Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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
Feb 18, 2020	2020_823653_0006	017672-19, 017679-19, 023206-19, 000245-20	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Woodhaven Long Term Care Residence
380 Church Street MARKHAM ON L6B 1E1

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

ROMELA VILLASPIR (653), DIANE BROWN (110)

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): January 20, 21, 22, 23, 24, 27, 28, 29, 30, 31, and February 3, 2020.

The following Critical Incident System (CIS) log intakes had been inspected:

CIS intakes related to falls:
Log #(s): 017679-19, 023206-19.

CIS intake log #017672-19 related to an injury sustained by a resident from unknown cause.
CIS intake log #000245-20 related to resident to resident abuse.

During the course of the inspection, the inspector conducted observations of resident care provision, resident interactions, reviewed the staff schedule, clinical health records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Nursing Students, Clinical Instructor, Personal Care Providers (PCPs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Falls Lead RN, Behavioural Support Ontario (BSO) nurse, Resident Care Co-ordinator (RCC), Program Support Services Manager (PSS Manager), Physiotherapist (PT), Nurse Practitioner (NP), Assistant Director of Care (ADOC), and the Director of Care (DOC).

PLEASE NOTE: A Compliance Order related to s. 6 (7) of the Long-Term Care Homes Act, S.O. 2007, identified in concurrent complaint inspection report #2020_823653_0005 (Log #020516-19) will be issued in this report.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- **5 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of resident #007 and the needs and preferences of that resident.

Resident #007 was identified at risk for falls and they had cognitive impairment.

Resident #007 had a fall on an identified date, and was reassessed for falls prevention under the post fall assessment.

The resident’s plan of care included an identified intervention.

An interview with Personal Care Provider (PCP) #120 shared that the identified intervention was not effective in preventing resident #007's falls, as the resident’s cognition was impaired so they would not be able to adhere to the identified intervention. [s. 6. (2)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #007 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Resident #007 had a fall on an identified date, and the resident was reassessed by way of a post fall assessment and a referral was sent to the Physiotherapist (PT).

A record review identified the PT assessment included two additional falls prevention interventions.

An interview with the PT stated that after their assessment, they verbally shared the recommendations with Registered Practical Nurse (RPN) #128. The PT stated that registered staff were to update the care plan with the recommendations.

A review of the resident’s written plan of care failed to include the two added interventions for falls prevention.

An observation was made of the resident on an identified date and time, which revealed that the falls prevention intervention was not implemented. Inspector #110's observations were confirmed with PCP #120 and the PT.

Separate interviews with PCP #120 and the Program Support Services Manager (PSS Manager) revealed unawareness of the PT's recommended falls prevention interventions.

A final interview with RPN #128 confirmed that registered staff were to update the resident's plan of care based on the PT's recommendations.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #007 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other. [s. 6. (4) (b)]

3. The licensee has failed to ensure that the care set out in the written plan of care was provided to residents #006, #007, #003, and #001 as specified in the plan.

The home submitted a Critical Incident Report (CIR) of resident #006's fall wherein they sustained injuries and was transferred to hospital for further assessment. Two days prior, resident #006 also had a fall in their bedroom, was transferred to the hospital, and had a significant change in condition.

A record review of an assessment identified resident #006 at risk for falls.

The resident's written plan of care indicated their falls prevention interventions.

Three separate observations conducted by Inspector #110 revealed that the falls prevention intervention identified in resident #006's written plan of care was not implemented by the registered staff.

A record review identified that at the time of the incident, PCP #130 found resident #006 in their bedroom lying on the floor. An interview with PCP #130 shared that the resident was not feeling well and stayed in bed over a meal service. The PCP stated that when delivering a meal tray to another resident, they passed resident #006's room and found them on the floor. The PCP could not recall if the identified falls prevention intervention was in place.

An interview with RPN #135 stated they were in the dining room at the time of the resident's fall when PCP #130 alerted them that the resident was on the floor. The RPN shared that they could not recall if the identified falls prevention intervention was in place.

A review of the post fall assessments of falls occurring in the resident's bedroom on five different dates from the last quarter failed to identify that the falls prevention intervention

was implemented as required by resident #006's written plan of care.

Further review of the post fall assessments and staff interviews confirmed that the resident's falls prevention intervention was not in place when the resident fell on three different occasions.

In separate interviews when discussing resident #006 and their fall history, Falls Lead Registered Nurse (RN) #112 and the Director of Care (DOC) shared they had done everything for resident #006 in regards to falls prevention. [s. 6. (7)]

4. As a result of identifying non-compliance for care not provided to resident #006 as set out in the written plan of care as it related to falls interventions, the sample size was expanded which included resident #007.

A review of the assessment provided to Inspector #110 identified resident #007 was at risk for falls.

The resident's written plan of care indicated their falls prevention interventions.

An observation was made by Inspector #110, which revealed that resident #007's falls prevention interventions were not implemented. Inspector #110's observations were confirmed with PCP #120 and the PT.

An interview with the PT confirmed that the care set out in the written plan of care was not provided to resident #007 as specified in the plan. [s. 6. (7)]

5. The home submitted a CIR to the Director for an incident that caused an injury to resident #003 for which they were taken to hospital, and which resulted in a significant change in the resident's health status. The CIR indicated resident #003 had an unwitnessed fall and was found on their bedroom floor. The resident was sent to hospital for further assessment and was diagnosed with an injury.

A review of resident #003's written plan of care indicated they were at risk for falls and staff were to ensure that an identified falls prevention intervention was in place when the resident was on their assistive device.

A review of the PT's progress note and an interview with them indicated at the time of resident #003's fall, they used an identified assistive device that had the falls prevention

intervention.

An interview with PCP #113 indicated they were assigned to resident #003's care on the identified shift when the incident happened. The PCP stated they were giving a shower to a co-resident and heard a loud noise, so they went to resident #003's bedroom to check on them. As they opened the door, they saw resident #003 was on the floor. When asked by the inspector if the falls prevention intervention was in place at the time of the incident, the PCP acknowledged it was not.

An interview with the Assistant Director of Care (ADOC) indicated the home's expectation was for staff to check the identified falls prevention intervention at the start of the shift to ensure they are working. The ADOC further indicated this had been explained to the staff with the new education on falls prevention. [s. 6. (7)]

6. The Ministry of Long-Term Care (MLTC) received a complaint related to resident #001's skin and wound care. An interview with the complainant indicated the resident was admitted to the home with an alteration in skin integrity that had gotten worse over time due to lack of care in the home.

A review of resident #001's health records indicated they were admitted in the hospital for 13 days.

A review of progress notes and the prescriber order form indicated on the day resident #001 returned to the home, RN #112 confirmed the treatment orders for their alteration in skin integrity with the physician.

Two separate observations by Inspector #653, of the treatment provision by two different registered staff revealed treatment was not provided as specified in the written plan of care.

An interview with RPN #110 indicated the expectation was for the registered staff to do the treatment according to the physician's order.

An interview with the ADOC acknowledged the above mentioned information and indicated the expectation was for staff to follow the order as specified. Further review of the prescriber order form and an interview with the ADOC indicated they had obtained clarification for the orders following Inspector #653's observation of the treatment carried out by RPN #110.

The licensee has failed to ensure that the care set out in the written plan of care was provided to residents #006, #007, #003, and #001 as specified in the plan. [s. 6. (7)]

7. The licensee has failed to ensure that resident #006 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

The home submitted a CIR of resident #006's fall wherein they sustained injuries and was transferred to hospital for further assessment. Two days prior, resident #006 also had a fall in their bedroom, was transferred to the hospital, and had a significant change in condition.

A record review indicated that resident #006 had a history of falls including falls on seven different occasions. A review of the post fall assessments identified the root cause of the resident's fall was refusing to adhere to an identified falls prevention intervention.

A record review identified the resident had cognitive impairment.

A review of the resident's written plan of care required the staff to remind resident #006 to adhere to the identified falls prevention intervention.

An interview with PCP #130 stated they had worked with resident #006 for six months to one year and two years ago they could adhere to the identified falls prevention intervention, however, this intervention was no longer effective as the resident's cognition had changed.

An interview with PCP #131 revealed they had provided care to resident #006 for one year and that the resident had never adhered to the identified falls prevention intervention as they cannot remember to do so.

An interview with RPN #132 shared that resident #006 has had a cognitive decline and forgets to adhere to the identified falls prevention intervention, and relying on the resident to remember was not consistent with their current needs.

The licensee has failed to ensure that resident #006 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary. [s. 6.

(10) (b)]

8. The licensee has failed to ensure that when resident #006 was being reassessed and the plan of care was being revised because care set out in the plan has not been effective, that different approaches were considered in the revision of the plan of care.

A review of the resident's health records revealed eight falls and their corresponding post fall assessments.

A review of the resident's written plan of care failed to identify changes related to the eight falls.

An interview with Falls Lead RN #112 shared that part of the resident's plan of care was effective and some parts were not, in the prevention of resident #006's falls.

During separate interviews with RPN #132, Falls Lead RN #112, and the DOC, they all shared with Inspector #110 that they felt they were doing everything for the resident to prevent the resident from falling.

The licensee has failed to ensure that when resident #006 was being reassessed and the plan of care was being revised because care set out in the plan has not been effective, that different approaches were considered in the revision of the plan of care. [s. 6. (11) (b)]

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 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that that the following rights of residents were fully respected and promoted: Cared for in a manner consistent with his or her needs.

The home submitted a CIR of resident #006's fall wherein they sustained injuries and was transferred to hospital for further assessment. Two days prior, resident #006 also had a fall in their bedroom, was transferred to the hospital, and had a significant change in condition.

A review of resident #006's health records indicated they had cognitive impairment.

A review of the resident's plan of care required staff to remind resident #006 to adhere to an identified falls prevention intervention.

An interview with RPN #116 shared the resident was confused and their cognition was getting worse. The staff shared the resident does not adhere to the identified falls prevention intervention, and other interventions have been implemented. An interview with RPN #132 along with PCPs #130 and #131 further confirmed the resident's cognition would not support them adhering to the identified falls prevention intervention.

A record review of seven different post fall assessments, indicated the root cause of the resident's fall included failing to adhere to the identified falls prevention intervention.

An interview with RPN #132 confirmed that knowing the resident's cognition and depending on the resident to adhere to the identified falls prevention intervention was not providing care according to their needs.

The licensee has failed to ensure that that the following rights of residents were fully respected and promoted: Cared for in a manner consistent with his or her needs. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #009 was protected from abuse by resident #008.

The home had notified the MLTC through a report, of an incident of resident to resident altercation resulting in an injury.

A review of resident #008’s health records indicated they had cognitive impairment.

A review of resident #008’s written plan of care indicated their responsive behaviours and the interventions in place to manage them.

A review of resident #008’s PCC progress notes for a period of five months, and separate interviews with PCPs #120, #121, #122, RPNs #124, #125, indicated most of resident #008’s altercations with co-residents occurred in an identified area. The staff indicated an intervention they implemented to ensure resident #008 and co-residents' safety.

An interview with PCP #123 indicated they were assigned to resident #009's care on the identified shift that the incident happened. The PCP remembered taking the resident to their room and provided care, and brought them to the identified area. The PCP placed resident #009 away from resident #008. PCP #123 took a co-resident from the identified area to their bedroom, and as they left, RPN #125 was about to enter the identified area but the RPN left something and went back to the medication room instead. At the time, residents #008 and #009 were the only ones in the identified area. After a few minutes, the PCP heard resident #009 was yelling, so they attended to the resident and saw resident #009 had an injury.

An interview with RPN #125 indicated at the time of the incident, they were outside the nursing station, and a PCP just came out of the identified area when they both heard resident #009 shouting. The RPN and the PCP both rushed inside the identified area and saw resident #009 sitting in their assistive device and resident #008 was standing beside them with resident #009's personal item in their hand. Resident #009's was noted with an injury.

An interview with the ADOC acknowledged that the incident between residents #008 and #009 fell under the category of abuse, as defined by the O. Reg. 79/10.

Non-compliance was found under Long-Term Care Homes Act (LTCHA), 2007 S.O. 2007 , c.8, s. 19. (1), within inspection report #2019_810654_0005 and a compliance order was issued to the home on October 16, 2019, with a compliance due date of January 20, 2020. Therefore, a written notification will be issued within this CIS inspection #2020_823653_0006. [s. 19. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used devices in the home in accordance with manufacturers' instructions.

The home submitted a CIR of resident #006's fall wherein they sustained injuries and was transferred to hospital for further assessment. Two days prior, resident #006 also had a fall in their bedroom, was transferred to the hospital, and had a significant change in condition.

A record review of an assessment identified resident #006 at risk for falls.

A review of the manufacturer's product instructions identified the correct positioning of resident #006's falls prevention device.

During an observation conducted by Inspector #110, the PCP showed the inspector the resident's falls prevention device. When asked if it was in the correct position, the PCP stated they thought it was to be placed in a different position, and repositioned the device.

RPN #132 was approached and stated they did not know the correct position of the device, turned it over and read the instructions on how it was to be applied. The RPN stated it was to be placed in an identified position.

As per Inspector #110's observation and staff interviews, the staff did not use resident #006's falls prevention device in accordance with the manufacturer's instructions. [s. 23.]

WN #5: 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 the staff used safe transferring and positioning techniques when assisting resident #002.

The home submitted a CIR to the Director for an incident that caused an injury to resident #002 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated an alteration in skin integrity was noted on resident #002, and the in-house diagnostic test that was done confirmed an injury. The resident was taken by the Substitute Decision-Maker (SDM) to the emergency room for assessment, and returned home the same day after receiving treatment.

A review of resident #002's written plan of care indicated they required an identified assistance for transfers.

Separate interviews with PCP #101, RPN #102, the PT, and the ADOC, acknowledged that based on resident #002's statement of how they sustained the injury during a transfer by a staff member from the bed to their assistive device, the staff member did not use safe transferring and position techniques when they assisted resident #002.

Non-compliance was found under O. Reg. 79/10, s. 36, within inspection report #2019_810654_0005 and a compliance order was issued to the home on October 16, 2019, with a compliance due date of February 24, 2020. Therefore, a written notification will be issued within this CIS inspection #2020_823653_0006. [s. 36.]

Issued on this 26th day of February, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROMELA VILLASPIR (653), DIANE BROWN (110)
Inspection No. / No de l'inspection :	2020_823653_0006
Log No. / No de registre :	017672-19, 017679-19, 023206-19, 000245-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 18, 2020
Licensee / Titulaire de permis :	Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	Chartwell Woodhaven Long Term Care Residence 380 Church Street, MARKHAM, ON, L6B-1E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Belisha Ke

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 compliant with s. 6 (7) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee shall do the following:

1. Review resident #006, #007, and #003's current falls prevention interventions as per their plan of care, with the Personal Care Providers (PCPs), Registered Practical Nurses (RPNs), and Registered Nurses (RNs), who are responsible for the resident's care. Maintain a record of the review, including the content, facilitator, attendees, dates, and times.

2. Develop and implement an auditing system to ensure all direct care staff provide care to residents #006, #007, and #003, as specified in their plan of care, as it relates to falls prevention interventions.

3. Ensure resident #001's current written plan of care including but not limited to the prescriber order forms and electronic Treatment Administration Record (eTAR) consistently reflect the prescribed treatments for their areas of altered skin integrity, and review them with the RPNs and RNs who are responsible for the resident's care. Maintain a record of the review, including the content, facilitator, attendees, dates, and times.

4. Develop and implement an auditing system to ensure all direct care staff provide care to resident #001 as specified in their plan of care, as it relates to their prescribed treatments for the areas of altered skin integrity.

The above mentioned documentation shall be made available to the inspector upon request. This order shall be complied no later than April 20, 2020.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the written plan of care was provided to residents #006, #007, #003, and #001 as specified in the plan.

The home submitted a Critical Incident Report (CIR) of resident #006's fall wherein they sustained injuries and was transferred to hospital for further assessment. Two days prior, resident #006 also had a fall in their bedroom, was

transferred to the hospital, and had a significant change in condition.

A record review of an assessment identified resident #006 at risk for falls.

The resident's written plan of care indicated their falls prevention interventions.

Three separate observations conducted by Inspector #110 revealed that the falls prevention intervention identified in resident #006's written plan of care was not implemented by the registered staff.

A record review identified that at the time of the incident, Personal Care Provider (PCP) #130 found resident #006 in their bedroom lying on the floor. An interview with PCP #130 shared that the resident was not feeling well and stayed in bed over a meal service. The PCP stated that when delivering a meal tray to another resident, they passed resident #006's room and found them on the floor. The PCP could not recall if the identified falls prevention intervention was in place.

An interview with Registered Practical Nurse (RPN) #135 stated they were in the dining room at the time of the resident's fall when PCP #130 alerted them that the resident was on the floor. The RPN shared that they could not recall if the identified falls prevention intervention was in place.

A review of the post fall assessments of falls occurring in the resident's bedroom on five different dates from the last quarter failed to identify that the falls prevention intervention was implemented as required by resident #006's written plan of care.

Further review of the post fall assessments and staff interviews confirmed that the resident's falls prevention intervention was not in place when the resident fell on three different occasions.

In separate interviews when discussing resident #006 and their fall history, Falls Lead Registered Nurse (RN) #112 and the Director of Care (DOC) shared they had done everything for resident #006 in regards to falls prevention. (110)

2. As a result of identifying non-compliance for care not provided to resident #006 as set out in the written plan of care as it related to falls interventions, the

sample size was expanded which included resident #007.

A review of the assessment provided to Inspector #110 identified resident #007 was at risk for falls.

The resident's written plan of care indicated their falls prevention interventions.

An observation was made by Inspector #110, which revealed that resident #007's falls prevention interventions were not implemented. Inspector #110's observations were confirmed with PCP #120 and the Physiotherapist (PT).

An interview with the PT confirmed that the care set out in the written plan of care was not provided to resident #007 as specified in the plan. (110)

3. The home submitted a CIR to the Director for an incident that caused an injury to resident #003 for which they were taken to hospital, and which resulted in a significant change in the resident's health status. The CIR indicated resident #003 had an unwitnessed fall and was found on their bedroom floor. The resident was sent to hospital for further assessment and was diagnosed with an injury.

A review of resident #003's written plan of care indicated they were at risk for falls and staff were to ensure that an identified falls prevention intervention was in place when the resident was on their assistive device.

A review of the PT's progress note and an interview with them indicated at the time of resident #003's fall, they used an identified assistive device that had the falls prevention intervention.

An interview with PCP #113 indicated they were assigned to resident #003's care on the identified shift when the incident happened. The PCP stated they were giving a shower to a co-resident and heard a loud noise, so they went to resident #003's bedroom to check on them. As they opened the door, they saw resident #003 was on the floor. When asked by the inspector if the falls prevention intervention was in place at the time of the incident, the PCP acknowledged it was not.

An interview with the Assistant Director of Care (ADOC) indicated the home's expectation was for staff to check the identified falls prevention intervention at the start of the shift to ensure they are working. The ADOC further indicated this had been explained to the staff with the new education on falls prevention. (653)

4. The Ministry of Long-Term Care (MLTC) received a complaint related to resident #001's skin and wound care. An interview with the complainant indicated the resident was admitted to the home with an alteration in skin integrity that had gotten worse over time due to lack of care in the home.

A review of resident #001's health records indicated they were admitted in the hospital for 13 days.

A review of progress notes and the prescriber order form indicated on the day resident #001 returned to the home, RN #112 confirmed the treatment orders for their alteration in skin integrity with the physician.

Two separate observations by Inspector #653, of the treatment provision by two different registered staff revealed treatment was not provided as specified in the written plan of care.

An interview with RPN #110 indicated the expectation was for the registered staff to do the treatment according to the physician's order.

An interview with the ADOC acknowledged the above mentioned information and indicated the expectation was for staff to follow the order as specified. Further review of the prescriber order form and an interview with the ADOC indicated they had obtained clarification for the orders following Inspector #653's observation of the treatment carried out by RPN #110.

The licensee has failed to ensure that the care set out in the written plan of care was provided to residents #006, #007, #003, and #001 as specified in the plan.

The severity of this issue was determined to be:
-a level 3 as there was actual harm to residents #006 and #003;
-a level 2 as there was actual risk to residents #007 and #001.

The scope was a level 2 as it related to four of six residents reviewed. The home had a level 4 compliance history as they had on-going non-compliance with s. 6 (7) of the LTCHA that included:
-Voluntary Plan of Correction issued June 27, 2017 (#2017_632502_0007);
-Compliance Order issued January 17, 2018 (#2017_530673_0015);
-Voluntary Plan of Correction issued October 1, 2018 (#2018_718604_0009);
-Compliance Order issued November 30, 2018 (#2018_486653_0028);
-Voluntary Plan of Correction issued October 16, 2019 (#2019_810654_0005).
(653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 20, 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:

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 18th day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

Service Area Office /
Bureau régional de services : Central East Service Area Office