Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 28, 2017	2017_616542_0002	029983-16, 029986-16, 032363-16, 032365-16, 032366-16, 032367-16, 032369-16, 032370-16, 032378-16	Follow up

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX3251 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

JENNIFER LAURICELLA (542), JULIE KUORIKOSKI (621), RYAN GOODMURPHY (638), SARAH CHARETTE (612)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 9-12, 2017.

This follow up inspection was related to nine Compliance Orders (COs) issued to the home on November 25, 2016. From the following inspections, the CO inspected were as follows;

Inspection # 2016_435621-0012,

CO #001, residents are protected from abuse by anyone and shall ensure that residents are not neglected,
CO #002, resident demonstrating responsive behaviours, triggers to be identified if possible and monitoring.

Inspection # 2016_391603_0022,

CO # 001, resident is reassessed and the plan of care reviewed and revised.

Inspection # 2016_391603_0024,

CO #001, the care set out in the plan of care is provided to the residents as specified,
CO #002, the pain management program,
CO #003, minimizing of restraints,
CO #004, retraining of all direct care staff on the home's policy on Zero Tolerance of Abuse and Neglect of Residents,
CO #005, 24 hour admission care plan,
CO #006, post falls assessments.

A Complaint and Critical Incident Inspection were conducted concurrently. Please refer to Complaint Inspection #2017_616542_0001 and Critical Incident #2017_616542_0003 for details.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Manager (s), Behavioural Supports Ontario (BSO), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Recreational Therapy, Vice President of Senior's Health, Maintenance, Housekeeping staff, Resident Assessment Instrument Coordinator (RAI), residents and family members.

The inspectors conducted daily observations of the provision of care and services to the residents, a review of resident health care records, staff training records, specific home investigation files and relevant policies, procedures and programs were reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (2)	CO #003	2016_391603_0024	612
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_435621_0012	621
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #004	2016_391603_0024	612
O.Reg 79/10 s. 52. (1)	CO #002	2016_391603_0024	612
O.Reg 79/10 s. 53. (4)	CO #002	2016_435621_0012	621
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2016_391603_0022	621

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 failed to ensure that the care set out in the plan of care was provided to residents as specified in their plan.

A) Inspector #542 was following up on an outstanding Compliance Order (CO) #001. The home was ordered to complete the following:

a) Review and revise resident #013's plan of care and once completed, communicate the information to all staff caring for resident #013.

b) Continue to conduct routinely scheduled audits of residents' plan of care to ensure they were providing care as specified in each resident's plan of care.

c) Complete the retraining to all direct care staff (RNs, RPNs, PSWs) on residents' plan of care and revisions to the plan of care, especially related to nursing measures.

d) Complete the retraining to all direct care staff related to the home's policies, procedures, and contingency plans when working with less staff than the regular deployment, especially related to filling vacant shifts and redeployment of staff.

Specific to c:

On January 12, 2017, Inspector #542 and #612 interviewed the Administrator who indicated that the licensee did not complete the retraining for the PSW staff on the residents' plans of care or the revisions to the plans of care. Inspector #542 and #612 also interviewed the Coordinator of Clinical Practice and Learning who confirmed the training was not completed on the residents' plans of care and the revisions with the PSWs.

B) A Critical Incident System (CIS) report was submitted to the Director, by Nurse Manager #105 for an incident of staff to resident neglect. The report identified that resident #008 was found for an extended period of time to have not received any assistance from staff regarding their personal care.

Inspector #621 reviewed the plan of care for resident #008. It was identified that staff were to assist resident #008 with all aspects of personal care.

Inspector #621 reviewed a copy of the home's internal safety report which identified that the VP of Senior's Health completed an investigation which confirmed that resident #008 was left without assistance with care for an extended period of time.

During an interview with PSW #124 on January 11, 2017, they reported to Inspector

#621 that they were on shift the day that resident #008 did not receive any care for an extended period of time and they confirmed that they did not document whether resident #008 required any assistance with care.

During an interview with Nurse Manager #105 on January 11, 2017, they reported to the Inspector that the home concluded that resident #008 was not provided with any personal care as per their plan of care over the extended period of time.

C) Critical Incident (CI) report was submitted to the Director for staff to resident neglect. The CI report indicated that resident #011 did not receive their wound treatment as ordered by the physician.

Inspector #542 completed a review of resident #011's physician's orders. It was documented, that resident #011 was to have a specific wound treatment completed twice weekly. Inspector #542 reviewed the treatment records during the time of the physician's order and found that there was no documentation over a seven day period to indicate that the wound dressing was completed as ordered by the physician.

On January 12, 2017, Inspector #542 met with resident #011's family member who indicated that resident #011 went without the proper wound dressing orders as ordered by the physician for seven days.

On January 12, 2017, Inspector #542 met with Nurse Manager #102 who verified that the home did not follow the physician's orders for seven days, therefore did not follow the plan of care for resident #011. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the 24 hour admission care plan set out clear directions to staff and others who provided direct care to the resident.

Inspector #612 was following up on an outstanding compliance order #005 issued during Inspection #2016_333577_0010 with a compliance date of December 31, 2016. The home was ordered to:

a) conduct routinely scheduled audits of 24-hour admission care plans to ensure they are providing clear direction in each resident's plan of care and subsequent plans of care, and once the audits were completed, members of the leadership team must review some of the audits for accuracy.

b) retrain all direct care staff (RNs, RPNs, and PSWs) on 24 hour admission care plans, especially related to nursing care measures.

Specific to b:

Inspector #612 interviewed RAI Coordinator #134 who stated that all RPN's and RN's had completed the retraining on the 24 hour admission care plans; however, it was not completed with the PSWs.

The Inspector interviewed the Coordinator of Clinical Practice and Learning who confirmed the training was not completed on the 24 hour admission care plans with PSWs. [s. 24. (3) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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 has fallen, the resident had been assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

During inspection #2016_391603_0024, Compliance Order (CO) #006 was served on November 25, 2016, related to post-falls assessments, whereby, the licensee was to;

a) ensure that resident #021 and all residents who have fallen, receive a post fall assessment using a clinically appropriate assessment instrument.
b) continue to conduct routinely scheduled audits to ensure that residents who have fallen, are receiving a post fall assessment.
c) review with all front line staff the home's electronic post fall assessment on Point Click Care and it's requirement for falls. The staff must sign off on the information received.
This order was to have been complied by December 31, 2016.

Specific to c;

A) Inspector #638 conducted interviews with RN #113, RPN #114, RPN #115, RPN #119 and RPN #133. Each staff member stated that they had not received any training or in servicing related to falls or the post fall assessment between November 25, 2016 and December 31, 2016. RPN #133 went on to state that they were unaware of any formal post fall assessment template available.

In an interview with Inspector #638, the Coordinator of Clinical Practice and Learning (CCPL) stated that the last training completed by the staff was the "Mock Falls" scenario,

completed in September 2016. The CCPL stated that there was no further training related to falls completed after the order report #2016_391603_0024 was served to the home on November 25, 2016, to their knowledge.

During an interview with the Inspector #638, the Administrator stated that there was no indication of any completed or documented review of the home's electronic post-fall assessment and its requirements for falls. The Administrator stated that the required training should have been completed prior to the compliance date on December 31, 2016.

Specific to a;

B) Inspector #638 reviewed post falls assessments for three residents (#018, #019 and #020) who had sustained a fall on a specific day in January, 2017, which were identified through an audit of the home's fall incidents on MED e-care.

Inspector #638 conducted a record review of resident #018's progress notes which indicated that on a specific day in January, 2017, the resident had sustained an unwitnessed fall.

In a review of the health care records for resident #018, the Inspector was unable to locate any post fall assessments completed on the resident through a review of the completed assessments within the home's electronic documentation system Med e-care.

In an interview with Inspector #638, RPN #119 stated that they were the responding registered staff member to the fall that resident #018 had sustained in January. The RPN stated that it was the home's expectation that a full post fall assessment was completed after every fall incident in the MED e-care system. RPN #119 stated that they had not completed the required post fall assessment as it was nearing the end of their shift and that RN #125 would continue with the post fall activities. RPN #119 stated that they did not specify to RN #125 that the post fall assessment was not completed and did not follow up to ensure that the post fall assessment had been completed as required.

Inspector #638 reviewed the home's policy titled "Fall Prevention and Management Program – LTC 3-60" approval date April 2014. It indicated that every resident who sustained a fall would receive a full post fall assessment from the registered staff responding to the fall. The home's definition of a fall was "any unintentional change in position where the resident ends up on the floor, ground or other lower level".

In an interview with Inspector #638, the Administrator stated that there was no completed post fall assessment for resident #018 after their fall in January, 2017, and that it was the expectation that every resident who had fallen receive a post fall assessment with no exception.

During a record review of resident #020's progress notes, Inspector #638 noted that the resident had sustained a fall without injury in January, 2017.

Inspector #638 conducted a review of resident #020's completed assessments on MED e-care. The Inspector was unable to locate any completed post fall assessments for the incident which had occurred in January, 2017.

In an interview with Inspector #638, RPN #133 stated that they were the responding RPN to resident #020's fall in January, 2017. The RPN stated that they completed their assessment and documentation in the progress notes. When the Inspector inquired about the home's post fall assessment template, RPN #133 stated that they were unaware that any formal template existed related to post falls assessments and therefore did not complete this assessment for resident #020.

In an interview with Inspector #638, RPN #115 stated that following every fall incident, the registered staff were required to complete the post fall assessment on MED e-care. The RPN went on to state that there were no exceptions to completing the post fall assessment and it was the home's policy to complete a post fall assessment after every fall.

In an interview with the Administrator, they stated that there was no completed post fall assessment completed for resident #020 after their fall in January, 2017. [s. 49. (2)]

Additional Required Actions:

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 6th day of March, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER LAURICELLA (542), JULIE KUORIKOSKI (621), RYAN GOODMURPHY (638), SARAH CHARETTE (612)
Inspection No. / No de l'inspection :	2017_616542_0002
Log No. / Registre no:	029983-16, 029986-16, 032363-16, 032365-16, 032366-16, 032367-16, 032369-16, 032370-16, 032378-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 28, 2017
Licensee / Titulaire de permis :	ST. JOSEPH'S CARE GROUP 35 NORTH ALGOMA STREET, P.O. BOX 3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	HOGARTH RIVERVIEW MANOR 300 LILLIE STREET, THUNDER BAY, ON, P7C-4Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pamela Nisbet

To ST. JOSEPH'S CARE GROUP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_391603_0024, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall

a) provide retraining for the direct care staff, specifically the Personal Support Workers (PSWs), regarding all residents' plan of care and revisions to the plan of care, related to nursing measures.

b) ensure resident #011's plan of care is followed specifically related to the physician's wound care orders.

c) ensure resident #008's plan of care is followed as per the resident's care needs, specifically but not limited to their continence care assistance, restraint monitoring and repositioning.

Grounds / Motifs :

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

A) Inspector #542 was following up on an outstanding Compliance Order (CO) #001. The home was ordered to complete the following:

a) Review and revise resident #013's plan of care and once completed, communicate the information to all staff caring for resident #013.

b) Continue to conduct routinely scheduled audits of residents' plan of care to ensure they were providing care as specified in each resident's plan of care.

c) Complete the retraining to all direct care staff (RNs, RPNs, PSWs) on residents' plan of care and revisions to the plan of care, especially related to nursing measures.

d) Complete the retraining to all direct care staff related to the home's policies, procedures, and contingency plans when working with less staff than the regular deployment, especially related to filling vacant shifts and redeployment of staff.

Specific to c:

On January 12, 2017, Inspector #542 and #612 interviewed the Administrator who indicated that the licensee did not complete the retraining for the PSW staff on the residents' plans of care or the revisions to the plans of care. Inspector #542 and #612 also interviewed the Coordinator of Clinical Practice and Learning who confirmed the training was not completed on the residents' plans of care and the revisions with the PSWs.

B) A Critical Incident System (CIS) report was submitted to the Director, by Nurse Manager #105 for an incident of staff to resident neglect. The report identified that resident #008 was found for an extended period of time to have not received any assistance from staff regarding their personal care.

Inspector #621 reviewed the plan of care for resident #008. It was identified that staff were to assist resident #008 with all aspects of personal care.

Inspector #621 reviewed a copy of the home's internal safety report which identified that the VP of Senior's Health completed an investigation which confirmed that resident #008 was left without assistance with care for an extended period of time.

During an interview with PSW #124 on January 11, 2017, they reported to Inspector #621 that they were on shift the day that resident #008 did not receive any care for an extended period of time and they confirmed that they did not document whether resident #008 required any assistance with care.

During an interview with Nurse Manager #105 on January 11, 2017, they reported to the Inspector that the home concluded that resident #008 was not provided with any personal care as per their plan of care over the extended

period of time.

C) Critical Incident (CI) report was submitted to the Director for staff to resident neglect. The CI report indicated that resident #011 did not receive their wound treatment as ordered by the physician.

Inspector #542 completed a review of resident #011's physician's orders. It was documented, that resident #011 was to have a specific wound treatment completed twice weekly. Inspector #542 reviewed the treatment records during the time of the physician's order and found that there was no documentation over a seven day period to indicate that the wound dressing was completed as ordered by the physician.

On January 12, 2017, Inspector #542 met with resident #011's family member who indicated that resident #011 went without the proper wound dressing orders as ordered by the physician for seven days.

On January 12, 2017, Inspector #542 met with Nurse Manager #102 who verified that the home did not follow the physician's orders for seven days, therefore did not follow the plan of care for resident #011. [s. 6. (7)]

LTCHA, 2007 S.O. 2007, s. 6.(7) was issued previously as a Compliance Order (CO) during inspection #2016_391603_0024, CO during inspection #2016_333577_0010, a Written Notification (WN) during inspection #2016_333577_0011, a WN and Voluntary Plan of Correction (VPC) during inspection # 2016_246196_0006, a WN and VPC during inspection #2016_245196_0005, a WN and CO during inspection #2016_264609_0006 and a WN during inspection #2015_333577_0012.

The decision to re-issue this compliance order was based on the scope which was widespread, the severity which indicated a potential for actual harm and the compliance history which despite previous non-compliance (NC) or compliance orders, NC continues with this area of the legislation. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 17, 2017

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_391603_0024, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

Order / Ordre :

The licensee shall ensure that all direct care staff are provided with retraining on all 24 hour admission care plans, specifically related to nursing care measures.

Grounds / Motifs :

1. The licensee has failed to ensure that the 24 hour admission care plan set out clear directions to staff and others who provided direct care to the resident.

Inspector #612 was following up on an outstanding compliance order #005 issued during Inspection #2016_333577_0010 with a compliance date of December 31, 2016. The home was ordered to:

a) conduct routinely scheduled audits of 24-hour admission care plans to ensure they are providing clear direction in each resident's plan of care and subsequent plans of care, and once the audits were completed, members of the leadership team must review some of the audits for accuracy.

b) retrain all direct care staff (RNs, RPNs, and PSWs) on 24 hour admission care plans, especially related to nursing care measures.

Specific to b:

Inspector #612 interviewed RAI Coordinator #134 who stated that all RPN's and RN's had completed the retraining on the 24 hour admission care plans; however, it was not completed with the PSWs.

The Inspector interviewed the Coordinator of Clinical Practice and Learning who confirmed the training was not completed on the 24 hour admission care plans with PSWs.

LTCHA, 2007, r. 24 (3) (b) was issued previously as a WN and CO during Inspection 2016_333577_0010, and a WN and CO during Inspection #2016_236196_0002.

The decision to re-issue this compliance order was based on the scope which was widespread, the severity which indicated a potential for actual harm and the compliance history which despite previous non-compliance (NC) or compliance orders, NC continues with this area of the legislation. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 17, 2017

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2016_391603_0024, CO #006;

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 shall ensure that residents who have fallen, are 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.

Grounds / Motifs :

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

During inspection #2016_391603_0024, Compliance Order (CO) #006 was served on November 25, 2016, related to post-falls assessments, whereby, the licensee was to;

a) ensure that resident #021 and all residents who have fallen, receive a post fall assessment using a clinically appropriate assessment instrument.
b) continue to conduct routinely scheduled audits to ensure that residents who have fallen, are receiving a post fall assessment.
c) review with all front line staff the home's electronic post fall assessment on Point Click Care and it's requirement for falls. The staff must sign off on the information received. This order was to have been complied by December 31, 2016.

Specific to c;

A) Inspector #638 conducted interviews with RN #113, RPN #114, RPN #115, RPN #119 and RPN #133. Each staff member stated that they had not received any training or in servicing related to falls or the post fall assessment between November 25, 2016 and December 31, 2016. RPN #133 went on to state that they were unaware of any formal post fall assessment template available.

In an interview with Inspector #638, the Coordinator of Clinical Practice and Learning (CCPL) stated that the last training completed by the staff was the "Mock Falls" scenario, completed in September 2016. The CCPL stated that there was no further training related to falls completed after the order report #2016_391603_0024 was served to the home on November 25, 2016, to their knowledge.

During an interview with the Inspector #638, the Administrator stated that there was no indication of any completed or documented review of the home's electronic post-fall assessment and its requirements for falls. The Administrator stated that the required training should have been completed prior to the compliance date on December 31, 2016.

Specific to a;

B) Inspector #638 reviewed post falls assessments for three residents (#018, #019 and #020) who had sustained a fall on a specific day in January, 2017, which were identified through an audit of the home's fall incidents on MED e-care.

Inspector #638 conducted a record review of resident #018's progress notes which indicated that on a specific day in January, 2017, the resident had sustained an unwitnessed fall.

In a review of the health care records for resident #018, the Inspector was unable to locate any post fall assessments completed on the resident through a review of the completed assessments within the home's electronic documentation system Med e-care.

In an interview with Inspector #638, RPN #119 stated that they were the

responding registered staff member to the fall that resident #018 had sustained in January. The RPN stated that it was the home's expectation that a full post fall assessment was completed after every fall incident in the MED e-care system. RPN #119 stated that they had not completed the required post fall assessment as it was nearing the end of their shift and that RN #125 would continue with the post fall activities. RPN #119 stated that they did not specify to RN #125 that the post fall assessment was not completed and did not follow up to ensure that the post fall assessment had been completed as required.

Inspector #638 reviewed the home's policy titled "Fall Prevention and Management Program – LTC 3-60" approval date April 2014. It indicated that every resident who sustained a fall would receive a full post fall assessment from the registered staff responding to the fall. The home's definition of a fall was "any unintentional change in position where the resident ends up on the floor, ground or other lower level".

In an interview with Inspector #638, the Administrator stated that there was no completed post fall assessment for resident #018 after their fall in January, 2017, and that it was the expectation that every resident who had fallen receive a post fall assessment with no exception.

During a record review of resident #020's progress notes, Inspector #638 noted that the resident had sustained a fall without injury in January, 2017.

Inspector #638 conducted a review of resident #020's completed assessments on MED e-care. The Inspector was unable to locate any completed post fall assessments for the incident which had occurred in January, 2017.

In an interview with Inspector #638, RPN #133 stated that they were the responding RPN to resident #020's fall in January, 2017. The RPN stated that they completed their assessment and documentation in the progress notes. When the Inspector inquired about the home's post fall assessment template, RPN #133 stated that they were unaware that any formal template existed related to post falls assessments and therefore did not complete this assessment for resident #020.

In an interview with Inspector #638, RPN #115 stated that following every fall incident, the registered staff were required to complete the post fall assessment on MED e-care. The RPN went on to state that there were no exceptions to

completing the post fall assessment and it was the home's policy to complete a post fall assessment after every fall.

In an interview with the Administrator, they stated that there was no completed post fall assessment completed for resident #020 after their fall in January, 2017.

LTCHA, 2007 S.O. 2007, r. 49. (2) was issued previously as a Written Notification (WN) and a Voluntary Plan of Correction (VPC) during inspection #2016_435621_0012, a WN and Compliance Order (CO) during inspection #2016_333577_0011 and a WN and VPC during inspection #2015_333577_0012.

The decision to re-issue this Compliance Order (CO) was based on the potential for risk of harm, the scope which was identified as a pattern and the compliance history which despite previous non-compliance (NC) or compliance orders, NC continues with this area of the legislation. (638)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 10, 2017

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 or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 28th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Lauricella

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