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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 30, 2019	2019_751649_0022	016544-19, 018542-19, 018772-19, 020957-19	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Weston Terrace Care Community
2005 Lawrence Avenue West TORONTO ON M9N 3V4

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

JULIEANN HING (649), JOY IERACI (665)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 13, 14, 15, 18, 19, 20, 21, and off-site November 25 and 26, 2019.

Log #020957-19/ CIS #2874-000036-19 related to prevention of abuse and neglect.
Log #016544-19/ CIS #2874-000029-19 related to falls prevention and management.
Logs #018542-19/ CIS #2874-000031-19 and #018772-19/ CIS #2874-000033-19 related to plan of care.

During the course of the inspection, the inspector(s) spoke with the director of care (DOC), assistant directors of care (ADOCs), nurse manager (NM), physiotherapist (PT), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), residents and family members.

A Voluntary Plan of Correction (VPC) related to O. Reg. 79/10 s. 8 (1) b was identified in Inspection Report #2019_751649_0021 and will be issued in this Inspection Report which was conducted concurrently with that inspection.

During the course of the inspection the inspectors reviewed residents' health records, staffing schedules, investigation notes, conducted observations related to the home's care processes, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff #112, #115, and #116 used safe transferring and positioning devices or techniques when assisting residents #003 and #011.

(i) A critical incident system (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) for an incident, where resident #003 sustained a fall resulting in an injury.

According to the CIS report PSW #112 told the home that resident #003 was in bed facing the wall, their bed was at a waist level, no fall mat was in place, when they left the resident unattended to retrieve a wet cloth from their washroom; the resident sustained a fall.

Resident #003 was not interviewable due to cognitive decline.

In an interview with PSW #112, they explained that they raised the resident’s bed to a waist level to provide care and left the resident in this position, then went into their washroom. According to the PSW the resident was facing the wall, and still asleep. While they were waiting on the water to warm-up, they would glance to ensure the resident was okay. They heard a loud sound and saw that the resident had fallen on the floor. The PSW told the inspector that they were waiting for someone to come and assist them, but did not call for someone to come and assist, when RN #110 came into the resident’s room. The PSW did not immediately report to RN #110 that the resident had a fall. The PSW acknowledged that safe transferring and positioning techniques were not used as the resident’s bed should have been in the lowest position and fall mats beside their bed when they were left unattended to go into the resident's washroom.

A review of the resident's care plan indicated they were at moderate risk for falls, and that their bed should be in the lowest position with fall mats on the floor due to the resident exhibiting an identified responsive behaviour when in bed.

In an interview with RN #110 and a review of their written statement, indicated that while they were conducting rounds they entered resident #011’s room, and observed them sitting on the floor beside the bed without the fall mats, and PSW #112 was attaching the sling to the resident. RN #110 asked PSW #112 if the resident fell and they responded that they did not. The RN helped PSW #112 with the resident’s transfer from the floor to their mobility device and continued their rounds. The RN returned to the resident’s room and observed them sitting comfortably in their mobility device. RN #110 asked PSW #112 a second time if the resident fell and the PSW denied it. The PSW explained that they received the resident on the fall mat in the morning as per their usual behaviour and the mat was removed before their transfer. During breakfast, the resident was observed crying, moaning, and calling for an identified person. According to the RN the resident

had responsive behaviours but never heard them calling for an identified person before. They administered pain medication to the resident and removed them from the dining room into the hallway for close monitoring, and when calmer they returned them to the dining room for breakfast. The RN went to morning report, then was called by PSW #112, and advised that resident #003 had a fall that morning. RN #110 immediately went to the resident inside their room, and observed from their expression that they were in pain. Their extremities were difficult to assess as they were leaning on one side of their body. The PT was passing by, and the RN asked them to assess the resident. The PT advised that the resident required an x-ray of an identified body area. RN #110 observed that an identified area of the resident's body was swollen, and painful to touch with decreased range of motion. The resident was transferred to hospital and returned to the home at approximately 2000 hours on the same day with a diagnosis of an injury. RN #110 confirmed that unsafe transfer and positioning techniques were used when PSW #112 assisted resident #003. The RN further explained that the PSW should have gathered the equipment they needed, and if leaving the resident unattended, place their bed in the lowest position with the fall mats besides their bed, as the resident have identified responsive behaviours while in bed.

In an interview with ADOC #111, they acknowledged that safe transferring and positioning techniques were not used when care was provided to resident #003.

As a result of non-compliance identified under the same legislative reference for resident #003, the sample was expanded to resident #011.

(ii) During an observation conducted on November 21, 2019, at 1126 hours, PSWs #115 and #116 transferred resident #011 from their mobility device to another device using an identified type of mechanical lift. It was observed that an identified size sling was used for the transfer.

A review of the resident's current written plan of care indicated that the resident required an identified type of mechanical lift with two team members for all transfers and a second size sling for toileting.

A review of the resident's lift and transfer assessment, indicated that the resident required an identified type of mechanical lift with a second size sling for transfers.

In an interview, PSW #115 indicated they were the full-time PSW for the resident and they have been using the first size sling to transfer the resident for quite some time. The

PSW stated that every resident has their own sling for transfers and they used the sling that had been provided in the resident's room.

In interviews, ADOC #111 who is the home's lead for lift and transfers, indicated that residents were assessed for lifts and transfers by completing the lift and transfer assessment in point click care (PCC). The ADOC indicated that the correct sling size must be used based on the assessment, to prevent the resident from falling, and/or compromise the resident's skin integrity. The ADOC confirmed that the PSWs did not use the correct sling size when the resident was transferred.

This non compliance was issued due to PSWs #115 and #116's failure to use safe transferring and positioning devices for resident #011. [s. 36.]

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. 48. Required programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to

reduce the incidence of falls and the risk of injury for residents #002, #003, #001, and #012.

(a) A CIS report was submitted to the MLTC related to staff to resident neglect resulting after resident #002's fall.

A review of resident #002's clinical record did not indicate any documentation of a post-fall assessment after their fall.

In an interview with PSW #101 who found the resident lying on the fall mat on the ground in their room, reported the resident’s fall to RN #128 who told them they will be there shortly.

In an interview with RPN #127, they acknowledged that they could not locate any documentation of a post-fall assessment in PCC of resident #002’s fall. According to RPN #127 they received a telephone call from RN #128 on the same day of the resident's fall who told them they forgot about the resident's fall.

In an interview with DOC #121, they acknowledged that a post-fall assessment was not completed when resident #002 sustained a fall.

(b) A CIS report was submitted to the MLTC related to staff to resident neglect resulting after resident #002's fall.

According to the CIS report, RPN #127 received a phone call from RN #128 instructing them to initiate head injury routine (HIR) monitoring for another resident instead of resident #002 identified on the CIS report. RPN #127 immediately initiated a HIR monitoring for resident #002. A follow-up call was made by the home to RN #128 inquiring about the fall, they reported that on their last shift PSW #101 notified them that another resident not the one identified on the CIS report had a fall. To address this issue RN #128 sent RN #102 who was working on the fourth floor to assess and respond to the fall. The CIS report stated it was unclear why RN #128 notified RPN #127 at the time mentioned above instead of at the time of the fall.

Resident #002 was no longer in the home at the time of this inspection.

In an interview with PSW #101 who was working the night shift when resident #002 sustained a fall, told the inspector that they responded to another resident's call bell, and

when they were leaving the room they heard the sound of a bed alarm coming from resident #002's room. Upon entering resident #002's room they observed the resident lying on a fall mat on the floor, and asked them if they were okay; the resident responded that they were. The PSW did not observe that the resident had any injuries or was in any immediate danger as a result of their fall, so they returned to the nursing station to inform RN #128. RN #128 stated that they will be there shortly. The PSW further explained that RN #128 asked them if the resident was okay and the PSW informed them that they were. The RN asked the PSW to put a pillow under the resident's head. The PSW told the inspector they went back to the resident's room and placed a pillow under their head and informed the resident that the nurse will be there shortly and continued with providing care to other residents. PSW #101 told the inspector they saw their co-worker PSW #126 and inquired if they knew if RN #128 had assessed resident #002. According to PSW #101 they were told by PSW #126 that RN #128 asked RN #102 to check on resident #002 and that there was miscommunication between RN #128 and RN #102 about which resident was on the floor. PSW #101 further explained that according to PSW #126, RN #102 left the unit after administering medication to resident #004. PSW #101 later returned to resident #002 and observed that they were still on the floor then continued with providing care to other residents. According to PSW #101 they spoke with RN #128 two or three times during the shift in passing in the hallway, and RN #128 responded that they had not attended to resident #002 yet, as they were still busy with another resident. PSW #101 further explained they were completing rounds before the end of their shift when they asked their co-worker PSW #126 to come and assist with getting resident #002 up from the floor. PSW #101 admitted to the inspector that they knew it was wrong to pick the resident up, and acknowledged that they did not communicate with RN #128 that they would assist the resident up from the floor. According to the PSW they did not communicate with RN #128 to determine if they had assessed the resident; they assumed that the resident was assessed given the time from when they first reported the resident's fall. PSW #101 told the inspector they transferred the resident to bed with PSWs #126 and #103 and provided care, and at that time the resident was responsive and did not indicate that they were in pain. PSW #101 further explained that when they came on shift the next day, they were told by RN #128 that they told them another resident fell and not resident #002. PSW #101 told the inspector that they referred to the resident by their room number rather than by their name as they had only worked with resident #002, who was fairly new a couple of times and did not know their name. The resident passed away two days later, the cause of death was unrelated to their fall.

In an interview with PSW #103 who is the full-time PSW assigned to resident #002

recalled upon their arrival to work, they found the resident lying on the fall mat on the floor between the window and their bed in their room. PSW #103 was told by PSW #101 that they were waiting for PSW #126 to come and help with the resident's transfer from the floor to their bed. According to PSW #103 they and two night PSWs (PSWs #101 and #126) assisted with the resident's transfer using an identified type of mechanical lift. PSW #103 told the inspector they reported resident #002's fall during report to their nurse (RPN #125) and other PSWs who were working that day.

In an interview with PSW #126, who was the second PSW working when the resident fell, told the inspector that they were not familiar with the resident. They became aware of the resident's fall from PSW #101. According to PSW #126 the first time they saw the resident was just before the end of their shift when they assisted PSWs #101 and #103 with transferring the resident to their bed. The inspector inquired if they were aware if the resident was assessed prior to their transfer and they responded that they told PSW #101 to call them for help when the nurse had completed their assessment. PSW #126 could not recall if they had mentioned the resident's fall to the oncoming day shift nurse. The PSW told the inspector that they heard PSW #101 telling the nurse over the phone that the resident in an identified room was on the floor, and did not hear that the PSW referred to the resident by their name. PSW #126 denied having any conversation with RN #128 about the resident.

In an interview with RPN #125, who was the full-time RPN who worked the next shift after the resident fall, denied receiving any report from the night RN #128 that resident #002 had a fall. According to the RPN they were not informed by PSW #103 that they had assisted with the resident's transfer from the fall mat on the floor before the start of their shift.

In an interview with RN #102 who was working when resident #002 fell, acknowledged that when a resident falls an assessment should be completed as soon as possible, and further explained if the nurse was not available to complete the assessment there are two other nurses working in the home on the night shift they could call. The RN further explained that when a PSW finds a resident on the floor they should not touch the resident and call the nurse to complete an assessment. The RN told the inspector they were not familiar with resident #002 because they did not work on that unit or with the resident before. They acknowledged that they were aware of resident #002's fall from RN #128 but denied being asked by RN #128 to complete a post-fall assessment of the resident. According to RN #102 they were asked by RN #128 to assist with the administration of medication to resident #004 and they mentioned to them about the

resident's fall. RN #102 further explained when they went to the identified floor from the other floor to administer the pain medication, they were informed by PSW #126 that the resident in an identified room had a fall. The RN told the inspector they received a telephone call from RN #128 at their private residence on the same day of the resident's fall, asking them if they had assessed the resident; they were surprised and explained to RN #128 that they had only asked them to give medication to resident #004.

In an interview with RPN #127 who received a telephone call from RN #128 on their shift telling them that they forgot that resident #002 had a fall last night, and they did not assess them as they were busy. According to the RPN they received direction from ADOC #100 to immediately initiate HIR monitoring. The RPN told the inspector they took the resident's vitals and completed a quick head to toe assessment, and a more thorough head to toe assessment was completed later. The inspector asked the RPN if the resident admitted to falling and they responded that the resident did not report a fall. RPN #127 acknowledged that there was no collaboration among the staff, as this was the first time they heard of resident #002's fall, and they did not receive any report from the previous shift about this until the phone call from RN #128.

In an interview with DOC #121 they acknowledged that there was no collaboration between RN #128 and the PSWs when the resident fell, since the resident was not assessed by RN #128.

This non-compliance was issued as there was no collaboration in assessment of the resident after they fell: the resident was transferred after they were left on the fall mat due to a fall, for approximately two hours, miscommunication between RN #128 and PSW #101 about which resident fell (resident #002 or resident #005), miscommunication between RN #128 and RN #102 about who told who what in term of the resident's assessment, and admission by RN #128 to RPN #127 that they forgot to assess resident #002.

(c) A CIS report was submitted to the MLTC related to staff to resident neglect resulting after resident #002's fall.

In an interview with PSW #101 who found the resident lying on the fall mat on the floor in their room, reported the resident's fall to RN #128 who told them they would be there shortly. PSW #101 further explained they were completing rounds before the end of their shift when they asked their co-worker PSW #126, to come and assist with transferring resident #002. PSW #101 admitted to the inspector that they knew it was wrong to

transfer the resident, and acknowledged they did not communicate with RN #128 if they had assessed the resident prior to transferring them. They assumed the RN had completed the assessment given the time from when they first reported the resident's fall.

In an interview with DOC #121, they acknowledged that the PSW should have followed up with the nurse prior to the resident's transfer to ensure they were assessed, therefore the home's fall policy was not followed.

(d) A CIS report was submitted to the MLTC related to staff to resident neglect resulting after resident #002's fall.

A review of the home's policy #VII-G-30.10 titled Falls Prevention and Management with a current revision date of April 2019 indicated when a fall occurs, all team members will:
(i) Ensure the resident is not moved before the completion of a preliminary assessment.
(ii) Instruct one team member to remove visitors and other residents from the immediate area.
(iii) Assist the resident to the nearest chair, if the resident has risen on their own post-fall.
the nurse will:
(i) Complete a post-falls assessment and head injury assessment as required.
(ii) Initiate a head injury routine if a head injury is suspected, or if the resident fall is un-witnessed and he/she is on anticoagulant therapy.

A review of the resident's HIR monitoring initiated after the resident sustained a fall in their room indicated they sustained an injury. A review of the HIR monitoring documentation indicated post-fall monitoring was not completed at identified scheduled times. In an interview with the DOC #121, they acknowledged the vitals for the above scheduled times were not completed after the resident's second fall. [s. 48. (1) 1.]

2. (a) A CIS report was submitted to the MLTC for an incident where resident#003 sustained a fall from their bed resulting in an injury.

A review of the home's policy #VII-G-30.10 titled Falls Prevention and Management with a current revision date of April 2019 directs all Team Members when a fall occurs:
-Ensure the resident is not moved before the completion of a preliminary assessment.

In an interview with PSW #112, who was with the resident when they fell from their bed on the above mentioned date, told the inspector that they were waiting for someone to come and assist them, when RN #110 came into the resident's room, and assisted with

the resident's transfer into their mobility device. PSW #112 did not immediately report the resident's fall to RN #110, therefore an assessment was not completed before the resident was transferred from the floor to their mobility device.

In an interview with RN #110, they acknowledged that they only became aware of resident #003's fall several hours later when PSW #112 reported the fall to them. They acknowledged that the home's falls prevention and management policy was not followed as PSW #112 did not immediately report the resident's fall, and they were transferred before an assessment was completed.

In an interview with ADOC #111, they acknowledged that RN #110 was not notified of the resident's fall immediately, which led to the assessment of the resident not being completed before they were transferred.

(b) A CIS report was submitted to the MLTC for an incident where resident#003 sustained a fall from their bed resulting in an injury.

A review of the resident's HIR monitoring initiated after the resident fell, indicated vitals were to be completed at an identified time. According to progress note documentation no entry was completed for the HIR monitoring at the identified time.

In an interview with RPN #104, who was working with the resident on the night shift, told the inspector they had taken the resident vitals at the scheduled time and recorded it in their private note book and later transcribed it into the resident's health records in PCC.

A review of resident #003's PCC documentation indicated below conflicts with what RPN #104 told the inspector.

Based on the above documentation completed by RPN #104 they did not complete the HIR monitoring at the scheduled time.

In an interview with ADOC #111, they acknowledged they was no documentation in the resident's health records of HIR monitoring at the scheduled time. The ADOC explained that the monitoring should be documented at the scheduled time.

(c) A CIS report was submitted to the MLTC for an incident where resident#003 sustained a fall from their bed resulting in an injury.

A review of the resident's care plan indicated they were at moderate risk for falls and required a chair alarm when up in their mobility device.

An observation conducted by Inspector #649 on November 18, 2019, indicated that resident #003 was sitting in their mobility device in an identified home area and a chair alarm was not observed. This observation was confirmed by PSW #123 and ADOC #111.

In an interview with RN #110, they acknowledged that the resident required a chair alarm when they are up in their mobility device. They explained that on the day of the observation, the chair alarm required a new battery and staff should have ensured that the battery was replaced.

In an interview with ADOC #111, they acknowledged that the staff did not implement the resident's fall prevention and management intervention of providing them with a functional chair alarm on the above mentioned date. [s. 48. (1) 1.]

3. A complaint was submitted to the MLTC, expressing concerns about the frequency of resident #001's falls and that they had observed the resident unattended on the toilet.

A review of the resident's HIR monitoring initiated after the resident sustained a fall in an identified home area, indicated three out of the four one-hour interval monitoring were not completed.

Interview with RPN #106 who was working on the evening shift when the resident fell told the inspector that the resident was sleeping, and they did not want to agitate the resident because they have responsive behaviours. The inspector inquired if that approach was acceptable and they responded no, but they did not want to wake the resident and agitate them. The RPN acknowledged that they had not followed the home's fall policy on HIR monitoring.

In an interview with ADOC #100, they acknowledged that the RPN should have completed HIR monitoring for resident #001. [s. 48. (1) 1.]

4. The home submitted a CIS report to the MLTC for an incident that caused injury to resident #012 for which the resident was taken to hospital and resulted in a significant change in the resident's health status. The CIS report indicated that resident #012 had a fall in their room and sustained an injury. The resident had a decrease in their level of consciousness (LOC) and was transferred to hospital and returned to the home more

than two weeks later.

A review of Sunnybrook Health Sciences Centre's consult note indicated that the resident was admitted after the resident was found on the floor in their room, had low LOC and suspected trauma. The resident was diagnosed with several injuries.

A review of the clinical records indicated that falls risk assessments were completed and the resident assessed as a moderate risk for falls on all three assessments.

A review of the progress notes indicated that the resident refused the clip alarm when the staff applied it to the resident. There were seven progress note entries during an identified period, documenting the resident's refusal of the clip alarm intervention. A further review of the post fall incident form which was completed after the resident's third fall indicated that the resident refused the alarm.

In separate interviews, RN #122 and NM #114 indicated that the resident was at risk of falls since admission to the home. The RN stated that when the clip alarm was implemented on an identified date, the resident would refuse it and removed the clip attached to them. The RN indicated that the resident would become upset and anxious from the sound of the alarm, since it was implemented in the plan of care. The NM indicated at the time of the above mentioned fall, the resident continued to remove the alarm clip. The RN and NM indicated that the plan of care was not revised until a later date, to use a sensor alarm instead of the clip alarm when in bed. They both stated that the clip alarm was not an effective intervention to manage the resident's falls, as the resident refused it.

In an interview, ADOC #111 who was the lead for the home's falls prevention program, indicated that when a resident has a fall, the registered staff were to ensure that fall interventions were in place. The ADOC stated that after each fall, the interventions were reviewed in the plan of care, to determine if the interventions were effective and review other alternative interventions that could be implemented. The ADOC confirmed they were aware that resident #012 was at risk of falls and the clip alarm was implemented on an identified date, to manage the resident's falls. The ADOC reviewed the progress notes in PCC related to the resident's refusal of the clip alarm and stated they were not aware that the resident had continually refused the intervention. The ADOC acknowledged that the clip alarm was not an effective intervention to manage the resident's falls. The ADOC reviewed the written plan of care and confirmed that at the time of the resident's fall on the above mentioned date, the resident had continually refused the clip alarm, and that

the plan of care was not reassessed and revised with alternative interventions to reduce the incidence of falls and the risk of injury, until the resident's return from hospital.

The evidence above was reviewed with the DOC in an interview. This non compliance was issued as the home failed to reassess and revise resident #012's plan of care to reduce the incidence of falls and the risk of injury, when the falls management interventions were not effective. [s. 48. (1) 1.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity.

A CIS report was submitted to the MLTC related to staff to resident neglect resulting after resident #002's fall.

According to the CIS report, RPN #127 received a phone call from RN #128 instructing them to initiate HIR monitoring for another resident instead of resident #002 identified on the CIS report. RPN #127 immediately initiated HIR monitoring for resident #002. A follow-up call was made by the home to RN #128 inquiring about the fall, they reported that on their last shift PSW #101 notified them that another resident not the one identified on the CIS report had a fall. To address this issue RN #128 sent RN #102 who was

working on the other floor to assess and respond to the fall. The CIS report stated it was unclear why RN #128 notified RPN #127 at the time mentioned above instead of at the time of the fall.

Resident #002 was no longer in the home at the time of this inspection.

In an interview with PSW #101, they told the inspector that they heard the sound of an alarm coming from resident #002's room and observed resident #002 lying on the fall mat on the floor in their room. According to PSW #101, they reported to RN #128 that resident #002 had a fall, and the RN advised that they will be there shortly. The PSW further explained that RN #128 asked them if the resident was okay and the PSW informed them that they were; they asked the PSW to put a pillow under the resident’s head. The PSW told the inspector they returned to the resident's room and placed a pillow under their head and informed the resident that the nurse will be there shortly, then continued with providing care to other residents. The PSW stated that they conducted residents’ rounds hourly. According to PSW #101 they spoke with RN #128 two or three times during the shift in passing in the hallway, and RN #128 responded that they were still busy with another resident who passed away. Just before the end of their shift PSW #101 and two other PSWs transferred the resident from the fall mat on the floor using the mechanical lift. PSW #101 did not communicate with RN #128 if they had assessed the resident, they assumed that the resident was assessed given the time from when they first reported the resident's fall.

According to the home’s investigation notes, PSW #101 told the home in an interview that they had checked on resident #002 twice after their fall. The home told the PSW that according to the home’s video surveillance they were seen entering the resident’s room once after their fall and did not return to the resident’s room until the time of their transfer; almost two hours later at which time to assist with the resident’s transfer. The home’s video surveillance showed that PSW #101 failed to monitor the resident after they fell and failed to follow-up with RN #128 if they had assessed the resident before they were transferred. PSW #103 told the home in an interview that when they came on shift, resident #002 was observed on the floor in their room calling out, asking to get them up.

In an interview with DOC #121, they told the inspector that according to the home’s video surveillance, RN #128 was observed going into a room on the unit where they remained for two hours. The DOC further explained approximately 30 minutes before the start of their shift PSW #103 walked past the resident’s room, and observed them on the floor and went to the nursing station to report it. According to the home's video surveillance,

RN #128 was observed entering resident #002's room a few minutes after PSW #103 left, and told the home that resident #002 was observed sitting in their mobility device, in no sign of distress. According to the DOC, the statement provided by RN #128 conflicts with the statements from the PSWs and what was observed on the home's video surveillance.

According to the home's investigation notes, PSW #103 told the home in an interview that when they came on shift, resident #002 was calling out asking to get them up as they knew they were not in their bed.

In an interview with RPN #127, they explained they received a telephone call from RN #128 on their shift, who told them that they forgot that resident #002 had a fall and did not assess them as they were busy. RPN #127 initiated a HIR monitoring for the resident's fall that took place earlier that day.

The staff actions above demonstrated that resident #002 was not treated with courtesy and respect when they sustained a fall as evidenced by the following: the resident was never monitored by PSW #101 after they fell since, they were left lying on the fall mat on the floor in their room for almost two hours, was heard by PSW #103 calling out asking to get them up, was never assessed by RN #128 after they fell due to miscommunication about which resident fell, and PSW #101's decision to transfer the resident from the floor before the end of their shift without any follow-up with RN #128 to determine if they assessed the resident. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

Issued on this 9th day of January, 2020

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

Original report signed by the inspector.

Ontario

Ministry of 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

Ministère 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 Operations Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JULIEANN HING (649), JOY IERACI (665)

Inspection No. / No de l'inspection : 2019_751649_0022

Log No. / No de registre : 016544-19, 018542-19, 018772-19, 020957-19

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

Report Date(s) / Date(s) du Rapport : Dec 30, 2019

Licensee / Titulaire de permis : 2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8

LTC Home / Foyer de SLD : Weston Terrace Care Community
2005 Lawrence Avenue West, TORONTO, ON, M9N-3V4

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

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 36.

Specifically, the licensee must:

1. Provide training to PSW #112 on the home's fall prevention and management policy, and the use of safe positioning techniques when providing positioning and transferring assistance to resident #003 and any other resident.
The training should include but not be limited to:
(i) Immediate reporting of a resident's fall to the nursing staff, and
(ii) The importance of assessing a resident before moving them after a fall.
A record of the training provided must be maintained that includes the topic covered, date of the education, and who provided the education.
2. Provide training to PSWs #115 and #116 to ensure use of correct sized sling as specified in the resident's plan of care.
A record of the training provided must be maintained that includes the topic covered, staff attendance records, date of the education, and who provided the education.
3. Conduct audits of PSW #112 to ensure safe positioning techniques are being used during the provision of care to resident #003 and any other resident.
A record of the audits completed must be maintained that includes residents' name and room number, date of the audit including the shift, and the name of staff who completed the audit.
4. Conduct audits of PSWs #115 and #116 to ensure use of correct sized sling as specified in resident's plan of care.
A record of the audits completed must be maintained that includes residents' name and room number, date of the audit including the shift, and the name of staff who completed the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that staff #112, #115, and #116 used safe transferring and positioning devices or techniques when assisting residents #011 and #003.

(i) A critical incident system (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) for an incident, where resident#003 sustained a fall resulting in an injury.

According to the CIS report PSW #112 told the home that resident #003 was in bed facing the wall, their bed was at a waist level, no fall mat was in place, when they left the resident unattended to retrieve a wet cloth from their washroom; the resident sustained a fall.

Resident #003 was not interviewable due to cognitive decline.

In an interview with PSW #112, they explained that they raised the resident’s bed to a waist level to provide care and left the resident in this position, then went into their washroom. According to the PSW the resident was facing the wall, and still asleep. While they were waiting on the water to warm-up, they would glance to ensure the resident was okay. They heard a loud sound and saw that the resident had fallen on the floor. The PSW told the inspector that they were waiting for someone to come and assist them, but did not call for someone to come and assist, when RN #110 came into the resident’s room. The PSW did not immediately report to RN #110 that the resident had a fall. The PSW acknowledged that safe transferring and positioning techniques were not used as the resident’s bed should have been in the lowest position and fall mats beside their bed when they were left unattended to go into the resident's washroom.

A review of the resident's care plan indicated they were at moderate risk for falls, and that their bed should be in the lowest position with fall mats on the floor due to the resident exhibiting an identified responsive behaviour when in bed.

In an interview with RN #110 and a review of their written statement, indicated that while they were conducting rounds they entered resident #011’s room, and observed them sitting on the floor beside the bed without the fall mats, and PSW

#112 was attaching the sling to the resident. RN #110 asked PSW #112 if the resident fell and they responded that they did not. The RN helped PSW #112 with the resident's transfer from the floor to their mobility device and continued their rounds. The RN returned to the resident's room and observed them sitting comfortably in their mobility device. RN #110 asked PSW #112 a second time if the resident fell and the PSW denied it. The PSW explained that they received the resident on the fall mat in the morning as per their usual behaviour and the mat was removed before their transfer. During breakfast, the resident was observed crying, moaning, and calling for an identified person. According to the RN the resident had responsive behaviours but never heard them calling for an identified person before. They administered pain medication to the resident and removed them from the dining room into the hallway for close monitoring, and when calmer they returned them to the dining room for breakfast. The RN went to morning report, then was called by PSW #112, and advised that resident #003 had a fall that morning. RN #110 immediately went to the resident inside their room, and observed from their expression that they were in pain. Their extremities were difficult to assess as they were leaning on one side of their body. The PT was passing by, and the RN asked them to assess the resident. The PT advised that the resident required an x-ray of an identified body area. RN #110 observed that an identified area of the resident's body was swollen, and painful to touch with decreased range of motion. The resident was transferred to hospital and returned to the home at approximately 2000 hours on the same day with a diagnosis of an injury. RN #110 confirmed that unsafe transfer and positioning techniques were used when PSW #112 assisted resident #003. The RN further explained that the PSW should have gathered the equipment they needed, and if leaving the resident unattended, place their bed in the lowest position with the fall mats besides their bed, as the resident have identified responsive behaviours while in bed.

In an interview with ADOC #111, they acknowledged that safe transferring and positioning techniques were not used when care was provided to resident #003.

As a result of non-compliance identified under the same legislative reference for resident #003, the sample was expanded to resident #011.

(ii) During an observation conducted on November 21, 2019, at 1126 hours, PSWs #115 and #116 transferred resident #011 from their mobility device to

another device using an identified type of mechanical lift. It was observed that an identified size sling was used for the transfer.

A review of the resident's current written plan of care indicated that the resident required an identified type of mechanical lift with two team members for all transfers and a second size sling for toileting.

A review of the resident's lift and transfer assessment, indicated that the resident required an identified type of mechanical lift with a second size sling for transfers.

In an interview, PSW #115 indicated they were the full-time PSW for the resident and they have been using the first size sling to transfer the resident for quite some time. The PSW stated that every resident has their own sling for transfers and they used the sling that had been provided in the resident's room.

In interviews, ADOC #111 who is the home's lead for lift and transfers, indicated that residents were assessed for lifts and transfers by completing the lift and transfer assessment in point click care (PCC). The ADOC indicated that the correct sling size must be used based on the assessment, to prevent the resident from falling, and/or compromise the resident's skin integrity. The ADOC confirmed that the PSWs did not use the correct sling size when the resident was transferred.

This non compliance was issued due to PSWs #115 and #116's failure to use safe transferring and positioning devices for resident #011.

The severity of this non-compliance was identified as actual harm, the scope was identified as patterned. Review of the home's compliance history revealed a compliance order (CO) was issued on June 13, 2019, under inspection report #2019_776613_0016 for non-compliance with the LTCHA, 2007, r. 36. Due to the severity of actual harm and previous non-compliance, a CO is warranted. (665)

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

May 14, 2020

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

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

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

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

Order / Ordre :

The Licensee must be complaint with O. Reg. 79/10, s. 48. (1) of the LTCHA 2007.

Specifically, the licensee must:

(1) Provide training to PSWs #101, #126, #103, #112, RPNs #104, #106, and RN #128 on the home's fall prevention and management policy.
The training should include but not be limited to:
(i) Immediately reporting and assessing a resident's fall to ensure completion of an assessment prior to the resident's transfer, identification of injuries, and prevention of further injuries.
(ii) The importance of assessing, monitoring, and documenting residents' HIR as per the home's policy.
A record of the training provided must be maintained that includes the topic covered, date of the education, staff attendance record, and who provided the education.
(2) Ensure that residents #002, #003, #001, and #012 and any other residents who have had multiple falls have their fall interventions reassessed and revised, to ensure they are effective in reducing the incidence of falls and the risk of injury.
(3) Develop a process to ensure that fall prevention interventions identified in residents' plan of care are implemented.

Grounds / Motifs :

1. The licensee has failed to ensure that there was an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury for residents #002, #003, #001, and #012.

(a) A CIS report was submitted to the MLTC related to staff to resident neglect resulting after resident #002's fall.

A review of resident #002's clinical record did not indicate any documentation of a post-fall assessment after their fall.

In an interview with PSW #101 who found the resident lying on the fall mat on the ground in their room, reported the resident's fall to RN #128 who told them

they will be there shortly.

In an interview with RPN #127, they acknowledged that they could not locate any documentation of a post-fall assessment in PCC of resident #002's fall. According to RPN #127 they received a telephone call from RN #128 on the same day of the resident's fall who told them they forgot about the resident's fall.

In an interview with DOC #121, they acknowledged that a post-fall assessment was not completed when resident #002 sustained a fall.

(b) A CIS report was submitted to the MLTC related to staff to resident neglect resulting after resident #002's fall.

According to the CIS report, RPN #127 received a phone call from RN #128 instructing them to initiate head injury routine (HIR) monitoring for another resident instead of resident #002 identified on the CIS report. RPN #127 immediately initiated a HIR monitoring for resident #002. A follow-up call was made by the home to RN #128 inquiring about the fall, they reported that on their last shift PSW #101 notified them that another resident not the one identified on the CIS report had a fall. To address this issue RN #128 sent RN #102 who was working on the fourth floor to assess and respond to the fall. The CIS report stated it was unclear why RN #128 notified RPN #127 at the time mentioned above instead of at the time of the fall.

Resident #002 was no longer in the home at the time of this inspection.

In an interview with PSW #101 who was working the night shift when resident #002 sustained a fall, told the inspector that they responded to another resident's call bell, and when they were leaving the room they heard the sound of a bed alarm coming from resident #002's room. Upon entering resident #002's room they observed the resident lying on a fall mat on the floor, and asked them if they were okay; the resident responded that they were. The PSW did not observe that the resident had any injuries or was in any immediate danger as a result of their fall, so they returned to the nursing station to inform RN #128. RN #128 stated that they will be there shortly. The PSW further explained that RN #128 asked them if the resident was okay and the PSW informed them that they

were. The RN asked the PSW to put a pillow under the resident's head. The PSW told the inspector they went back to the resident's room and placed a pillow under their head and informed the resident that the nurse will be there shortly and continued with providing care to other residents. PSW #101 told the inspector they saw their co-worker PSW #126 and inquired if they knew if RN #128 had assessed resident #002. According to PSW #101 they were told by PSW #126 that RN #128 asked RN #102 to check on resident #002 and that there was miscommunication between RN #128 and RN #102 about which resident was on the floor. PSW #101 further explained that according to PSW #126, RN #102 left the unit after administering medication to resident #004. PSW #101 later returned to resident #002 and observed that they were still on the floor then continued with providing care to other residents. According to PSW #101 they spoke with RN #128 two or three times during the shift in passing in the hallway, and RN #128 responded that they had not attended to resident #002 yet, as they were still busy with another resident. PSW #101 further explained they were completing rounds before the end of their shift when they asked their co-worker PSW #126 to come and assist with getting resident #002 up from the floor. PSW #101 admitted to the inspector that they knew it was wrong to pick the resident up, and acknowledged that they did not communicate with RN #128 that they would assist the resident up from the floor. According to the PSW they did not communicate with RN #128 to determine if they had assessed the resident; they assumed that the resident was assessed given the time from when they first reported the resident's fall. PSW #101 told the inspector they transferred the resident to bed with PSWs #126 and #103 and provided care, and at that time the resident was responsive and did not indicate that they were in pain. PSW #101 further explained that when they came on shift the next day, they were told by RN #128 that they told them another resident fell and not resident #002. PSW #101 told the inspector that they referred to the resident by their room number rather than by their name as they had only worked with resident #002, who was fairly new a couple of times and did not know their name. The resident passed away two days later, the cause of death was unrelated to their fall.

In an interview with PSW #103 who is the full-time PSW assigned to resident #002 recalled upon their arrival to work, they found the resident lying on the fall mat on the floor between the window and their bed in their room. PSW #103 was told by PSW #101 that they were waiting for PSW #126 to come and help with

the resident's transfer from the floor to their bed. According to PSW #103 they and two night PSWs (PSWs #101 and #126) assisted with the resident's transfer using an identified type of mechanical lift. PSW #103 told the inspector they reported resident #002's fall during report to their nurse (RPN #125) and other PSWs who were working that day.

In an interview with PSW #126, who was the second PSW working when the resident fell, told the inspector that they were not familiar with the resident. They became aware of the resident's fall from PSW #101. According to PSW #126 the first time they saw the resident was just before the end of their shift when they assisted PSWs #101 and #103 with transferring the resident to their bed. The inspector inquired if they were aware if the resident was assessed prior to their transfer and they responded that they told PSW #101 to call them for help when the nurse had completed their assessment. PSW #126 could not recall if they had mentioned the resident's fall to the oncoming day shift nurse. The PSW told the inspector that they heard PSW #101 telling the nurse over the phone that the resident in an identified room was on the floor, and did not hear that the PSW referred to the resident by their name. PSW #126 denied having any conversation with RN #128 about the resident.

In an interview with RPN #125, who was the full-time RPN who worked the next shift after the resident fall, denied receiving any report from the night RN #128 that resident #002 had a fall. According to the RPN they were not informed by PSW #103 that they had assisted with the resident's transfer from the fall mat on the floor before the start of their shift.

In an interview with RN #102 who was working when resident #002 fell, acknowledged that when a resident falls an assessment should be completed as soon as possible, and further explained if the nurse was not available to complete the assessment there are two other nurses working in the home on the night shift they could call. The RN further explained that when a PSW finds a resident on the floor they should not touch the resident and call the nurse to complete an assessment. The RN told the inspector they were not familiar with resident #002 because they did not work on that unit or with the resident before. They acknowledged that they were aware of resident #002's fall from RN #128 but denied being asked by RN #128 to complete a post-fall assessment of the resident. According to RN #102 they were asked by RN #128 to assist with the

administration of medication to resident #004 and they mentioned to them about the resident's fall. RN #102 further explained when they went to the identified floor from the other floor to administer the pain medication, they were informed by PSW #126 that the resident in an identified room had a fall. The RN told the inspector they received a telephone call from RN #128 at their private residence on the same day of the resident's fall, asking them if they had assessed the resident; they were surprised and explained to RN #128 that they had only asked them to give medication to resident #004.

In an interview with RPN #127 who received a telephone call from RN #128 on their shift telling them that they forgot that resident #002 had a fall last night, and they did not assess them as they were busy. According to the RPN they received direction from ADOC #100 to immediately initiate HIR monitoring. The RPN told the inspector they took the resident's vitals and completed a quick head to toe assessment, and a more thorough head to toe assessment was completed later. The inspector asked the RPN if the resident admitted to falling and they responded that the resident did not report a fall. RPN #127 acknowledged that there was no collaboration among the staff, as this was the first time they heard of resident #002's fall, and they did not receive any report from the previous shift about this until the phone call from RN #128.

In an interview with DOC #121 they acknowledged that there was no collaboration between RN #128 and the PSWs when the resident fell, since the resident was not assessed by RN #128.

This non-compliance was issued as there was no collaboration in assessment of the resident after they fell: the resident was transferred after they were left on the fall mat due to a fall, for approximately two hours, miscommunication between RN #128 and PSW #101 about which resident fell (resident #002 or resident #005), miscommunication between RN #128 and RN #102 about who told who what in term of the resident's assessment, and admission by RN #128 to RPN #127 that they forgot to assess resident #002.

(c) A CIS report was submitted to the MLTC related to staff to resident neglect resulting after resident #002's fall.

In an interview with PSW #101 who found the resident lying on the fall mat on

the floor in their room, reported the resident's fall to RN #128 who told them they would be there shortly. PSW #101 further explained they were completing rounds before the end of their shift when they asked their co-worker PSW #126, to come and assist with transferring resident #002. PSW #101 admitted to the inspector that they knew it was wrong to transfer the resident, and acknowledged they did not communicate with RN #128 if they had assessed the resident prior to transferring them. They assumed the RN had completed the assessment given the time from when they first reported the resident's fall.

In an interview with DOC #121, they acknowledged that the PSW should have followed up with the nurse prior to the resident's transfer to ensure they were assessed, therefore the home's fall policy was not followed.

(d) A CIS report was submitted to the MLTC related to staff to resident neglect resulting after resident #002's fall.

A review of the home's policy #VII-G-30.10 titled Falls Prevention and Management with a current revision date of April 2019 indicated when a fall occurs, all team members will:
(i) Ensure the resident is not moved before the completion of a preliminary assessment.
(ii) Instruct one team member to remove visitors and other residents from the immediate area.
(iii) Assist the resident to the nearest chair, if the resident has risen on their own post-fall.
the nurse will:
(i) Complete a post-falls assessment and head injury assessment as required.
(ii) Initiate a head injury routine if a head injury is suspected, or if the resident fall is un-witnessed and he/she is on anticoagulant therapy.

A review of the resident's HIR monitoring initiated after the resident sustained a fall in their room indicated they sustained an injury. A review of the HIR monitoring documentation indicated post-fall monitoring was not completed at identified scheduled times. In an interview with the DOC #121, they acknowledged the vitals for the above scheduled times were not completed after the resident's second fall. (649)

2. (a) A CIS report was submitted to the MLTC for an incident where resident #003 sustained a fall from their bed resulting in an injury.

A review of the home's policy #VII-G-30.10 titled Falls Prevention and Management with a current revision date of April 2019 directs all Team Members when a fall occurs:
-Ensure the resident is not moved before the completion of a preliminary assessment.

In an interview with PSW #112, who was with the resident when they fell from their bed on the above mentioned date, told the inspector that they were waiting for someone to come and assist them, when RN #110 came into the resident's room, and assisted with the resident's transfer into their mobility device. PSW #112 did not immediately report the resident's fall to RN #110, therefore an assessment was not completed before the resident was transferred from the floor to their mobility device.

In an interview with RN #110, they acknowledged that they only became aware of resident #003's fall several hours later when PSW #112 reported the fall to them. They acknowledged that the home's falls prevention and management policy was not followed as PSW #112 did not immediately report the resident's fall, and they were transferred before an assessment was completed.

In an interview with ADOC #111, they acknowledged that RN #110 was not notified of the resident's fall immediately, which led to the assessment of the resident not being completed before they were transferred.

(b) A CIS report was submitted to the MLTC for an incident where resident#003 sustained a fall from their bed resulting in an injury.

A review of the resident's HIR monitoring initiated after the resident fell, indicated vitals were to be completed at an identified time. According to progress note documentation no entry was completed for the HIR monitoring at the identified time.

In an interview with RPN #104, who was working with the resident on the night shift, told the inspector they had taken the resident vitals at the scheduled time

and recorded it in their private note book and later transcribed it into the resident's health records in PCC.

A review of resident #003's PCC documentation indicated below conflicts with what RPN #104 told the inspector.

Based on the above documentation completed by RPN #104 they did not complete the HIR monitoring at the scheduled time.

In an interview with ADOC #111, they acknowledged they was no documentation in the resident's health records of HIR monitoring at the scheduled time. The ADOC explained that the monitoring should be documented at the scheduled time.

(c) A CIS report was submitted to the MLTC for an incident where resident#003 sustained a fall from their bed resulting in an injury.

A review of the resident's care plan indicated they were at moderate risk for falls and required a chair alarm when up in their mobility device.

An observation conducted by Inspector #649 on November 18, 2019, indicated that resident #003 was sitting in their mobility device in an identified home area and a chair alarm was not observed. This observation was confirmed by PSW #123 and ADOC #111.

In an interview with RN #110, they acknowledged that the resident required a chair alarm when they are up in their mobility device. They explained that on the day of the observation, the chair alarm required a new battery and staff should have ensured that the battery was replaced.

In an interview with ADOC #111, they acknowledged that the staff did not implement the resident's fall prevention and management intervention of providing them with a functional chair alarm on the above mentioned date. (649)

3. A complaint was submitted to the MLTC, expressing concerns about the frequency of resident #001's falls and that they had observed the resident unattended on the toilet.

A review of the resident's HIR monitoring initiated after the resident sustained a fall in an identified home area, indicated three out of the four one-hour interval monitoring were not completed.

Interview with RPN #106 who was working on the evening shift when the resident fell told the inspector that the resident was sleeping, and they did not want to agitate the resident because they have responsive behaviours. The inspector inquired if that approach was acceptable and they responded no, but they did not want to wake the resident and agitate them. The RPN acknowledged that they had not followed the home's fall policy on HIR monitoring.

In an interview with ADOC #100, they acknowledged that the RPN should have completed HIR monitoring for resident #001. (649)

4. The home submitted a CIS report to the MLTC for an incident that caused injury to resident #012 for which the resident was taken to hospital and resulted in a significant change in the resident's health status. The CIS report indicated that resident #012 had a fall in their room and sustained an injury. The resident had a decrease in their level of consciousness (LOC) and was transferred to hospital and returned to the home more than two weeks later.

A review of Sunnybrook Health Sciences Centre's consult note indicated that the resident was admitted after the resident was found on the floor in their room, had low LOC and suspected trauma. The resident was diagnosed with several injuries.

A review of the clinical records indicated that falls risk assessments were completed and the resident assessed as a moderate risk for falls on all three assessments.

A review of the progress notes indicated that the resident refused the clip alarm when the staff applied it to the resident. There were seven progress note entries during an identified period, documenting the resident's refusal of the clip alarm intervention. A further review of the post fall incident form which was completed after the resident's third fall indicated that the resident refused the alarm.

In separate interviews, RN #122 and NM #114 indicated that the resident was at risk of falls since admission to the home. The RN stated that when the clip alarm was implemented on an identified date, the resident would refuse it and removed the clip attached to them. The RN indicated that the resident would become upset and anxious from the sound of the alarm, since it was implemented in the plan of care. The NM indicated at the time of the above mentioned fall, the resident continued to remove the alarm clip. The RN and NM indicated that the plan of care was not revised until a later date, to use a sensor alarm instead of the clip alarm when in bed. They both stated that the clip alarm was not an effective intervention to manage the resident's falls, as the resident refused it.

In an interview, ADOC #111 who was the lead for the home's falls prevention program, indicated that when a resident has a fall, the registered staff were to ensure that fall interventions were in place. The ADOC stated that after each fall, the interventions were reviewed in the plan of care, to determine if the interventions were effective and review other alternative interventions that could be implemented. The ADOC confirmed they were aware that resident #012 was at risk of falls and the clip alarm was implemented on an identified date, to manage the resident's falls. The ADOC reviewed the progress notes in PCC related to the resident's refusal of the clip alarm and stated they were not aware that the resident had continually refused the intervention. The ADOC acknowledged that the clip alarm was not an effective intervention to manage the resident's falls. The ADOC reviewed the written plan of care and confirmed that at the time of the resident's fall on the above mentioned date, the resident had continually refused the clip alarm, and that the plan of care was not reassessed and revised with alternative interventions to reduce the incidence of falls and the risk of injury, until the resident's return from hospital.

The evidence above was reviewed with the DOC in an interview. This non compliance was issued as the home failed to reassess and revise resident #012's plan of care to reduce the incidence of falls and the risk of injury, when the falls management interventions were not effective.

The severity of this non-compliance was identified as actual harm, the scope was identified as isolated. Review of the home's compliance history revealed a voluntary plan of correction (VPC) was issued on August 26, 2019, under

inspection report #2019_810654_0003 for the non-compliance with the LTCHA, 2007, r. 48. (1) 1. Due to the severity of actual harm and previous non-compliance, a CO is warranted. (649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : May 14, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 30th day of December, 2019

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : JulieAnn Hing

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