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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 11, 2018	2018_624196_0022	015305-18, 015312-18	Follow up

Licensee/Titulaire de permis

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

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

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

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

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

Inspection Summary/Résumé de l'inspection

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

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

The following intakes were inspected upon during this Follow Up Inspection:

- One intake regarding Compliance Order (CO) #001, issued during inspection #2018_633577_0006, pursuant to O.Reg. 79/10 s. 134, residents' drug regimes; and

- One intake regarding CO #002, issued during inspection #2018_633577_0006, pursuant to the LTCHA, 2007, s. 6. (7), plan of care.

Critical Incident System (CIS) inspection #2018_624196_0024 and Complaint inspection #2018_624196_0023 were conducted concurrently with this Follow Up inspection.

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

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

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

The following Inspection Protocols were used during this inspection:

Medication
Personal Support Services

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 134.	CO #001	2018_633577_0006	693

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 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 complaint was received by the Director with concerns regarding the provision of care for resident #010.

Inspector #196 observed resident #010 with a meal tray that included a type of food with a specific diet texture.

The Inspector reviewed the resident's current care plan which indicated the resident had a medical condition, was on a particular diet, and a specific diet texture for different types of foods. In addition, there was a goal that indicated that this resident was to receive the appropriate diet texture to minimize the risk of injury.

During an interview, RPN #145 reported to the Inspector that resident #010 was identified as at risk for injury in their care plan.

During an interview with Dietary Manager #128, they reported to the Inspector that the provision of a specific texture of food to resident #010 was incorrect, and that there had been an appropriate texture of food available to provide to the resident.

During an interview with RD #146, they reported to the Inspector that the provision of a specific texture of a type of food was the incorrect diet texture for resident #010. [s. 6. (7)]

2. Four complaints were received by the Director in 2018, which alleged multiple areas of concern related to the care of resident #001.

A Critical Incident System (CIS) report was received by the Director on a specific date in 2018, which specified that the home received a letter from a complainant on a specific date in 2018, concerning alleged neglect of resident #001, related to their care.

Inspector #577 conducted a record review of resident #001's care plan, specific to personal care needs.

a) The care plan interventions related to feeding and nutrition indicated that staff were to follow a number of specific feeding and nutritional interventions for resident #001.

During four observations at meal times, Inspector #577 noted that several of the specific feeding and nutritional interventions were not provided to the resident, as indicated in the care plan.

During meal observations on three consecutive days in 2018, Inspector #577 did not observe resident #001 to have been given a certain amount of the specific textured fluid with their meals; in addition the nutritional intervention was not given during two meals.

During an interview with PSW #136, they reported to Inspector #577 that a specific utensil for resident #001 was appropriate, and reported there were no specific interventions related to feeding resident #001. The Inspector reviewed the care plan interventions with PSW #136. They confirmed that they did not give the resident the nutritional intervention or the specific type of fluid.

During an interview with PSW #137, they reported to the Inspector that the resident fed themselves initially and the staff would assist them; the resident was to be given an amount of food then the specific type of fluid; and the resident was to be given a certain amount of the specific fluid with each meal and a nutritional intervention with each meal.

During an interview with RPN #138, they reported that resident #001's feeding needed to be supervised; staff were to alternate food with the specific type of fluid when feeding; staff were to sit with the resident at all meals; and a nutritional intervention was to be provided with all meals.

b) The care plan interventions related to fluid balance (initiated on a specific date in 2018) indicated that staff were to:
- ensure that resident received at least a certain amount of specific fluid a day; if resident had been noted to have less than the specified amount of fluid per day, for 48 hours (hrs), they were to notify the Registered Nurse to assess need for supplemental hydration and to notify the family.

A record review of the oral fluid flow sheets for a specific month in 2018, indicated that for 25 out of 28 days or 89 per cent, resident #001 had less than the specified amount of fluid per day. There was no documentation which identified that the RN or family had been notified.

During an interview with RPN #139, they reported that they had not notified the RN or family when resident #001's fluids had been less than the specified amount of fluid per day.

During an interview with RPN #141, they reported to the Inspector that there had been

some days where the resident's oral fluid intake had been less than the specified amount of fluid per day and they had not notified the RN or the family.

During an interview with RN #140, they reported that staff had not notified them when resident #001's oral fluid intake had been less than the specified amount of fluid per day within the last month.

c) The care plan interventions related to bathing indicated the following:
- resident to be bathed using a specialized intervention; and
- resident to have a tub bath on an identified number of days per week.

During a record review of the bath records for resident #001, Inspector #577 identified the following:
- in one specific month in 2018, eight bed baths were provided; and
- in another month in 2018, four bed baths, two tub baths, and two showers were provided.

During an interview with PSW #142, they reported that resident #001 did not like a certain aspect of bathing, so the staff had been giving the resident bed baths and a shower using the specialized intervention. The PSW reported the resident did not request bed baths and had never had a tub bath.

During an interview with PSW #143, they reported that on the day previous, they had given the resident a bed bath. They further reported that resident #001 had a skin integrity concern and didn't think it was best to have transferred them into a tub chair.

During an interview with PSW #137, they reported that the resident received a shower with the specialized intervention and previously had tub baths when they were able to stand. They further reported that the unit did not currently have a certain size of bath sling.

During an interview with PSW #143, they reported that they obtained resident information from the care plan binders on the unit.

During an interview with RPN #144, they reported that RHWs and PSWs were responsible to have reviewed the kardex and care plan for resident care information.

During an interview with RHW #135, they reported that they were responsible to review

the paper care plan and kardex in the binders.

A review of the home's policy titled "Care Planning – RC-05-01-01" revised April 2017, indicated that a care plan was a guide that directed care that was provided to the resident.

During an interview with Clinical Manager (CM) #130, they reported that all staff should be following resident #001's care plan interventions, specifically in regards to the provision of personal care. They further reported that staff should not have been giving resident #001 bed baths unless the resident had refused, and the bath of choice was a tub bath. They further reported that there were occasions where the resident had refused a bath and staff would have given a bed bath or shower; and confirmed that bath record documentation had not indicated any bath refusals. [s. 6. (7)]

3. A CIS report was submitted to the Director for a fall where resident #025 sustained a specific type of injury.

Inspector #625 reviewed the resident's current care plan that indicated staff were to encourage the resident to ask for assistance with the use of their call bell and were to ensure the call bell was within the resident's reach at all times. The care plan also identified that the resident required staff members to push their mobility aid for locomotion.

Inspector #625 reviewed the home's policy "Falls Prevention and Management Program – RD-15-01-01" last updated February 2017, which identified call bells were to be used for falls risk reduction, universal falls precautions included ensuring call bells were accessible; and ways to reduce falls included keeping all call lights within arm's length of residents.

On a date during the inspection, the Inspector observed the resident seated in their mobility aid past the foot of their bed, looking out the window of their room. Their call bell was wrapped around the upper bed side rail of the bed rail furthest from the resident and was not within the resident's reach.

During an interview with PSW #151, they acknowledged that the resident did not have their call bell within their reach, but should have. The PSW attempted to place the call bell near the resident but was not able to release the cord enough to do so. The PSW stated it was attached to the bed frame with a tie which would need to be cut off to allow

the resident to reach the call bell from the window. They also stated that the resident did sit and look out the window and, if the tie was in place, the call bell would not have been within the resident's reach at any time they were positioned there.

During an interview with RN #155, they reviewed resident #025's current care plan and stated that the care plan had not been followed if the resident's call bell had not been within their reach.

During an interview with CM #106, they acknowledged that care had not been provided as per resident #025's care plan of care, with respect to call bell use, if their call bell had not been within their reach as observed by the Inspector. [s. 6. (7)]

4. A CIS report was submitted to the Director for an injury experienced by resident #026, on a date in 2018, for which the resident was taken to the hospital and that resulted in a specific type of injury. The report identified that the resident had experienced a specific number of falls in one month in 2018 and another number of falls in the following month in 2018.

Inspector #625 reviewed resident #026's progress notes from an approximate eight month time period in 2018, which identified the resident had experienced a specific number of falls during that time.

Inspector #625 also reviewed resident #026's screening tool for this type of injury, dated on a specific date in 2018, which indicated the resident was at risk for this specific injury and unsafe ambulation.

Inspector #625 reviewed resident #026's current care plan which identified that staff were to ensure the resident's specific injury prevention device was on their bed and on themselves, were functioning properly, that the resident was to have a specific injury prevention device at their bedside and required a safety device when in their mobility aid. The care plan also identified that resident #026 required a specified amount of assistance to push their mobility aid for locomotion on the unit and staff assistance to transfer. The care plan detailed that staff were to continue to remind resident #026 not to self-transfer and staff were to remind resident #030 not to assist resident #026 to transfer, but to ask staff when needed, due to multiple injuries.

The Inspector also reviewed a documented titled "Negotiated Risk Agreement", dated on a specific date in 2018. The agreement identified different options provided to the

substitute decision-maker (SDM). The agreement identified that "consequences of the risk" of a specific injury by resident #026.

During the inspection, Inspector #625 observed resident #026 and resident #030, walking in the hallway outside of resident #026's room. Resident #026 was pushing their mobility aid and walking behind it, while resident #030 walked beside the resident, holding their arm. The Inspector noted a specific injury prevention device on the mobility aid seat and a specific injury prevention device clipped to the back of the mobility aid seat. The alarm boxes for the both specific injury prevention devices were both off and did not light up to indicate they were on. The Inspector then observed resident #026 ambulating, past the nursing station, pushing their mobility aid, with the resident #030 beside them where PSW #162 and multiple other PSWs were present, but did not intervene.

During another observation, the Inspector observed the Physiotherapist (PT) #149 intervene when they saw resident #026 begin to ambulate by pushing their mobility aid, with resident #030 beside them. The PT encouraged resident #026 to sit in the mobility aid and applied the specific injury prevention device onto the resident.

On another day during the inspection, the Inspector observed resident #026 seated in their mobility aid with the specific injury prevention device clipped to the top of the mobility aid seat back, not attached to the resident's clothing as required.

On another day, the Inspector observed resident #026 seated in their mobility aid with the specific injury prevention device again clipped to the seat back. The specific injury prevention device indicator light was not lit up to indicate that the device was on and the resident's safety device was not applied but was tucked behind their back.

During a second observation, on the same day, five hours after the first, the Inspector again observed the specific injury prevention device clipped to the mobility aid seat back and unlit indicator lights on the specific injury prevention device which, when lit, would identify the status as "in use", "low battery" or "signal lost".

On another day, the Inspector observed the resident's safety device clipped to their mobility aid seat back and their specific injury prevention device turned off. When the Inspector asked about the specific injury prevention device, staff then turned the device on and assisted the resident to stand. The Inspector noted that, when the resident stood, the specific injury prevention device did not sound as required.

During interviews with resident #026's co-resident, resident #030, they stated that the resident had not fallen out of their mobility aid for years. Resident #030 stated they did not let resident #026 walk alone as they would accompany the resident, the specific injury prevention device on the mobility aid did not work and they had not heard the alarms on the sound for some time.

During an interview with PSW #163, they stated that resident #026's co-resident, resident #030 took the resident for walks and "walked" the resident on a specific date during the inspection.

During an interview with Inspector #625, PSW #164 stated they had found resident #026 in their washroom, out of their mobility aid by themselves, with no alarms sounding.

During an interview with PSW #162, they stated that resident #026's co-resident, resident #030, helped the resident to walk, and the resident would also get up on their own but required help, which was why the resident needed the specific injury prevention device in use. The PSW identified that the specific injury prevention device had not been attached to the resident's clothing and could not tell if the resident's other specific injury prevention device was working, stating staff would check the device at a later time.

During an interview with PSW #159, they confirmed that the one specific injury prevention device was not properly clipped to resident #026, that the other specific injury prevention device was turned off and, when the PSW turned it on, it did not function and stated it needed new batteries. The PSW stated that resident #026 could walk on their own but the staff were not comfortable with the resident walking alone. The PSW identified that resident #026's co-resident, resident #030, would take off the resident's specific injury prevention device. The PSW stated that PSW #165 completed resident #026's care that morning, and would know if the other specific injury prevention device had been on that morning.

During an interview with PSW #165, they stated that they had discovered resident #026 in their washroom with the co-resident present. They stated that no specific injury prevention device alarms had been ringing when they had arrived to provide morning care to the resident. The PSW identified that they had not applied the specific injury prevention device to the resident, or turned on the specific injury prevention device after providing care to the resident; although, the resident still needed to use the devices.

During an interview with PSW #167, they stated that they did not know the details of the functioning of one type of specific injury prevention device and were not sure how they could tell if it was on. The PSW further stated that resident #026 did not need the specific injury prevention device and the co-resident walked and exercised them.

During interviews with PSW #157, they stated that resident #026 no longer used the specific injury prevention devices. The PSW stated the resident did not use a specific injury prevention device in bed as they were toileted three times throughout the night and no longer used the specific injury prevention device as they did exercises, "doing laps" as they walked the hallways on the unit up to six times, with resident #030. The PSW also stated that the resident's specific injury prevention device in their mobility aid was also no longer used. The PSW identified that the resident had medical conditions before but that "physio" said it was okay for the resident to walk with a certain co-resident.

During an interview with RPN #160, they confirmed that resident #026's most recent screening tool for this kind of injury, deemed them to be at a particular risk for injury and unsafe ambulation. The RPN identified that, based on their clinical assessment, resident #026 would need to use the specific injury prevention device on their bed and on their mobility aid.

During an interview with PTA #158, they stated that resident #026 used a specific injury prevention device but that, if another type of specific injury prevention device was present, it did not work. The PTA stated that "yes, for sure" the resident continued to require the use of the specific injury prevention devices on their mobility aid and that the resident experienced a lot of falls. The PTA identified that a co-resident, resident #030, would take the resident to the washroom, that since the resident's injury, that a co-resident had transferred them to the washroom and that the resident had fallen. The PTA acknowledged that it was not safe for resident #026 to ambulate on their own or with the co-resident; and they tried to reinforce using the call bell and asking for help.

During an interview with PT #149, they stated that resident #026 had used specific injury prevention devices which would sound when the co-resident assisted them to transfer.

During an interview with CM #130, they acknowledged that resident #026 should use their specific injury prevention devices and safety device as listed in their care plan. The CM stated that resident #026 did ambulate with a co-resident on the unit and that they saw this, which is why a Negotiated Risk Assessment was in place. They identified that staff were required to remind the resident and encourage them not to ambulate with the

co-resident when they saw it happening. The CM indicated that the staff were not providing care to resident #026 as per their plan of care if they did not attach the specific injury prevention device to the resident, if the specific injury prevention device was not turned on or did not work, if the bed specific injury prevention device was not applied, and if the resident engaged in the method of locomotion on the unit observed by the Inspector. [s. 6. (7)]

Additional Required Actions:

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

Issued on this 19th day of October, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196), KATHERINE BARCA (625), MELISSA HAMILTON (693)
Inspection No. / No de l'inspection :	2018_624196_0022
Log No. / No de registre :	015305-18, 015312-18
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 11, 2018
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, P.O. Box 3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	Hogarth Riverview Manor 300 Lillie Street, THUNDER BAY, ON, P7C-4Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lina Johnson

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: 2018_633577_0006, CO #002;

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 must be in compliance with s. 6 (7) of the LTCHA. Specifically the licensee must;

a) Ensure resident #010's plan of care are followed specifically related to diet texture
b) Ensure that resident #025's and #026's plans of care are followed specifically, but not limited to falls prevention and management
c) Ensure that resident #001's plan of care are followed specifically, but not limited to bathing, nutrition and hydration and feeding assistance.

Grounds / Motifs :

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

The Inspectors conducted a Follow up inspection to Compliance Order (CO) #002 served to the licensee on June 11, 2018, under inspection report #2018_333577_0006. The CO required the home to do the following by June 30, 2018;
"The licensee must be in compliance with s. 6 (7) of the LTCHA. Specifically the licensee must;
a) conduct routinely scheduled audits of residents' plans of care to ensure they are providing care as specified in each residents' plans of care
b) ensure all residents' plans of care are followed specifically related to the physician's wound care orders
c) ensure resident #023's and #024's plans of care are followed specifically, but

not limited to their continence care assistance and repositioning."

While the licensee complied with sections “a”, “b” and “c”, non-compliance continued to be identified involving other residents, pursuant to the LTCHA 2007, c. 8, s. 6. (7).

A CIS report was submitted to the Director for a fall where resident #025 sustained a specific type of injury.

Inspector #625 reviewed the resident’s current care plan that indicated staff were to encourage the resident to ask for assistance with the use of their call bell and were to ensure the call bell was within the resident’s reach at all times. The care plan also identified that the resident required staff members to push their mobility aid for locomotion.

Inspector #625 reviewed the home’s policy “Falls Prevention and Management Program – RD-15-01-01” last updated February 2017, which identified call bells were to be used for falls risk reduction, universal falls precautions included ensuring call bells were accessible; and ways to reduce falls included keeping all call lights within arm’s length of residents.

On a date during the inspection, the Inspector observed the resident seated in their mobility aid past the foot of their bed, looking out the window of their room. Their call bell was wrapped around the upper bed side rail of the bed rail furthest from the resident and was not within the resident’s reach.

During an interview with PSW #151, they acknowledged that the resident did not have their call bell within their reach, but should have. The PSW attempted to place the call bell near the resident but was not able to release the cord enough to do so. The PSW stated it was attached to the bed frame with a tie which would need to be cut off to allow the resident to reach the call bell from the window. They also stated that the resident did sit and look out the window and, if the tie was in place, the call bell would not have been within the resident’s reach at any time they were positioned there.

During an interview with RN #155, they reviewed resident #025’s current care plan and stated that the care plan had not been followed if the resident’s call bell had not been within their reach.

During an interview with CM #106, they acknowledged that care had not been provided as per resident #025's care plan of care, with respect to call bell use, if their call bell had not been within their reach as observed by the Inspector. [s. 6. (7)]
(196)

2. Four complaints were received by the Director in 2018, which alleged multiple areas of concern related to the care of resident #001.

A Critical Incident System (CIS) report was received by the Director on a specific date in 2018, which specified that the home received a letter from a complainant on a specific date in 2018, concerning alleged neglect of resident #001, related to their care.

Inspector #577 conducted a record review of resident #001's care plan, specific to personal care needs.

a) The care plan interventions related to feeding and nutrition indicated that staff were to follow a number of specific feeding and nutritional interventions for resident #001.

During four observations at meal times, Inspector #577 noted that several of the specific feeding and nutritional interventions were not provided to the resident, as indicated in the care plan.

During meal observations on three consecutive days in 2018, Inspector #577 did not observe resident #001 to have been given a certain amount of the specific textured fluid with their meals; in addition the nutritional intervention was not given during two meals.

During an interview with PSW #136, they reported to Inspector #577 that a specific utensil for resident #001 was appropriate, and reported there were no specific interventions related to feeding resident #001. The Inspector reviewed the care plan interventions with PSW #136. They confirmed that they did not give the resident the nutritional intervention or the specific type of fluid.

During an interview with PSW #137, they reported to the Inspector that the resident fed themselves initially and the staff would assist them; the resident was to be given an amount of food then the specific type of fluid; and the resident

was to be given a certain amount of the specific fluid with each meal and a nutritional intervention with each meal.

During an interview with RPN #138, they reported that resident #001's feeding needed to be supervised; staff were to alternate food with the specific type of fluid when feeding; staff were to sit with the resident at all meals; and a nutritional intervention was to be provided with all meals.

b) The care plan interventions related to fluid balance (initiated on a specific date in 2018) indicated that staff were to:
- ensure that resident received at least a certain amount of specific fluid a day; if resident had been noted to have less than the specified amount of fluid per day, for 48 hours (hrs), they were to notify the Registered Nurse to assess need for supplemental hydration and to notify the family.

A record review of the oral fluid flow sheets for a specific month in 2018, indicated that for 25 out of 28 days or 89 per cent, resident #001 had less than the specified amount of fluid per day. There was no documentation which identified that the RN or family had been notified.

During an interview with RPN #139, they reported that they had not notified the RN or family when resident #001's fluids had been less than the specified amount of fluid per day.

During an interview with RPN #141, they reported to the Inspector that there had been some days where the resident's oral fluid intake had been less than the specified amount of fluid per day and they had not notified the RN or the family.

During an interview with RN #140, they reported that staff had not notified them when resident #001's oral fluid intake had been less than the specified amount of fluid per day within the last month.

c) The care plan interventions related to bathing indicated the following:
- resident to be bathed using a specialized intervention; and
- resident to have a tub bath on an identified number of days per week.

During a record review of the bath records for resident #001, Inspector #577 identified the following:
- in one specific month in 2018, eight bed baths were provided; and

- in another month in 2018, four bed baths, two tub baths, and two showers were provided.

During an interview with PSW #142, they reported that resident #001 did not like a certain aspect of bathing, so the staff had been giving the resident bed baths and a shower using the specialized intervention. The PSW reported the resident did not request bed baths and had never had a tub bath.

During an interview with PSW #143, they reported that on the day previous, they had given the resident a bed bath. They further reported that resident #001 had a skin integrity concern and didn't think it was best to have transferred them into a tub chair.

During an interview with PSW #137, they reported that the resident received a shower with the specialized intervention and previously had tub baths when they were able to stand. They further reported that the unit did not currently have a certain size of bath sling.

During an interview with PSW #143, they reported that they obtained resident information from the care plan binders on the unit.

During an interview with RPN #144, they reported that RHWs and PSWs were responsible to have reviewed the kardex and care plan for resident care information.

During an interview with RHW #135, they reported that they were responsible to review the paper care plan and kardex in the binders.

A review of the home's policy titled "Care Planning – RC-05-01-01" revised April 2017, indicated that a care plan was a guide that directed care that was provided to the resident.

During an interview with Clinical Manager (CM) #130, they reported that all staff should be following resident #001's care plan interventions, specifically in regards to the provision of personal care. They further reported that staff should not have been giving resident #001 bed baths unless the resident had refused, and the bath of choice was a tub bath. They further reported that there were occasions where the resident had refused a bath and staff would have given a bed bath or shower; and confirmed that bath record documentation had not

indicated any bath refusals. [s. 6. (7)] (196)

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

A complaint was received by the Director with concerns regarding the provision of care for resident #010.

Inspector #196 observed resident #010 with a meal tray that included a type of food with a specific diet texture.

The Inspector reviewed the resident's current care plan which indicated the resident had a medical condition, was on a particular diet, and a specific diet texture for different types of foods. In addition, there was a goal that indicated that this resident was to receive the appropriate diet texture to minimize the risk of injury.

During an interview, RPN #145 reported to the Inspector that resident #010 was identified as at risk for injury in their care plan.

During an interview with Dietary Manager #128, they reported to the Inspector that the provision of a specific texture of food to resident #010 was incorrect, and that there had been an appropriate texture of food available to provide to the resident.

During an interview with RD #146, they reported to the Inspector that the provision of a specific texture of a type of food was the incorrect diet texture for resident #010. [s. 6. (7)] (196)

4. A CIS report was submitted to the Director for an injury experienced by resident #026, on a date in 2018, for which the resident was taken to the hospital and that resulted in a specific type of injury. The report identified that the resident had experienced a specific number of falls in one month in 2018 and another number of falls in the following month in 2018.

Inspector #625 reviewed resident #026's progress notes from an approximate eight month time period in 2018, which identified the resident had experienced a specific number of falls during that time.

Inspector #625 also reviewed resident #026's screening tool for this type of injury, dated on a specific date in 2018, which indicated the resident was at risk for this specific injury and unsafe ambulation.

Inspector #625 reviewed resident #026's current care plan which identified that staff were to ensure the resident's specific injury prevention device was on their bed and on themselves, were functioning properly, that the resident was to have a specific injury prevention device at their bedside and required a safety device when in their mobility aid. The care plan also identified that resident #026 required a specified amount of assistance to push their mobility aid for locomotion on the unit and staff assistance to transfer. The care plan detailed that staff were to continue to remind resident #026 not to self-transfer and staff were to remind resident #030 not to assist resident #026 to transfer, but to ask staff when needed, due to multiple injuries.

The Inspector also reviewed a documented titled "Negotiated Risk Agreement", dated on a specific date in 2018. The agreement identified different options provided to the substitute decision-maker (SDM). The agreement identified that "consequences of the risk" of a specific injury by resident #026.

During the inspection, Inspector #625 observed resident #026 and resident #030, walking in the hallway outside of resident #026's room. Resident #026 was pushing their mobility aid and walking behind it, while resident #030 walked beside the resident, holding their arm. The Inspector noted a specific injury prevention device on the mobility aid seat and a specific injury prevention device clipped to the back of the mobility aid seat. The alarm boxes for the both specific injury prevention devices were both off and did not light up to indicate they were on. The Inspector then observed resident #026 ambulating, past the nursing station, pushing their mobility aid, with the resident #030 beside them where PSW #162 and multiple other PSWs were present, but did not intervene.

During another observation, the Inspector observed the Physiotherapist (PT) #149 intervene when they saw resident #026 begin to ambulate by pushing their mobility aid, with resident #030 beside them. The PT encouraged resident #026 to sit in the mobility aid and applied the specific injury prevention device onto the resident.

On another day during the inspection, the Inspector observed resident #026 seated in their mobility aid with the specific injury prevention device clipped to

the top of the mobility aid seat back, not attached to the resident's clothing as required.

On another day, the Inspector observed resident #026 seated in their mobility aid with the specific injury prevention device again clipped to the seat back. The specific injury prevention device indicator light was not lit up to indicate that the device was on and the resident's safety device was not applied but was tucked behind their back.

During a second observation, on the same day, five hours after the first, the Inspector again observed the specific injury prevention device clipped to the mobility aid seat back and unlit indicator lights on the specific injury prevention device which, when lit, would identify the status as "in use", "low battery" or "signal lost".

On another day, the Inspector observed the resident's safety device clipped to their mobility aid seat back and their specific injury prevention device turned off. When the Inspector asked about the specific injury prevention device, staff then turned the device on and assisted the resident to stand. The Inspector noted that, when the resident stood, the specific injury prevention device did not sound as required.

During interviews with resident #026's co-resident, resident #030, they stated that the resident had not fallen out of their mobility aid for years. Resident #030 stated they did not let resident #026 walk alone as they would accompany the resident, the specific injury prevention device on the mobility aid did not work and they had not heard the alarms on the sound for some time.

During an interview with PSW #163, they stated that resident #026's co-resident, resident #030 took the resident for walks and "walked" the resident on a specific date during the inspection.

During an interview with Inspector #625, PSW #164 stated they had found resident #026 in their washroom, out of their mobility aid by themselves, with no alarms sounding.

During an interview with PSW #162, they stated that resident #026's co-resident, resident #030, helped the resident to walk, and the resident would also get up on their own but required help, which was why the resident needed the specific

injury prevention device in use. The PSW identified that the specific injury prevention device had not been attached to the resident's clothing and could not tell if the resident's other specific injury prevention device was working, stating staff would check the device at a later time.

During an interview with PSW #159, they confirmed that the one specific injury prevention device was not properly clipped to resident #026, that the other specific injury prevention device was turned off and, when the PSW turned it on, it did not function and stated it needed new batteries. The PSW stated that resident #026 could walk on their own but the staff were not comfortable with the resident walking alone. The PSW identified that resident #026's co-resident, resident #030, would take off the resident's specific injury prevention device. The PSW stated that PSW #165 completed resident #026's care that morning, and would know if the other specific injury prevention device had been on that morning.

During an interview with PSW #165, they stated that they had discovered resident #026 in their washroom with the co-resident present. They stated that no specific injury prevention device alarms had been ringing when they had arrived to provide morning care to the resident. The PSW identified that they had not applied the specific injury prevention device to the resident, or turned on the specific injury prevention device after providing care to the resident; although, the resident still needed to use the devices.

During an interview with PSW #167, they stated that they did not know the details of the functioning of one type of specific injury prevention device and were not sure how they could tell if it was on. The PSW further stated that resident #026 did not need the specific injury prevention device and the co-resident walked and exercised them.

During interviews with PSW #157, they stated that resident #026 no longer used the specific injury prevention devices. The PSW stated the resident did not use a specific injury prevention device in bed as they were toileted three times throughout the night and no longer used the specific injury prevention device as they did exercises, "doing laps" as they walked the hallways on the unit up to six times, with resident #030. The PSW also stated that the resident's specific injury prevention device in their mobility aid was also no longer used. The PSW identified that the resident had medical conditions before but that "physio" said it was okay for the resident to walk with a certain co-resident.

During an interview with RPN #160, they confirmed that resident #026's most recent screening tool for this kind of injury, deemed them to be at a particular risk for injury and unsafe ambulation. The RPN identified that, based on their clinical assessment, resident #026 would need to use the specific injury prevention device on their bed and on their mobility aid.

During an interview with PTA #158, they stated that resident #026 used a specific injury prevention device but that, if another type of specific injury prevention device was present, it did not work. The PTA stated that "yes, for sure" the resident continued to require the use of the specific injury prevention devices on their mobility aid and that the resident experienced a lot of falls. The PTA identified that a co-resident, resident #030, would take the resident to the washroom, that since the resident's injury, that a co-resident had transferred them to the washroom and that the resident had fallen. The PTA acknowledged that it was not safe for resident #026 to ambulate on their own or with the co-resident; and they tried to reinforce using the call bell and asking for help.

During an interview with PT #149, they stated that resident #026 had used specific injury prevention devices which would sound when the co-resident assisted them to transfer.

During an interview with CM #130, they acknowledged that resident #026 should use their specific injury prevention devices and safety device as listed in their care plan. The CM stated that resident #026 did ambulate with a co-resident on the unit and that they saw this, which is why a Negotiated Risk Assessment was in place. They identified that staff were required to remind the resident and encourage them not to ambulate with the co-resident when they saw it happening. The CM indicated that the staff were not providing care to resident #026 as per their plan of care if they did not attach the specific injury prevention device to the resident, if the specific injury prevention device was not turned on or did not work, if the bed specific injury prevention device was not applied, and if the resident engaged in the method of locomotion on the unit observed by the Inspector. [s. 6. (7)]

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

a history of non-compliance in this area of the legislation as follows:
- a Compliance Order (CO) was issued from the Resident Quality Inspection #2018_633577_0006, on June 11, 2018;
- a Written Notification (WN) was issued from a Complaint Inspection #2018_655679_0005, on March 22, 2018;
- a Written Notification (WN) was issued from a Complaint Inspection #2018_657681_0002, on February 2, 2018;
- a Voluntary Plan of Correction (VPC) was issued from a Complaint Inspection #2017_509617_0020, on November 14, 2017;
- a CO was issued from a Complaint inspection #2017_509617_0018, on December 27, 2017;
- a CO was issued from a Follow Up Inspection #2017_616542_0002, on March 7, 2017;
- a CO with a Director's Referral (DR) was issued from a Follow Up Inspection #2016_391603_0024, on November 25, 2016;
- a CO was issued from a Follow Up Inspection #2016_333577_0010, on July 13, 2016;
- a WN was issued from a Complaint Inspection #2016_333577_0011, on July 6, 2016;
- a Voluntary Plan of Correction (VPC) was issued from a Follow Up Inspection #2016_246196_0006,
on March 29, 2016;
- a VPC was issued from a Complaint Inspection #2016_246196_0005, on March 17, 2016; and
- a CO was issued from a Complaint inspection #2016_264609_0006, on March 7, 2016. (196)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 11th day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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