an identified number of staff members, using an identified device.

Inspector #693 reviewed the home’s CIS investigation file. The investigation notes identified that during an interview with Interim CM #100, PSW #105 indicated that they completed an identified kind of transfer for resident #035. The PSW indicated that the resident’s care plan indicated that they required assistance of an identified number of staff members, with an identified device for transfers, and that the PSW should have called for assistance from another staff member to complete the transfer for resident #035. The home’s investigation contained an identified document, addressed to PSW #105, from CM #100. The letter indicated that it was regarding an improper lift, for a resident who required an identified kind of transfer, utilizing an identified device. The letter indicated that the PSW preformed the transfer in an identified way and that as per care plan, an identified number of staff were required for the transfer.

Inspector #693 reviewed the home's policy, titled, “Mechanical Lifts Procedure, LLP-01-01-03", last updated on January 22, 2020. The policy indicated that staff

were to check the care planning documents for the approved transfer process for a resident. Additionally, Inspector #693 reviewed the home's policy, titled, "Transfer Devices Pre-Transfer Review, LLP-01-01-05", last updated on January 22, 2020. The policy indicated that residents were assessed on their assistance required to transfer safely from one surface to another, and from one position to another on the same surface.

During an interview with PSW #105, they indicated that they transferred resident #035, on an identified date, in a specified way, when at that time the resident required assistance from an identified number of staff members, utilizing an identified device. The PSW indicated that they knew the resident required an identified device for a transfer but, thought the resident could transfer safely in the way in which they completed the transfer.

During an interview with CM #100, they stated that on an identified date, PSW #105 completed an improper transfer of resident #035, had not followed the resident's care plan, or the home's policy. [s. 36.]

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 / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home.

A CIS report was submitted to the Director, on an identified date, for the improper or incompetent treatment of resident #032 on an identified date. The report further indicated that on an identified date, it was reported that resident #032 sustained a fall at an identified time, that resulted in an area of altered skin integrity to an identified area of the resident's body, and another area of altered skin integrity to an identified area of their body. On an identified date, the SDM of resident #032, reported to CM #109, that they were concerned that resident #032 was not checked on for some time, as the resident reported to them that they had lied on the floor for an identified period of time prior to getting help.

Inspector #693 reviewed resident #032's medical record and identified a form titled, "Clinical Monitoring Record." The record indicated that resident #032 fell on an identified date, at an identified time, and the first set of assessments were documented at an identified time on an identified date. The form indicated that the following were to be monitored every hour for four hours and then every eight hours for 72 hours: neurological vital signs for an unwitnessed fall, vital signs, pain and changes in behaviour. Additionally, the form directed staff to complete a

client safety report if there was a fall with injury. A review of this "Clinical Monitoring Record", identified that pain assessments were recorded on three identified dates, at three identified times. Attached to the "Clinical Monitoring Record" was a checklist that indicated the following process was to be followed for every resident fall: the "Clinical Monitoring Record" was to be initiated, and used to assess neurological vital signs, vital signs, pain, bruising, changes in functional and cognitive status and changes in range of motion, as well that staff were to document the results of all assessments and actions taken during the 72 hours post-fall follow-up in MED e-care as a follow up note to the original incident.

Inspector #693 reviewed the progress notes, electronically on MED e-care for resident #032. A progress note from an identified date, at an identified time, indicated that resident #032 was heard calling out for help, and was found in an identified position, with an area of altered skin integrity to an identified area of the resident's body, and another area of altered skin integrity to an identified area of their body. Inspector #693, reviewed the progress notes for the 72-hour post fall period, for their fall on an identified date. Assessments of pain, bruising, changes in functional and cognitive status and changes in range of motion, were documented on the day shift of an identified date, and the night shift of an identified date. There were no assessments related to the fall documented in MED e-care for the day shifts of identified dates, or for the night shifts of identified dates.

Inspector #693 reviewed the home's CIS investigation file, and identified that RPN #107, was the registered staff member, responsible for the care of resident #032 on an identified shift. The investigation indicated that the RPN had not completed the required client safety report, after the fall.

During an interview with RPN #110, they stated that when a resident had experienced an unwitnessed fall, and sustained an injury, the registered staff member was responsible for completing an assessment of the resident, which included completing the "Clinical Monitoring Record", and a client safety report. The RPN stated that the neurovitals, pain assessment, vitals, and changes in behavior needed to be assessed from the time of the fall, and every hour for four hours and every eight hours for 72 hours post fall. RPN #110 reviewed the "Clinical Monitoring Record" form, for resident #032's fall on an identified date, and stated that the pain assessment was only completed three times on the sheet and should have been completed 13 times. The RPN stated that sometimes nurses documented the pain assessments in the progress notes on MED e-care.

Inspector #693 reviewed the home's policy, titled, "Fall Prevention and Management Program, RC-15-0101, LRC-15-01-01", last updated January 22, 2020. The policy indicated that that if a resident experienced an unwitnessed fall, staff were to have completed a "Clinical Monitoring Record." The policy also directed staff to assess the following; for 72 hours post fall, at each shift: pain, bruising, change in functional status, change in cognitive status; and changes in range of motion.

During an interview with CM #109, they stated that when a resident had an unwitnessed fall, staff were to have initiated and completed the "Clinical Monitoring Record", as well as complete a client safety report, in addition to other mandatory tasks required by the home's policy. The CM stated that registered staff were to assess and document results for pain, vital signs, neurological vital signs, changes in functional or cognitive status, and changes in range of motion. The Clinical Manager reviewed the documentation for resident #032's unwitnessed fall on an identified date, and confirmed that the "Clinical Monitoring Record" was not fully completed, assessments of pain, bruising, change in functional status, change in cognitive status; and changes in range of motion were not done at each shift for 72 hours post fall, and the required client safety report was not completed. [s. 48. (1) 1.]

2. A CIS report was submitted to the Director, on an identified date, for a fall that caused an injury to resident #029, on an identified date, in which they were taken to the hospital. An additional CIS report was submitted to the Director, on an identified date, for the same incident for the improper or incompetent treatment of resident #029. The CIS report indicated that resident #029 sustained an unwitnessed fall on an identified date, and was sent to the hospital on an identified date, where identified injuries were confirmed.

Inspector #693 reviewed the progress notes, for resident #029, related to their fall, on an identified date, in MED e-care, and identified a progress note, composed by RPN #112, that indicated resident #029 had an unwitnessed fall without injury at an identified time, on an identified date. A progress note composed by the DOC, on an identified date, indicated that resident #029's identified area of their body was assessed, and was a certain condition, resident experienced a symptom on identified assessment and was unable to move their identified area of their body, resident experienced pain at rest and with movement, resident was transferred to the hospital for further investigations and assessments.

Inspector #693 reviewed resident #029's medical record and identified a form titled, "Clinical Monitoring Record." The record indicated that resident #020, fell on an identified date, at an identified time. In addition, the record indicated that the following were to be monitored every hour for four hours and then every eight hours for 72 hours: neurological vital signs for an unwitnessed fall, vital signs, pain and changes in behaviour. A review of this "Clinical Monitoring Record", identified that pain assessments were documented on two identified dats, at specified times. Vital signs were documented on identified dates and times, additionally at an identified time on an identified date , it was recorded under the vital signs portion of the form that the resident was sleeping. Neurovital signs were documented on January 18, 2020, at 1840 hrs and 2040 hrs, January 19, 2020, at 0540 hrs, 1340 hrs, and 2140 hrs, additionally at 1940 hrs on January 18, 2020, it was recorded under the neurovital signs portion of the form that the resident was sleeping.

Inspector #693 reviewed the home's CIS investigation file. The investigation notes indicated that through investigation, which included interviews and a review of video surveillance, the home determined that RPN #112 did not complete an assessment of resident #029, post fall on January 18, 2020, before instructing PSW #128 to help lift the resident to bed with a mechanical lift, did not complete any hands-on physical assessment of the resident at anytime post fall, did not notify resident #029's POA, did not call an RN to assess resident, did not complete a post-fall huddle, and did not fully complete the required post falls assessment.

During an interview with RPN #130, they indicated that when a resident had an unwitnessed fall, registered staff were to assess the environment, complete a physical assessment of the resident, if the resident had a suspected injury they were required to call the Registered Nurse to assess resident, initiate the "Clinical Monitoring Record"; this included monitoring neurological vital signs for an unwitnessed fall, vital signs, pain and changes in behaviour, every hour for four hours and then every eight hours for 72 hours, post falls assessment on MED e-care, post falls huddle with staff present, notify the physician, and complete a client safety report. RPN #130 reviewed the "Clinical Monitoring Record" from resident #029's fall on January 18, 2020 and indicated that the form was not completed at the times it should have been, as well that the registered staff should wake the resident up to complete the post-falls assessment and not document "sleeping" on the record.

During an interview with PSW #128, they indicated that they were working on January 19, 2020, when resident #029 sustained a fall. The PSW stated that a Therapeutic Recreation staff member found the resident on the floor in the hallway outside of their room and called for help. PSW #128 stated that they attended to the resident with RPN #112, and RPN #112 instructed the PSW to get the lift and help the RPN lift the resident into their bed. PSW #128 stated that RPN #112, did not complete an assessment of the resident, before the staff transferred the resident with a lift, and stated the RPN just looked at the resident. PSW #112 stated that it was obvious the resident was in pain, as they were saying they were and grabbing towards their an area of their body. The PSW reported that once the resident was in bed, RPN #112 did not complete a further assessment, and this included not completing vital signs. The PSW stated that the resident told them they would like to go to the hospital as they were in pain, and the PSW reported this to the RPN. PSW #128 stated that RPN #112 did not do anything to treat resident #029's pain or attempt to send the resident for further assessments.

Inspector #693 reviewed the home's policy, titled, "Fall Prevention and Management Program, LRC-15-01-01", last updated January 22, 2020. The policy indicated that after a resident fell, staff were required to complete an initial physical and neurological assessment, to have treated any injuries and managed pain, hold a post fall huddle, complete a post fall assessment, notify the SDM, and if a resident experienced an unwitnessed fall, staff were to have completed a "Clinical Monitoring Record." The policy also directed staff to assess the following; for 72 hours post fall, at each shift: pain, bruising, change in functional status, change in cognitive status; and changes in range of motion. In addition, the policy indicated on the 'Post Fall Clinical Pathway', that staff were to move the resident using a mechanical lift after a fall, following assessment by the nurse and approval for transfer.

During an interview with the DOC, they indicated that the "Clinical Monitoring Record" was not completed for the required times post fall; pain, bruising, change in functional status, change in cognitive status, and changes in range of motion were not assessed each shift as required, post fall; RPN #112 did not complete a physical assessment of resident #029 or manage their pain; the resident was transferred with a lift prior to being assessed; the POA and RN were not notified; RPN #112 did not complete a post falls huddle; or a post falls assessment, as required. The DOC indicated that the home's falls prevention and management

program, was not implemented appropriately for resident #029's fall on January 18, 2020, and this could have contributed to the resident's injuries. [s. 48. (1) 1.]

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 / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

WN #4: 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. (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 the care set out in the plan of care was provided to the resident as specified in the plan.

A CIS report was received by the Director on an identified date, related to staff to resident neglect. The CIS report indicated that the family member of resident #002 had found the resident in an identified condition, as they needed to assistance with an identified ADL and staff had not answered their call bell.

A review of the home's policy, "Plan of Care - RC-05-01-01", revised June 2019, indicated that the plan of care identified care needs to allow the care team to implement strategies to provide appropriate care; it served as a communication

tool which promoted the safe and effective resident care and provided documentation which identified immediate risks to safety and care needs to allow the care team to implement strategies to mitigate risk and provide appropriate care; the plan of care would be reflective of the resident's goals and preferences and as the resident's status changed, members of the interdisciplinary team were to update the plan of care so that at any point in time, the plan of care continued to be reflective of the current needs and preferences of the resident.

Inspector #577 reviewed resident #002's most current care plan which identified that staff were to have ensured that the resident's identified falls prevention interventions were in working order while they were in identified positions.

A record review of resident #002's progress notes on admission indicated a request for an identified falls prevention intervention.

During observations on identified dates, resident #002 was observed to be in an identified position, and Inspector #577 noted that the resident's identified falls prevention intervention was not in place.

During an interview with PSW #145 on an identified date, together with Inspector #577, they reviewed the resident's care plan which indicated the use of an identified falls prevention interventions. They advised Inspector #577 that resident #002 had never had the identified falls prevention interventions.

During an interview with PSW #143, together with Inspector #577, they observed resident #002's room and they confirmed that the resident did not have identified falls prevention interventions in place. They reported that they don't recall the resident ever having the identified falls prevention interventions.

During observations on July 24, 2020, Inspector #577 noted an identified falls prevention intervention, in place for resident #002.

Inspector spoke with PSW #145 after observation, and they reported that they had an RPN locate an identified falls prevention intervention, after they and the Inspector reviewed that resident's care plan.

During an interview with the DOC, together with Inspector #577, they reviewed the progress note on admission which indicated a request for an identified falls prevention intervention and the current care plan which indicated the intervention.

They advised that they were unaware whether the resident ever utilized the identified falls prevention interventions. [s. 6. (7)]

2. A CIS report was submitted to the Director on an identified date, for improper or incompetent care of a resident that resulted in harm or risk to a resident. The report included information received on an identified date, by CM #109 via email from the POA of resident #021 and included photographs from a camera within resident #021's room.

According to the report, resident #021 was left for an approximate amount of time in an identified position.

A review of the home's policy titled, "Personal Assistance Service Devices (PASDs) RC-22-01-05", last updated February 2017, indicated that "CARE STAFF - Monitor, check and reposition residents with a PASD q2h, and more often as necessary, for safety and comfort" and "Apply PASD to resident and monitor regularly to ensure comfort and safety".

A review of resident #021's care plan for use of an identified PASD, effective on a specified date, included a focus related to PASD use and identified ambulatory status and identified interventions.

In an interview, PSW #146 reported that resident #021 was in their identified ambulation device on that evening; they were in an identified position; they had noticed it and had someone come to help.

In an interview, CM #109 reported that they had determined that incompetent care had occurred regarding resident #021's identified positioning. They further added that the PSW #146 had left the resident in the same position at an identified time; and PSW #146 was not that familiar with the resident's care plan. They further reported to the inspector that PSW #146, had not followed the residents care plan for safe positioning. [s. 6. (7)]

3. A CIS report was submitted to the Director on an identified date, for staff to resident neglect related to specific care. The report indicated that the POA of resident #004 had brought forward a complaint that the resident had not been provided with specific care for an extended time period based upon their video records.

A review of resident #004's care plan was conducted. Under an identified focus on the care plan, it indicated that if the resident exhibited identified behaviours, specific interventions were to be utilized. The care plan for another identified focus, listed specific interventions.

The home's investigation file was reviewed. Investigation notes from an interview with RPN #147 indicated that they had been told by the oncoming nurse that the resident was exhibiting an identified behaviour and needed assistance with an identified ADL; RPN #147 had [gone] in room asked if [they] needed assistance with an identified ADL and the resident had exhibited an identified behaviour, and the RPN did not follow the care plan. An identified document, addressed to RPN #147, indicated that a resident had not been assisted with an identified ADL, during an identified period of time; and the care plan was not followed and the expectation that care will be followed as outlined in the care plan.

In an interview, RPN #147 reported to the inspector that the resident had exhibited an identified behaviour, during an identified period of time.

During an interview, CM #109 reported that the staff had not followed the care plan; that RPN #147 was aware that the resident needed to be assisted with an identified ADL and it wasn't done. [s. 6. (7)]

4. A CIS report was submitted to the Director on an identified date, for an incident of alleged staff to resident physical abuse that had occurred on an identified date. The report indicated that the POA of resident #004 had brought forward a complaint that the resident had received care that was of a certain characteristic and the approach was of another characteristic, as viewed by the POA from a camera within the resident's room. The POA alleged that a PSW heaved [resident #004] towards the other PSW and that [the resident's] identified body part flew off the bed and then were thrown back up on the bed. This incident was reported by the POA on the date the CIS was submitted to the Director.

A review of resident #004's care plan was conducted. Under an identified focus on the care plan, it indicated that if the resident exhibited identified behaviours, specific interventions were to be utilized.

The home's investigation file was reviewed. Investigation notes included an identified document, addressed to PSW #148, which indicated that the PSW did not follow the care plan of a resident for identified behaviours.

In an interview with PSW #148, they reported that they were working with another PSW; and there was indication that resident #004 needed assistance with an identified ADL; they had explained to the resident what had to be done; the resident exhibited identified behaviours.

In an interview with CM #109, they reported that PSW #148 had said resident #004 had exhibited identified behaviours, and they were fearful that they may lose their job if they didn't provide care to the resident. The CM further reported that PSW #148 didn't follow the care plan; they should have utilized specific interventions. [s. 6. (7)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident

was assessed and that where the condition or circumstances of the resident require, 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, on an identified date, for a fall that caused an injury to resident #029, on an identified date, in which they were taken to the hospital. An additional CIS report was submitted to the Director, on an identified date, for the same incident for the improper or incompetent treatment of resident #029. The CIS report indicated that resident #029 sustained an unwitnessed fall on an identified date, and was sent to the hospital on an identified date, where identified injuries were confirmed.

During separate interviews with RPNs #110, and #130, they reported that after any resident fell, the registered staff were required to complete a post fall assessment tool, electronically on MED e-care. The RPNs, indicated that they were to complete as much information in the tool as possible, relating to the specific fall.

Inspector #693 reviewed the electronic assessments, on MED e-care, for resident #029, and identified an assessment, titled, “SJCG Post Fall Assessment Tool”, completed on an identified date. The assessment was completed by RPN #112. RPN #112, had documented the resident’s name and room number, date of fall, time of fall, that the fall was unwitnessed, and the resident had no injury or pain, that neurovital and vital signs were taken, and that the resident was not utilizing restraints at the time of the fall. The following portions of the assessment tool were left blank: family member notification, post fall huddle documentation; including contributing factors, cause of fall, and follow up recommendations, record of medications that the resident consumed, and fall prevention interventions.

Inspector #693 reviewed the home’s policy, titled, “Fall Prevention and Management Program, LRC-15-01-01", last updated January 22, 2020. The policy indicated that after a resident fell, staff were required to complete a post fall assessment, which included an area to summarize the post fall team huddle.

During an interview with the DOC, they indicated that RPN #112 did not fully complete the post fall assessment as required, and the information that was documented, was not an appropriate assessment of resident #029’s fall on an identified date. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may have constituted a criminal offence.

See WN #1, finding #2 in Follow Up inspection #2020_768693_0011 report, for further details.

A CIS report was received by the Director on an identified date, related to alleged staff to resident abuse. The report indicated verbal abuse towards resident #001 by PSW #140.

During a review of the CIS report, there had been no documentation that the police had been notified. A review of the home's investigation records had not included a record of the police being notified.

A review of the home's policy, "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences – LRC-02-01-03", revised on October 23, 2019, indicated that the police would be notified if there were grounds to believe a criminal code offense had been committed.

During an interview with Interim Clinical Manager #102, they confirmed with Inspector #577 that their investigation had confirmed verbal and emotional abuse by PSW #140 to resident #001, and they had not notified the police. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. In making a report to the Director under subsection 23(2) of the Act, the licensee failed to have included the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

A CIS report was received by the Director on an identified date, related to alleged staff to resident abuse. The report indicated verbal abuse towards resident #001 by PSW #140.

During a review of the CIS report, Inspector #577 found that there wasn't a full description of the alleged abuse, but a statement that indicated verbal abuse towards resident #001. Inspector #577 found that the report did not include a description of the verbal abuse, what was said to the resident or what led up to the occurrence.

During an interview with Interim Clinical Manager #102, they confirmed with Inspector #577 that they did not document a full description of the events involving resident #001 and PSW #140. [s. 104. (1) 1.]

WN #8: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of any missing resident who returned to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.

Inspector #757 reviewed appendix 1 of the home's policy "Critical Incident Reporting - RC-09-01-06", titled "Ontario LTC Mandatory and Critical Reporting Requirements", last updated June 2020. The appendix indicated that when any missing resident returns to the home with an injury or any adverse change in a condition, regardless of the length of time the resident was missing, the home must immediately initiate and submit the on-line CIS form. The appendix further indicated that if the incident occurred after hours, to call the ServiceOntario after hours reporting line followed by filling out a CIS form first thing the following business day.

A CIS report, was submitted by the home to the Director on an identified date, related to an incident that occurred on an identified date. The report was related to resident #013, who had left the home for a casual leave of absence, and had not returned to the home at the anticipated identified time. The resident was returned to the home by the police at an identified time on a specific date. The report indicated that the resident returned to the home with identified injuries. The report further indicated that the RN did not follow the home's protocol or report the incident to the Ministry of Long-Term Care.

The Inspector reviewed resident #013's electronic progress notes from an identified date. A progress note written by RN #121 at an identified time indicated that the resident received a skin assessment by RPN #127. A progress note written by RPN #127 at 1910 hrs indicated that they had cleansed and dressed wounds to identified areas of the resident's body.

During an interview with RN #121, they indicated that they could not recall if they had notified the ministry of the incident.

The Inspector conducted an interview with CM #102, who confirmed that the after hours reporting line should have been called the day the incident occurred, but had not been. The CM stated that they were unsure why RN #121 had not reported the incident, and that they should have. [s. 107. (1) 4.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record was kept up to date at all times.

A CIS report was submitted to the Director, on an identified date, for a fall that caused an injury to resident #029, on an identified date, in which they were taken to the hospital. An additional CIS report was submitted to the Director, on an identified date, for the same incident for the improper or incompetent treatment of resident #029. The CIS report indicated that resident #029 sustained an unwitnessed fall on an identified date, and was sent to the hospital on an identified date, where identified injuries were confirmed.

Inspector #693 reviewed the progress notes and electronic assessments for resident #029, related to their fall, on an identified date, in MED e-care. A progress note, and post-falls electronic assessment, composed by RPN #112, indicated that resident #029 had an unwitnessed fall without injury at an identified time, and vital signs were taken and stable.

Inspector #693 reviewed the resident's medical record, and identified a form, titled "Clinical Monitoring Record." The form indicated that resident #029 fell on an identified date, and their vital signs were recorded as specific values.

Inspector #693 reviewed the home's CIS investigation file. The investigation notes contained interview notes between the DOC and PSW #128, in which they indicated that RPN #112 did not complete any hands-on assessment of resident #029. In addition, notes made by the DOC upon review of the video footage from the time of resident #029's fall on an identified date, indicate that RPN #112 was never seen bringing a vitals machine or required equipment to resident #029 to complete the assessment of their vital signs.

During an interview with the DOC, they indicated that there were many steps missed by RPN #112 in their assessment of resident #029, post fall on an identified date. The DOC stated that the RPN did not complete a physical assessment and this included not taking vital signs. The DOC indicated that the vitals signs that were recorded for resident #029 at an identified time on the date of the fall, by RPN #112 were falsified, and the resident's health record was inaccurate for that time. [s. 231. (b)]

Issued on this 28th day of September, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by MELISSA HAMILTON (693) - (A1)

Inspection No. / No de l'inspection : 2020_768693_0013 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 023069-19, 023859-19, 000362-20, 001220-20, 001221-20, 001369-20, 001530-20, 003301-20, 003303-20, 003588-20, 003602-20, 003640-20, 003790-20, 003917-20, 004212-20, 004271-20, 005624-20, 006300-20, 006745-20, 006821-20, 007397-20, 007438-20, 007590-20, 007938-20, 008097-20, 008843-20, 008939-20, 009484-20, 009707-20, 009792-20, 010318-20, 010387-20, 010434-20, 010923-20, 010925-20, 010945-20, 011471-20, 011811-20, 011813-20, 011991-20, 012251-20, 013037-20, 013198-20, 013417-20, 013674-20, 013745-20, 013821-20, 013981-20, 014078-20, 014107-20 (A1)

Type of Inspection / Genre d'inspection : Critical Incident System

Report Date(s) / Date(s) du Rapport : Sep 28, 2020(A1)

Ontario

Ministry of Long-Term Care

Ministère 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

Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	Hogarth Riverview Manor 300 Lillie Street, THUNDER BAY, ON, P7C-4Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sheila Clark

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(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 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 shall be compliant with section 20. (1), of the Long-Term Care Homes Act, 2007.

Specifically, the licensee shall ensure that all staff are compliant with the home's policy to promote zero tolerance of abuse and neglect of all residents.

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.

A Critical Incident System (CIS) report was received by the Director on an identified date, related to staff to resident neglect. The CIS report indicated that the family member of resident #002 had found the resident in an identified condition, as they needed an identified Activity of Daily Living (ADL) to be completed and staff had not answered their call bell.

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

A review of the home's policy, "Zero Tolerance of Resident Abuse and Neglect

Program, LRC-02-01-01", last updated in October, 2019, indicated that the home was committed to have provided a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times. They had zero tolerance for abuse and neglect and any form of abuse or neglect by any person, whether through deliberate acts or negligence, would not be tolerated.

A review of the home's internal investigation notes by Inspector #577, identified that PSW #143 had attended to resident #002, attached an identified assistive device, activated their call bell, and waited an identified number of minutes. PSW #143 reported that staff had not answered their call bell, they realized it was an identified time, so they removed the assistive device from the resident; they told the resident that they would tell the oncoming staff to assist them with an identified ADL and they left the resident.

A review of resident #002's care plan at the time of the incident indicated that resident #002 required the assistance of an identified device for a specified ADL.

During an interview with PSW #143, they advised Inspector #577 that resident #002 needed to be assisted with an identified ADL, they attached an identified assistive device for another identified device and called for assistance on the call bell; when staff had not answered the call bell, and realized staff were in report, they removed the identified device and communicated to the oncoming staff that resident #002 required assistance with the identified ADL.

During an interview with CM #117, they advised Inspector #577 that PSW #143 had provided incompetent care to resident #002 when they had not completed the care for the resident, left them and had not waited for assistance. [s. 20. (1)]

(577)

2. A CIS report was received by the Director on an identified date, related to staff to resident neglect of residents #005 and #006. The report alleged that resident #005 was found in a particular condition, without specified care complete, at an identified time. Similarly, resident #006 was found in a particular condition and had not been provided with specified care, at an identified time.

A review of the home's policy, "Zero Tolerance of Resident Abuse and Neglect:

Response and Reporting - RC-02-01-02", revised June 2019, which indicated that anyone who witnessed or suspected abuse or neglect by another resident, staff or other person must notify management immediately; any employee or person who became aware of an alleged, suspected or witnessed resident incident of abuse or neglect would report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior supervisor on shift at the time; the person reporting the suspected abuse would follow the home's reporting process and provincial requirements to ensure the information was provided to the home Administrator/designate immediately.

A review of the home's policy, titled, "Care and Comfort Rounds, LRC-12-01-06", last updated on December 18, 2019, indicated that the home would schedule regular care and comfort rounds at set intervals to proactively anticipate resident needs related to pain, positioning, prompted toileting, proximity to personal items and other comfort and safety issues; comfort rounds were scheduled every hour to proactively address pain, position, prompted toileting and possessions.

a) A review of resident #005's care plan at the time of the incident indicated that the resident required an identified level of assistance for an identified ADL and utilized a specific product, at all times.

A review of the investigation file included the following documentation:

-PSW #139 provided morning care and did not provide the resident with an identified product and only assisted them with an identified ADL at a specified time, on an identified date;
-PSW #137 found the resident in an identified condition, at an identified time, without the utilization of a specified product; their ambulation device was described as being a certain condition; they informed RPN #138; and
-RPN #138 was informed of alleged neglect and had not immediately informed the RN; they indicated that a discussion with the PSWs was sufficient.

b) A review of resident #006's care plan at the time of the incident indicated that the resident required an identified product.

A review of the investigation file included the following:

- PSW #139 provided morning care and did not provide the resident with identified interventions after an identified time on an identified date;
- the resident was not checked at change of shift; PSW #144 found them in an identified condition at an identified time;
-an identified document, from an identified date, from CM #100 to PSW #139, which indicated that they had worked a specified shift on identified dates, where they had not provided care to two residents at an identified time and had not completed the care as required;
-an identified document, from an identified date, from CM #100 to PSW #136, which indicated they had not immediately reported alleged neglect/incompetent care to a registered staff member or CM, but had reported it to the Manager two days later via email;
-an identified document, from an identified date, from CM #100 to PSW #137, which indicated that the care of a resident was not provided until a specified time and was reported as incompetent care. It was determined that they did not complete care as documented; it was expected that they check all the residents assigned to them and all care provided was documented; and
-an identified document, from an identified date, from CM #100 to RPN #138, which indicated that a staff member had brought concerns to them of alleged neglect towards a resident, and they had not reported it to the RN or Manager immediately, but felt that a discussion with the PSWs was sufficient.

A review of an email from PSW #136 to CM #100, sent two days after the incident, indicated that PSW #137 had reported to them that they found resident #005 in a particular condition and without the use of an identified product; it was the second occurrence with a different staff; believed that the resident did not accept care from identified staff; and an incident from the day before where PSW #137 reported to them that they found resident #006 in their ambulation device in a particular condition.

During an interview with RPN #138, they advised Inspector #577 that PSW #137 informed them about care concerns related to resident #005 and #006, and they didn't report it.

During an interview with PSW #137, they advised Inspector #577 that they had not checked resident #006 after shift change, and their co-worker found the resident to be in a particular condition, at a certain time. They found resident #005 to be in a

particular condition and not utilizing an identified product, when they checked them at an identified time.They further reported that they informed RPN #138.

During an interview with PSW #136, they advised Inspector #577 that PSW #137 had reported to them that they found resident #005 in an identified condition, without the use of an identified product and resident #006 was found in a particular condition; PSW #137 reported to them that resident #005 doesn't like identified PSWs and had noticed that when identified staff members offered them care, they would refuse to use a required product and would be found in an identified condition. PSW #136 indicated that they were advised that PSW #137 didn't report these incidents to the RPN, so they sent an email to the CM, as for two consecutive days, PSW #139 left two residents in an identified condition.

During an interview with PSW #139, they advised Inspector #577 that they provided care to resident #005 and they had refused to use an identified product. They reported that they don't recall whether resident #005 and #006 were checked every hour or assisted with a specified ADL at an identified time.

During an interview with CM #100, they advised the Inspector, that PSW #139 neglected to have provided specified care for resident #005 and #006, as they weren't assisted with an identified ADL or provided with identified interventions, at a specific time; identified care wasn't provided to resident #006 until the an identified; resident #005 wasn't provided with an identified product (refused) and wasn't provided specific interventions at an identified time. The CM indicated that resident #005 was checked at an identified time, and found to be in a particular condition without the use of an identified product. The CM advised that the residents should have been checked at an identified time. In addition, the CM indicated that PSW #144 found resident #006 in a particular condition and they reported it to PSW #137, who then reported both resident incidents to RPN #138. CM #100 indicated that RPN #138 didn't report the incidents. CM #100 advised that PSW #139 failed to follow the care plans, failed to provide identified care at an identified time (both residents) and should have checked resident #006 and #005 at an identified time; as well, the staff should have been checking the resident's every hour, and at identified times. Further, PSW #136 and RPN #138 had not immediately reported alleged neglect. [s. 20. (1)] (577)

3. A CIS report was submitted to the Director on an identified date, for an incident of staff to resident verbal abuse that had occurred on an identified date. The report

identified that PSW #135 had sworn at resident #026.

The LTCHA 2007 defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

The home's investigation records were reviewed and included an identified document addressed to PSW #135 that read, "your actions constitute verbal abuse of a resident …".

In an interview, PSW #134 described the incident in which PSW #135 had exhibited an identified behaviour and said [expletive] to the resident.

In an interview, CM #109 acknowledged that the home's policy on and zero tolerance of abuse had not been complied with, as verbal abuse had occurred when PSW #135 had sworn at resident #026. [s. 20. (1)]

The decision to issue this Compliance Order (CO) was based on the scope which was a pattern, the severity which was minimal harm or risk. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation, as follows:

-a Voluntary Plan of Correction (VPC) was issued from a Critical Incident System (CIS) inspection #2020_633577_0008, on June 9, 2020;
-a VPC was issued from a CIS inspection #2019_740621_0036, on January 6, 2020;
-a VPC was issued from CIS inspection #2019_746692_0019, on August 20, 2019;
-a VPC was issued from a Complaint inspection #2019_633577_0010, on June 4, 2019;
-a Written Notification (WN) was issued from a CIS inspection #2019_768693_0002, on February 12, 2019;
-a CO and Director's Referral (DR) was issued from a CIS inspection #2018_624196_0024, on October 11, 2018;
-a CO was issued from a Complaint inspection #2018_655679_0005, on March 22, 2018;
-a WN was issued from a CIS inspection #2018_657681_0001, on February 2, 2018;
-a VPC was issued from a Complaint inspection #2017_509617_0020, on November

14, 2017; and
-a WN was issued from a CIS inspection #2017_509617_0017, on October 11, 2017.

(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 05, 2020(A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with section 36. of Ontario Regulation 79/10. The licensee shall ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Specifically the licensee must:

a) Ensure that staff use safe transferring and positioning devices or techniques
when assisting resident #002, #028, #035, and all other residents.

Grounds / Motifs :

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

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CIS report was received by the Director on an identified date, related to staff to resident neglect. The CIS report indicated that the family member of resident #002 had found the resident in an identified condition, as they needed an identified Activity of Daily Living (ADL) to be completed and staff had not answered their call bell.

A review of home's policy, "Mechanical Lifts Procedure, LLP-01-01-03", last updated on January 22, 2020, indicated that two people were required when positioning a sling on a resident.

A review of the home's internal investigation notes by Inspector #577, identified that PSW #143 had attended to resident #002, and attached their transfer sling while they waited for further staff assistance.

During an interview with PSW #143, they advised Inspector #577 that resident #002 needed assistance with an ADL and they attached an assistive device for another device and called for assistance on the call bell; when staff had not answered the call bell, they removed the device and communicated to the on coming staff that resident #002 required assistance with an identified ADL.

During an interview with CM #117, they advised Inspector #577 that PSW #143 had not followed the home's "Safe Lifting with Care" policy when they had attached the assisitive device onto resident #002 without a second staff member. [s. 36.] (577)

2. A CIS report was submitted to the director on an identified device, for the improper and incompetent treatment of resident #028. The CIS report indicated that PSW #104, reported to CM #100, that on an identified device, during care, resident #028 required an identified level of assistance to transfer, using an identified assisitive device, but was transferred improperly by PSW #103, by means of a transfer with an identified level of assistance.

Inspector #693 reviewed resident #028's care plan that was current on an identified date. The care plan, last updated on a specified date, identified that resident #028 would transfer safely with an identified level of assistance, using an identified assisitive device.

During an interview with PSW #106, they indicated that it was the home's policy, to always have an identified number of staff members participate in an identified type of transfer of a resident.

Inspector #693 reviewed the home's investigation notes. The investigation notes identified that during an interview with Interim Clinical Manager #102, PSW #103 indicated that they completed an identified type of transfer for resident #028, on an identified date, as they thought the resident was going to fall and wanted to prevent an injury. The investigation notes further indicated that during an interview with Interim Clinical Manager #102, PSW #104 stated that they offered to help PSW #103 multiple times with the transfer, but PSW #103 was adamant that they would do the transfer alone. The home's investigation file contained an identified document, written to PSW #103, from Interim Clinical Manager #102. The letter indicated on an identified date, it was reported that PSW #103 transferred a resident by an identified means, when the resident required a different identified method and mechanism to transfer. The letter further indicated that it's purpose was to bring attention to PSW #103, the appropriate safety precautions that should be exercised when operating a mechanical lift and expectations to follow the home's policy.

Inspector #693 reviewed the home's policy, titled, "Mechanical Lifts, LLP-01-01-02", last updated January 22, 2020. The policy indicated that two trained staff were always required when a transfer was performed, using a mechanical lift.

During an interview with Interim Clinical Manager #102, they stated that resident #028 was to be transferred, using an identified device, with an identified number of staff members participating in the lift, as well that the home's policy required two staff members for all mechanical lift transfers. The Interim Clinical Manager indicated that PSW #103 completed an improper transfer of resident #028. [s. 36.] (693)

3. A CIS report was submitted to the Director on an identified date, for the improper and incompetent treatment of resident #035. The CIS report indicated that RPN #142, reported to CM #100, that on an identified date, resident #035 had been transferred by PSW #105, while assisting with an identified ADL, and the resident required assistance from an identified number of staff members, utilizing an identified device.

Inspector #693 reviewed resident #035's care plan that was current on an identified

date. The care plan, last updated on an identified date, indicated that resident #035 would transfer safely with the assistance of an identified number of staff members, using an identified device.

Inspector #693 reviewed the home's CIS investigation file. The investigation notes identified that during an interview with Interim CM #100, PSW #105 indicated that they completed an identified kind of transfer for resident #035. The PSW indicated that the resident's care plan indicated that they required assistance of an identified number of staff members, with an identified device for transfers, and that the PSW should have called for assistance from another staff member to complete the transfer for resident #035. The home's investigation contained an identified document, addressed to PSW #105, from CM #100. The letter indicated that it was regarding an improper lift, for a resident who required an identified kind of transfer, utilizing an identified device. The letter indicated that the PSW preformed the transfer in an identified way and that as per care plan, an identified number of staff were required for the transfer.

Inspector #693 reviewed the home's policy, titled, "Mechanical Lifts Procedure, LLP-01-01-03", last updated on January 22, 2020. The policy indicated that staff were to check the care planning documents for the approved transfer process for a resident. Additionally, Inspector #693 reviewed the home's policy, titled, "Transfer Devices Pre-Transfer Review, LLP-01-01-05", last updated on January 22, 2020. The policy indicated that residents were assessed on their assistance required to transfer safely from one surface to another, and from one position to another on the same surface.

During an interview with PSW #105, they indicated that they transferred resident #035, on an identified date, in a specified way, when at that time the resident required assistance from an identified number of staff members, utilizing an identified device. The PSW indicated that they knew the resident required an identified device for a transfer but, thought the resident could transfer safely in the way in which they completed the transfer.

During an interview with CM #100, they stated that on an identified date, PSW #105 completed an improper transfer of resident #035, had not followed the resident's care plan, or the home's policy. [s. 36.]

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 decision to issue this Compliance Order (CO) was based on the scope which was widespread, the severity which was minimal harm or risk. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation, as follows:

-a Voluntary Plan of Correction (VPC) was issued from a Critical Incident System (CIS) inspection #2020_655679_0003, on February 7, 2020;
-a Written Notification (WN) from a CIS inspection #2019_740621_0036, on Janaury 6, 2020;
-a WN from a CIS inspection #2019_671684_0036, on October 31, 2019;
-a CO from CIS inspection #2019_768693_0021, on September 18, 2019;
-a VPC was issued from a Complaint Inspection #2019_633577_0010, on June 4, 2019;
-a VPC was issued from a Complaint Inspection #2018_624196_0023, on October 11, 2018;
-a WN was issued from a CIS Inspection #2017_509617_0023, on January 5, 2018; and
-a CO was issued from a CIS Inspection #2017_509617_0017, on October 11, 2017. (693)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 19, 2020(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee must be in compliance with section 48. (1) 1. of O. Reg. 79/10.

Specifically the licensee must:

a) Ensure that the falls prevention and management program is implemented in the home.

b) Conduct random audits of the assessments and documentation completed after a resident falls, to ensure implementation of the home's falls prevention and management program.

c) Maintain a record of all audits conducted and actions taken by the home, to address any errors in assessments or documentation.

Grounds / Motifs :

1. The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home.

A CIS report was submitted to the Director, on an identified date, for the improper or incompetent treatment of resident #032 on an identified date. The report further indicated that on an identified date, it was reported that resident #032 sustained a fall at an identified time, that resulted in an area of altered skin integrity to an identified area of the resident's body, and another area of altered skin integrity to an identified area of their body. On an identified date, the SDM of resident #032, reported to CM #109, that they were concerned that resident #032 was not checked on for some time, as the resident reported to them that they had lied on the floor for an identified period of time prior to getting help.

Inspector #693 reviewed resident #032's medical record and identified a form titled, "Clinical Monitoring Record." The record indicated that resident #032 fell on an identified date, at an identified time, and the first set of assessments were documented at an identified time on an identified date. The form indicated that the following were to be monitored every hour for four hours and then every eight hours for 72 hours: neurological vital signs for an unwitnessed fall, vital signs, pain and changes in behaviour. Additionally, the form directed staff to complete a client safety report if there was a fall with injury. A review of this "Clinical Monitoring Record", identified that pain assessments were recorded on three identified dates, at three identified times. Attached to the "Clinical Monitoring Record" was a checklist that indicated the following process was to be followed for every resident fall: the "Clinical Monitoring Record" was to be initiated, and used to assess neurological vital signs, vital signs, pain, bruising, changes in functional and cognitive status and changes in range of motion, as well that staff were to document the results of all assessments and actions taken during the 72 hours post-fall follow-up in MED e-care as a follow up note to the original incident.

Inspector #693 reviewed the progress notes, electronically on MED e-care for resident #032. A progress note from an identified date, at an identified time, indicated that resident #032 was heard calling out for help, and was found in an identified position, with an area of altered skin integrity to an identified area of the resident's body, and another area of altered skin integrity to an identified area of their body. Inspector #693, reviewed the progress notes for the 72-hour post fall period, for their

fall on an identified date. Assessments of pain, bruising, changes in functional and cognitive status and changes in range of motion, were documented on the day shift of an identified date, and the night shift of an identified date. There were no assessments related to the fall documented in MED e-care for the day shifts of identified dates, or for the night shifts of identified dates.

Inspector #693 reviewed the home's CIS investigation file, and identified that RPN #107, was the registered staff member, responsible for the care of resident #032 on an identified shift. The investigation indicated that the RPN had not completed the required client safety report, after the fall.

During an interview with RPN #110, they stated that when a resident had experienced an unwitnessed fall, and sustained an injury, the registered staff member was responsible for completing an assessment of the resident, which included completing the "Clinical Monitoring Record", and a client safety report. The RPN stated that the neurovitals, pain assessment, vitals, and changes in behavior needed to be assessed from the time of the fall, and every hour for four hours and every eight hours for 72 hours post fall. RPN #110 reviewed the "Clinical Monitoring Record" form, for resident #032's fall on an identified date, and stated that the pain assessment was only completed three times on the sheet and should have been completed 13 times. The RPN stated that sometimes nurses documented the pain assessments in the progress notes on MED e-care.

Inspector #693 reviewed the home's policy, titled, "Fall Prevention and Management Program, RC-15-0101, LRC-15-01-01", last updated January 22, 2020. The policy indicated that that if a resident experienced an unwitnessed fall, staff were to have completed a "Clinical Monitoring Record." The policy also directed staff to assess the following; for 72 hours post fall, at each shift: pain, bruising, change in functional status, change in cognitive status; and changes in range of motion.

During an interview with CM #109, they stated that when a resident had an unwitnessed fall, staff were to have initiated and completed the "Clinical Monitoring Record", as well as complete a client safety report, in addition to other mandatory tasks required by the home's policy. The CM stated that registered staff were to assess and document results for pain, vital signs, neurological vital signs, changes in functional or cognitive status, and changes in range of motion. The Clinical Manager reviewed the documentation for resident #032's unwitnessed fall on an identified

date, and confirmed that the "Clinical Monitoring Record" was not fully completed, assessments of pain, bruising, change in functional status, change in cognitive status; and changes in range of motion were not done at each shift for 72 hours post fall, and the required client safety report was not completed. [s. 48. (1) 1.]

(693)

2. A CIS report was submitted to the Director, on an identified date, for a fall that caused an injury to resident #029, on an identified date, in which they were taken to the hospital. An additional CIS report was submitted to the Director, on an identified date, for the same incident for the improper or incompetent treatment of resident #029. The CIS report indicated that resident #029 sustained an unwitnessed fall on an identified date, and was sent to the hospital on an identified date, where identified injuries were confirmed.

Inspector #693 reviewed the progress notes, for resident #029, related to their fall, on an identified date, in MED e-care, and identified a progress note, composed by RPN #112, that indicated resident #029 had an unwitnessed fall without injury at an identified time, on an identified date. A progress note composed by the DOC, on an identified date, indicated that resident #029's identified area of their body was assessed, and was a certain condition, resident experienced a symptom on identified assessment and was unable to move their identified area of their body, resident experienced pain at rest and with movement, resident was transferred to the hospital for further investigations and assessments.

Inspector #693 reviewed resident #029's medical record and identified a form titled, "Clinical Monitoring Record." The record indicated that resident #020, fell on an identified date, at an identified time. In addition, the record indicated that the following were to be monitored every hour for four hours and then every eight hours for 72 hours: neurological vital signs for an unwitnessed fall, vital signs, pain and changes in behaviour. A review of this"Clinical Monitoring Record", identified that pain assessments were documented on two identified dats, at specified times. Vital signs were documented on identified dates and times, additionally at an identified time on an identified date , it was recorded under the vital signs portion of the form that the resident was sleeping. Neurovital signs were documented on January 18, 2020, at 1840 hrs and 2040 hrs, January 19, 2020, at 0540 hrs, 1340 hrs, and 2140 hrs, additionally at 1940 hrs on January 18, 2020, it was recorded under the

neurovital signs portion of the form that the resident was sleeping.

Inspector #693 reviewed the home's CIS investigation file. The investigation notes indicated that through investigation, which included interviews and a review of video surveillance, the home determined that RPN #112 did not complete an assessment of resident #029, post fall on January 18, 2020, before instructing PSW #128 to help lift the resident to bed with a mechanical lift, did not complete any hands-on physical assessment of the resident at anytime post fall, did not notify resident #029's POA, did not call an RN to assess resident, did not complete a post-fall huddle, and did not fully complete the required post falls assessment.

During an interview with RPN #130, they indicated that when a resident had an unwitnessed fall, registered staff were to assess the environment, complete a physical assessment of the resident, if the resident had a suspected injury they were required to call the Registered Nurse to assess resident, initiate the "Clinical Monitoring Record"; this included monitoring neurological vital signs for an unwitnessed fall, vital signs, pain and changes in behaviour, every hour for four hours and then every eight hours for 72 hours, post falls assessment on MED e-care, post falls huddle with staff present, notify the physician, and complete a client safety report. RPN #130 reviewed the "Clinical Monitoring Record" from resident #029's fall on January 18, 2020 and indicated that the form was not completed at the times it should have been, as well that the registered staff should wake the resident up to complete the post-falls assessment and not document "sleeping" on the record.

During an interview with PSW #128, they indicated that they were working on January 19, 2020, when resident #029 sustained a fall. The PSW stated that a Therapeutic Recreation staff member found the resident on the floor in the hallway outside of their room and called for help. PSW #128 stated that they attended to the resident with RPN #112, and RPN #112 instructed the PSW to get the lift and help the RPN lift the resident into their bed. PSW #128 stated that RPN #112, did not complete an assessment of the resident, before the staff transferred the resident with a lift, and stated the RPN just looked at the resident. PSW #112 stated that it was obvious the resident was in pain, as they were saying they were and grabbing towards their an area of their body. The PSW reported that once the resident was in bed, RPN #112 did not complete a further assessment, and this included not completing vital signs. The PSW stated that the resident told them they would like to go to the hospital as they were in pain, and the PSW reported this to the RPN. PSW

#128 stated that RPN #112 did not do anything to treat resident #029's pain or attempt to send the resident for further assessments.

Inspector #693 reviewed the home's policy, titled, "Fall Prevention and Management Program, LRC-15-01-01", last updated January 22, 2020. The policy indicated that after a resident fell, staff were required to complete an initial physical and neurological assessment, to have treated any injuries and managed pain, hold a post fall huddle, complete a post fall assessment, notify the SDM, and if a resident experienced an unwitnessed fall, staff were to have completed a "Clinical Monitoring Record." The policy also directed staff to assess the following; for 72 hours post fall, at each shift: pain, bruising, change in functional status, change in cognitive status; and changes in range of motion. In addition, the policy indicated on the 'Post Fall Clinical Pathway', that staff were to move the resident using a mechanical lift after a fall, following assessment by the nurse and approval for transfer.

During an interview with the DOC, they indicated that the "Clinical Monitoring Record" was not completed for the required times post fall; pain, bruising, change in functional status, change in cognitive status, and changes in range of motion were not assessed each shift as required, post fall; RPN #112 did not complete a physical assessment of resident #029 or manage their pain; the resident was transferred with a lift prior to being assessed; the POA and RN were not notified; RPN #112 did not complete a post falls huddle; or a post falls assessment, as required. The DOC indicated that the home's falls prevention and management program, was not implemented appropriately for resident #029's fall on January 18, 2020, and this could have contributed to the resident's injuries. [s. 48. (1) 1.]

The decision to issue this Compliance Order (CO) was based on the scope which was a pattern, the severity which was minimal harm or risk. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation, as follows:

-a Voluntary Plan of Correction (VPC) was issued from a Critical Incident System (CIS) inspection #2019_768693_0021 2020_655679_0003, on September 18, 2019; and
-a VPC from a Complaint inspection #2018_624196_0030, on December 20, 2018.
(693)

Ontario

Ministry of Long-Term Care

Ministère 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 : Oct 19, 2020(A1)

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Ordre(s) de l'inspecteur

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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 Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Ontario

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Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère 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 28th day of September, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by MELISSA HAMILTON (693) - (A1)

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