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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
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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
Jul 30, 2020	2020_565647_0006 (A1)	023161-19, 002737-20, 002739-20, 003455-20, 003940-20, 004873-20	Critical Incident System

Licensee/Titulaire de permis

Lakeland Long Term Care Services Corporation
6 Albert Street PARRY SOUND ON P2A 3A4

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

Lakeland Long Term Care Services
6 Albert Street PARRY SOUND ON P2A 3A4

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

Amended by JENNIFER BROWN (647) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee had requested and been granted an extension to the compliance due date for CO #01 and CO #02.

Issued on this 30th day of July, 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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
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Long-Term Care Home/Foyer de soins de longue durée

Lakeland Long Term Care Services
6 Albert Street PARRY SOUND ON P2A 3A4

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

Amended by JENNIFER BROWN (647) - (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): On site inspection took place from March 9 - 13, 2020. An off site inspection continued and took place on March 16 - 18, May 11 - 15, 19 - 21, 25 - 29, and June 1 - 4, 2020.

The following intakes were completed in this Critical Incident System (CIS) inspection:

-two logs were related to the improper use of as assisted device,

-two logs were related to a fall with injury, and

-one log was related to staff to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Interim Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), residents, and substitute decision makers (SDM).

During the course of the inspection, the Inspector(s) also conducted a daily tour of the resident care areas, observed staff to resident interactions, resident to resident interactions, and the provisions of care, reviewed internal documents, and policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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) The licensee submitted a Critical Incident (CI) report to the Director, on an identified date, for improper care related to an assisted device. A review of the CI report indicated that resident #003 received assistance by direct care staff member #102, who used the wrong assisted device.

A review of resident #003's plan of care at the time of the incident, and a review of the most recent identified assessment for resident #003, both indicated that resident #003 was to receive assistance with an identified type of assisted device.

In a review of the home's internal investigation notes, it was identified that direct care staff member #102 had provided assistance to resident #003 with an incorrect assisted device.

In an interview with direct care staff member #102, they indicated that they had chosen to use the wrong assisted device as they felt the resident was better suited for another identified device. Direct care staff member #102 stated they had received applicable training and that it was the home's policy that all staff will ensure that residents receive appropriate assistance, however chose another assisted device to assist the resident.

B) The licensee submitted a second CI report to the Director, on an identified date, for improper care related to an assisted device. A review of the CI report indicated that resident #007 received assistance by direct care staff member #102, who used the wrong assisted device.

A review of resident #007's plan of care at the time of the incident, and a review of the most recent identified assessment for resident #007, both indicated that resident #007 was to receive assistance with an identified type of assisted device.

In a review of the home's internal investigation notes, it was identified that direct care staff member #102 had provided assistance to resident #007 with an incorrect assisted device.

In an interview with direct care staff member #102, they indicated that they had chosen to use the wrong assisted device as they felt the resident was better suited for another identified device. Direct care staff member #102 stated they had received applicable training and that it was the home's policy that all staff will ensure that residents receive appropriate assistance, however chose another assisted device to assist the resident.

C) The licensee submitted a third CI report to the Director, on an identified date, for improper care related to an assisted device. A review of the CI report indicated that resident #008 received assistance by direct care staff member #110, who used the wrong assisted device.

A review of resident #008's plan of care at the time of the incident, and a review of the most recent identified assessment for resident #008, both indicated that resident #008 was to receive assistance with an identified type of assisted device.

In an interview with direct care staff member #110, they indicated that they had chosen to use the wrong assisted device as they did not feel it made a difference of which device to use. Direct care staff member #110 stated they had received applicable training and that it was the home's policy that all staff will ensure that residents receive appropriate assistance, however chose another assisted device to assist the resident.

A review of a specific home policy directed staff to use the appropriate device. The policy also indicated that the outcome "will ensure that residents are transferred safely".

In an interview with Registered staff member #106, they indicated that all residents were assessed using an identified assessment tool by a multidisciplinary team. After this assessment was completed, the Physiotherapist (PT) was responsible for updating the visual cue in the room and the care plan. The Registered staff would also communicate it through the white board, team binders, emails and shift report. Registered staff member #106 concluded this interview by stating "there is really no excuse for someone not to know" what assisted device to choose.

In an interview with the PT, they indicated that upon any resident admission or

any resident that had a change in their health status, the resident would receive an identified assessment. The PT indicated that the process included the involvement of, the PT, the Registered Staff member, and the direct care staff member that was most familiar with the resident. Together, these disciplines would speak with the resident and their Substitute Decision Maker (SDM) if applicable, to assess the level of assistance the resident required, that included the appropriate assisted device, and would also include any applicable medical diagnosis that would impact the resident's ability to transfer safely. Once the assessment was completed, the PT would update the plan of care, revise the visual card in the resident's room, and supply the resident with their personal assisted device based on the outcome of the multidisciplinary assessment.

In an interview with the Director of Care (DOC), they indicated that direct care staff member #102 had transferred resident's #003 and #007 using an incorrect assisted device, and direct care staff member #110 had provided assistance to resident #008 using an incorrect assisted device. The DOC further indicated that these actions placed these residents at risk during transfer, and therefore, they were not transferred safely. [s. 36.]

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. 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 resident #010 fell, that they were assessed and if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CI report was submitted to the Director for an incident that caused injury to a resident. The CI report identified that resident #010 had an unwitnessed fall.

Inspector #647 reviewed resident #010's electronic progress notes regarding the incident. The electronic progress note identified that after staff members heard resident #010 yelling, they went to their room and found resident #010 on the floor. A review of the incident note indicated that there was an injury to an identified area.

A review of an identified assessment tool, indicated that the assessment record for the injury was initiated at the time of the fall. There was no assessment documented for three of the required intervals.

Inspector #647 reviewed a specific home policy that directed staff to complete an identified assessment tool after a resident had fallen.

In an interview with Registered staff member #113, they identified that they initiated the assessment and documented on the identified assessment record as they are required to do after any unwitnessed fall as applicable, however did not assess resident #010 at the next required interval. The Registered staff member #113 indicated to the Inspector that they did not have time to assess the resident due to other role responsibilities prior to their shift ending.

In an interview with Registered staff member #111, they identified that they worked the following shift post fall and the identified assessment was still in

progress. The Inspector identified to Registered staff member #111 that there had been no documented assessments for the required intervals. Registered staff member #113 indicated to the Inspector, that they did not complete the two required assessment as the resident was in the dining room at the time.

In an interview with the Administrator, they identified that the identified assessment would be started after an unwitnessed fall or after a fall in which the resident had an identified injury. They further indicated that the identified assessment was required to be completed at all of the assigned intervals to ensure a thorough assessment had been completed. [s. 49. (2)]

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 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.

Physical abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "the use of physical force by anyone other than a resident that causes physical injury or pain".

A CI report was submitted to the Director, which indicated that resident #001 was alleged to have been physically abused by direct care staff member #109. The report further indicated that direct care staff member #104 reported to the DOC that they witnessed direct care staff member #109 responding to resident #001's responsive behaviours and described what was observed. Registered staff member #106 assessed resident #001 post incident which resulted in the appearance of a red mark on an identified body part.

Inspector #647 reviewed the home's investigation notes, and subsequently interviewed direct care staff member #104, who had witnessed the incident. During the interview, direct care staff member #104 indicated that while they and direct care staff member #109 had provided care to resident #001, resident #001 had exhibited responsive behaviours. Direct care staff member #104 indicated that the resident had exhibited responsive behaviours towards direct care staff member #109, that resulted in a scratch. Direct care staff member #104 then witnessed direct care staff member #109 use physical force toward the resident.

During an interview with direct care staff member, they explained to the Inspector the events that took place. Direct care staff member #109 indicated that resident #001 was exhibiting responsive behaviour and scratched them. Direct care staff member #109, further described their actions towards the resident. Direct care staff member #109 denied the allegation of physically force, however later identified the resident sustained an identified injury.

A review of the homes policy titled "Abuse", last updated July 31, 2019, identified that the home has zero tolerance for abuse and neglect. Any form of abuse or neglect by any person, whether through deliberate acts or negligence, will not be tolerated.

During an interview with the Administrator and the DOC, they confirmed to Inspector #647, that at the time of the incident, direct care staff member #109 used unnecessary force while providing care to resident #001. The Administrator further identified that as a consequence, the home failed to comply with their Zero

Tolerance of Resident Abuse and Neglect policy. [s.20. (1)]

2. During a further review of the above CI, it indicated that the home submitted it to the Director on an identified date, however, resident #001 was alleged to have been physically abused by direct care staff member #109 two days prior.

A review of the licensee's policy titled, "Abuse - Investigation", last revised July 2019, directed any person who had reasonable grounds to suspect abuse or neglect of a resident were to immediately report the suspicion to the Director. The licensee's policy further directed an employee who was advised of/or had first hand knowledge of abuse/neglect or suspected abuse/neglect to immediately inform their manager/supervisor.

Inspector #647 reviewed the home's investigation notes, and subsequently interviewed direct care staff member #104, who had witnessed the incident. During the interview, direct care staff member #104 indicated that when they witnessed direct care staff member #109 use physical force towards the resident, it met the definition of physical abuse. During this same interview, direct care staff member #104, verified to the Inspector that their understanding of mandatory reporting requirements, were that every form of abuse was required to be immediately reported to their supervisor/manager who would report to the Ministry. When the Inspector asked why direct care staff member #104 did not report the alleged abuse to their immediate supervisor, they indicated that they only wanted to report it to the Interim Director of Care, and therefore, waited 48 hours.

Inspector #647 interviewed the DOC, who indicated that all staff were trained on mandatory reporting of any alleged or suspected abuse. The DOC also identified that staff were to contact the manager on call for alleged or suspected abuse to be reported to the Director immediately, and it was not. [s. 20. (1)]

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 written policy to promote zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM), if any, and any other persons designated by the resident or SDM were given an opportunity to participate fully in the development and implementation of the resident's care plan.

A CI report was submitted to the Director for an incident that caused injury. The CI report identified that, resident #010 had an unwitnessed fall.

A review of a policy titled "Falls Prevention and Management", last revised on December 16, 2020, indicated for the Registered Staff to "notify the Power of Attorney (POA)/SDM of the fall, interventions, and status of the resident."

A review was completed by Inspector #647 of the resident's plan of care, under an identified focus, indicated "POA will be notified".

A review of the electronic progress notes for resident #010 indicated that Registered staff member #113 had not called the SDM, despite resident #010 having an injury. Registered staff member #111 documented in the progress notes "SDM to be notified", however did not call the SDM during the following shift. The progress notes indicated that Registered staff member #112 contacted the SDM, approximately 12 hours after the fall, and not until the resident's injury progressed and required medical intervention.

During interviews with Registered staff members #113, and #111, they both indicated that the SDM should have been contacted earlier and not wait for almost 12 hours to provide them with an opportunity to participate in the plan of care.

In an interview with the Administrator, they identified that the SDM was not informed of resident #010's fall with injury as soon as what was expected. The Administrator further indicated that because notifying the SDM was delayed, it did not allow them an opportunity to participate fully in the implementation of the resident's plan of care. [s. 6. (5)]

Issued on this 30th day of July, 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 JENNIFER BROWN (647) - (A1)
Inspection No. / No de l'inspection :	2020_565647_0006 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	023161-19, 002737-20, 002739-20, 003455-20, 003940-20, 004873-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 30, 2020(A1)
Licensee / Titulaire de permis :	Lakeland Long Term Care Services Corporation 6 Albert Street, PARRY SOUND, ON, P2A-3A4
LTC Home / Foyer de SLD :	Lakeland Long Term Care Services 6 Albert Street, PARRY SOUND, ON, P2A-3A4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Steve White

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

To Lakeland Long Term Care Services Corporation, 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 :

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 r. 36 of O. Reg 79/10.

Specifically, the licensee shall:
1. Review the policy with all nursing staff related to safe transferring and positioning devices and techniques.

2. Educate all direct care staff to the process of utilizing a specific transferring device.

Grounds / Motifs :

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

A) The licensee submitted a Critical Incident (CI) report to the Director, on an identified date, for improper care related to an assisted device. A review of the CI report indicated that resident #003 received assistance by direct care staff member #102, who used the wrong assisted device.

A review of resident #003's plan of care at the time of the incident, and a review of the most recent identified assessment for resident #003, both indicated that resident #003 was to receive assistance with an identified type of assisted device.

In a review of the home's internal investigation notes, it was identified that direct care staff member #102 had provided assistance to resident #003 with an incorrect assisted device.

In an interview with direct care staff member #102, they indicated that they had chosen to use the wrong assisted device as they felt the resident was better suited for another identified device. Direct care staff member #102 stated they had received applicable training and that it was the home's policy that all staff will ensure that residents receive appropriate assistance, however chose another assisted device to assist the resident.

B) The licensee submitted a second CI report to the Director, on an identified date, for improper care related to an assisted device. A review of the CI report indicated that resident #007 received assistance by direct care staff member #102, who used the wrong assisted device.

A review of resident #007's plan of care at the time of the incident, and a review of the most recent identified assessment for resident #007, both indicated that resident #007 was to receive assistance with an identified type of assisted device.

In a review of the home's internal investigation notes, it was identified that direct care staff member #102 had provided assistance to resident #007 with an incorrect assisted device.

In an interview with direct care staff member #102, they indicated that they had chosen to use the wrong assisted device as they felt the resident was better suited for another identified device. Direct care staff member #102 stated they had received applicable training and that it was the home's policy that all staff will ensure that residents receive appropriate assistance, however chose another assisted device to assist the resident.

C) The licensee submitted a third CI report to the Director, on an identified date, for improper care related to an assisted device. A review of the CI report indicated that resident #008 received assistance by direct care staff member #110, who used the wrong assisted device.

A review of resident #008's plan of care at the time of the incident, and a review of the most recent identified assessment for resident #008, both indicated that resident #008 was to receive assistance with an identified type of assisted device.

In an interview with direct care staff member #110, they indicated that they had chosen to use the wrong assisted device as they did not feel it made a difference of which device to use. Direct care staff member #110 stated they had received applicable training and that it was the home's policy that all staff will ensure that residents receive appropriate assistance, however chose another assisted device to assist the resident.

A review of a specific home policy directed staff to use the appropriate device. The policy also indicated that the outcome "will ensure that residents are transferred safely".

In an interview with Registered staff member #106, they indicated that all residents were assessed using an identified assessment tool by a multidisciplinary team. After this assessment was completed, the Physiotherapist (PT) was responsible for updating the visual cue in the room and the care plan. The Registered staff would also communicate it through the white board, team binders, emails and shift report. Registered staff member #106 concluded this interview by stating "there is really no excuse for someone not to know" what assisted device to choose.

In an interview with the PT, they indicated that upon any resident admission or any resident that had a change in their health status, the resident would receive an identified assessment. The PT indicated that the process included the involvement of, the PT, the Registered Staff member, and the direct care staff member that was most familiar with the resident. Together, these disciplines would speak with the resident and their Substitute Decision Maker (SDM) if applicable, to assess the level of assistance the resident required, that included the appropriate assisted device, and would also include any applicable medical diagnosis that would impact the resident's ability to transfer safely. Once the assessment was completed, the PT would update the plan of care, revise the visual card in the resident's room, and supply the resident with their personal assisted device based on the outcome of the multidisciplinary assessment.

In an interview with the Director of Care (DOC), they indicated that direct care staff member #102 had transferred resident's #003 and #007 using an incorrect assisted device, and direct care staff member #110 had provided assistance to resident #008 using an incorrect assisted device. The DOC further indicated that these actions placed these residents at risk during transfer, and therefore, they were not

transferred safely.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 3 compliance history, one or more related areas of non-compliance in the last 36 months that included:
- Voluntary Plan of Corrective Action (VPC) issued October 31, 2018, (2018_679638_0019). (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 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. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

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

Specifically, the licensee shall:
1. Review the policy with all nursing staff related to post-fall assessments.

2. Develop and implement an auditing system to ensure residents receive a specific assessment when required.

3. Educate all nursing staff on the above mentioned auditing system.

Grounds / Motifs :

1. The licensee has failed to ensure that when resident #010 fell, that they were assessed and if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CI report was submitted to the Director for an incident that caused injury to a resident. The CI report identified that resident #010 had an unwitnessed fall.

Inspector #647 reviewed resident #010's electronic progress notes regarding the incident. The electronic progress note identified that after staff members heard resident #010 yelling, they went to their room and found resident #010 on the floor. A review of the incident note indicated that there was an injury to an identified area.

A review of an identified assessment tool, indicated that the assessment record for the injury was initiated at the time of the fall. There was no assessment documented for three of the required intervals.

Inspector #647 reviewed a specific home policy that directed staff to complete an identified assessment tool after a resident had fallen.

In an interview with Registered staff member #113, they identified that they initiated the assessment and documented on the identified assessment record as they are required to do after any unwitnessed fall as applicable, however did not assess resident #010 at the next required interval. The Registered staff member #113 indicated to the Inspector that they did not have time to assess the resident due to other role responsibilities prior to their shift ending.

In an interview with Registered staff member #111, they identified that they worked the following shift post fall and the identified assessment was still in progress. The Inspector identified to Registered staff member #111 that there had been no documented assessments for the required intervals. Registered staff member #113 indicated to the Inspector, that they did not complete the two required assessment as the resident was in the dining room at the time.

In an interview with the Administrator, they identified that the identified assessment would be started after an unwitnessed fall or after a fall in which the resident had an identified injury. They further indicated that the identified assessment was required to be completed at all of the assigned intervals to ensure a thorough assessment had been completed.

The severity of this issue was determined to be a level 3 as there was actual harm or actual risk. The scope of the issue was a level 1 as it related to one out of three residents reviewed. The home had a level 2 compliance history, of one or more areas of non-compliance to a different subsection in the last 36 months. (647)

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

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

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

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.

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

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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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

À l'attention du/de la registrateur(e)
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 30th day of July, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JENNIFER BROWN (647) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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