Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**
**Division de la responsabilisation et de la performance du système de santé**
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| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Sep 5, 6, 7, 11, 13, 18, 19, 20, 21, 24, 25, 26, 2012 | 2012_044161_0036 | Critical Incident |

**Licensee/Titulaire de permis**

VALLEY STREAM MANOR INC.
1433 York Mills Drive, Orleans, ON, K4A-2N9

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

VALLEY STREAM MANOR
2 Valley Stream Drive, OTTAWA, ON, K2H-0A5

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

KATHLEEN SMID (161)

## Inspection Summary/Résumé de l'inspection

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

**During the course of the inspection, the inspector(s) spoke with the co-owner Marketing and Public Relations for Retirement Living Ottawa, General Manager/Administrator, Director of Care, Assistant Director of Care, Admissions Co-ordinator, Registered Nurse, Registered Practical Nurses, Health Care Aides, Physiotherapist and an Occupational Therapist.**

**During the course of the inspection, the inspector(s) reviewed Resident # 001's health record, a Critical Incident Report sent to the Ministry of Health and Long Term Care, polices and procedures related to fall prevention, head injury routines, and the prevention of abuse and neglect of Residents.**

**The following Inspection Protocols were used during this inspection:**

**Falls Prevention**

**Prevention of Abuse, Neglect and Retaliation**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 19. Duty to protect**

**Specifically failed to comply with the following subsections:**

**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 :**

The licensee failed to comply with LTCHA 2007 S.O. 2007, c.8, s. 19(1) in that the home did not protect a resident from neglect by a staff member(s).

Ontario Regulation 79/10, made under the Long Term Care Homes Act 2007, defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The following occurrence demonstrates a pattern of inaction that jeopardized the health, safety and well-being of Resident # 001 who died unexpectedly in August 2012 as a result of a head injury sustained on a date in July 2012 at the home.

Resident # 001's progress notes indicate that during the 16 days she/he resided at Valley Stream Manor, she/he experienced 5 falls. A review of Resident # 001's health record indicated that she/he was not reassessed for falls risk nor was her/his plan of care reviewed and revised.

The home's Fall Prevention and Management Policy # VII-G-60.00 Post Falls Assessment indicates that when a resident has fallen and if a head injury is suspected, Registered Nursing staff will initiate a head injury monitoring routine for 48 hours post fall for signs of neurological changes.

The home's Head Injury Policy # VII-G-10.22 indicates that for any resident who has sustained a head injury following a fall, the resident will have a head injury assessment routine initiated for 48 hours. The Registered Nursing staff will document their assessments and all interventions taken on the progress notes and the vital sign recordings on VII-G-10.22 (a) Head Injury Routine Monitoring Record every 30 minutes for two hours, every hour for six hours, every 4 hours for 8 hours and every 8 hours for 56 hours.

Resident # 001 was admitted to hospital in July 2012 and transferred to Valley Stream Manor eight days later. According to the Hospital Discharge Summary of July 2012, Resident # 001 experienced multiple falls during the previous six months with a rapid progression of postural instability. On the date of her/his admission to Valley Stream Manor, Resident # 001 underwent a Falls Risk Assessment whereby multiple risk factors for falls were identified.

On a date in July 2012 Resident # 001 was found in her/his room lying on her/his back with a laceration to her/his head. She/He was not wearing footwear nor was a wheelchair or walker close to her/him. An ambulance was called and Resident # 001 was transferred to hospital. Three and one-half hours later, Resident # 001 was transferred from the hospital back to the home.

Upon Resident # 001's return to the home Registered Nurse #S108 initiated the home's Head Injury Policy # VII-G-10.22 at 01:00 hours which was 25 minutes after Resident # 001 returned to the home.

A review of Resident # 001's Head Injury Routine Record of August 2012 indicated that Registered Nurse #S108 assessed the resident using the Head Injury assessment monitoring tool at 01:00 hours and 06:00 hours. Registered Nurse #S108 did not assess Resident # 001 at 01:30, 02:00, 02:30, 03:30, 04:30, 05:30, 06:30, nor was she/he assessed at 07:30 by the Registered Nurse #S109 on the day shift in August 2012. The home's Head Injury Policy # VII-G-10.22 frequency of assessments was not followed.

On the same day shift in August 2012 at 08:05, a Health Care Aide reported to Registered Nurse #S109 that Resident # 001 did not respond to the Health Care Aide attempts to wake her/him up and get her/him ready for breakfast. Registered Nurse #S109 immediately assessed Resident # 001 and found her/him unresponsive to verbal or tactile stimuli. An ambulance was immediately called and Resident # 001 was transferred to hospital where a CAT Scan of Resident # 001's head showed an subdural haemorrhage with herniation. She/He passed away several hours later in the emergency room.

On September 5, 2012 the Director of Care indicated to the inspector that on the night that Resident # 001 had fallen and returned from the hospital, Registered Nurse #S108 "only did 2 sets of head injury assessments." In the morning the resident was found unresponsive, sent to hospital where she/he died as a result of a head injury sustained due to the fall

the day before.

*Additional Required Actions:*

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

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**WN #2: 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 subsections:**

**s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident;**
**(b) the goals the care is intended to achieve; and**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care.**
**2. The outcomes of the care set out in the plan of care.**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**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;**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

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**Findings/Faits saillants :**

The licensee failed to comply with LTCHA 2007 c. 8, s. 6 (10) (c) in that the licensee did not ensure that a resident was reassessed and the plan of care reviewed and revised at any time when care set out in the plan has not been effective.

Resident # 001 was admitted to hospital in July 2012 and transferred to Valley Stream Manor eight days later. According to the Hospital Discharge Summary of July 2012, Resident # 001 experienced multiple falls during the previous six months with a rapid progression of postural instability. On the date of her/his admission to Valley Stream Manor, Resident # 001 underwent a Falls Risk Assessment whereby multiple risk factors for falls were identified. The staff interventions in Resident # 001's care plan were to reinforce the resident's need to call for assistance, call bell in reach when in bed, encourage resident to use handrails or assistive devices properly and to put up one bed rail when resident in bed.

Resident # 001's progress notes indicate that during the 16 days she/he resided at Valley Stream Manor, she/he experienced 5 falls the details of which are as follows:

On a date in July 2012 two staff members heard Resident # 001 moan and a thump noise. She/He was found lying on her/his right side on the floor by the foot of her/his bed. A review of Resident # 001's health record indicated that she/he was not reassessed for falls risk nor her/his plan of care reviewed and revised.

Seven days later following the first fall in July 2012 Resident # 001 was found on floor of her/his room in the doorway. . A review of Resident # 001's health record indicated that she/he was not reassessed for falls risk nor her/his plan of care reviewed and revised.

The day following fall #2, fall #3 occurred. Resident # 001 was observed by staff member # S106 unsteady on her/his feet. As she/he was falling, Resident # 001 landed partially on her/his bed with staff member # S106 catching her/him and lowering her/him to the floor so that she/he would not hit her/his head. A review of Resident # 001's health record indicated that she/he was not reassessed for falls risk nor her/his plan of care reviewed and revised.

The day following fall #3, fall #4 occurred. Resident # 001 stood up with her/his walker and lost her/his balance. A health care aide was at her/his side and was able to stop her/his fall. A review of Resident # 001's health record indicated that she/he was not reassessed for falls risk nor her/his plan of care reviewed and revised.

The day following fall #4, fall #5 occurred. Resident # 001 was found in her/his room lying on her/his back with a laceration to her/his head. A review of Resident # 001's health record indicated that she/he was not reassessed for falls risk nor her/his plan of care reviewed and revised.

Resident # 001's Head Injury Routine Record on a date in August 2012 was reviewed. It is documented by Registered Nurse # S108, that she conducted Head Injury assessments on Resident # 001 at 01:00 and 06:00 hours.

Resident # 001's Progress notes on the same date in August 2012 at 05:51 states "resident slept quietly through the night, neuro status remains unchanged and vitals remain stable." There is no documentation to indicate that Resident # 001's neurological status and vital signs were reassessed after 01:00 and before 06:00 hours during the night of the same date in August 2012.

Discussion on September 5, 2012 with the Director of Care who confirmed that Resident # 001 was not reassessed for falls risk and the plan of care was not reviewed and revised.

Discussion on September 5, 2012 with the Director of Care who confirmed that on the night of the date in August 2012 Resident # 001 returned from hospital whereby Registered Nurse #S108 "only did 2 sets of head injury assessments." In the morning the resident was found unresponsive, sent to hospital where she/he died as a result of her/his head injury sustained due to her/his last fall on a date in July 2012.

The licensee failed to comply with LTCHA 2007 S.O. 2007, c.8, s. 6(9)(1) in that the provision of care set out in the plan of care was not documented.

On the date of admission to the home in July 2012 a Falls Risk Assessment was completed by staff member # S107 on Resident # 001. Question 10 of the Fall Risk Assessment states as follows "Drop in systolic blood pressure of 20 mmHG or more between lying and standing" and provides for a yes or no response. The No response was checked off. Resident # 001's lying and standing blood pressures are not documented on the Falls Risk Assessment form nor elsewhere in Resident # 001's health record.

On a date in September 2012 the inspector asked the Director of Care for the documentation of Resident # 001's lying and standing blood pressures that were allegedly done by staff member # S107 during the Falls Assessment on the date of admission in July 2012. The Director of Care provided the inspector with a document titled Weights and Vitals which does not identify the resident's name, date nor time. The Director of Care and staff member # S107 stated that this document reflects that on the day of admission in July 2012, Resident # 001's sitting blood pressure was recorded as 89/50. The lying and standing blood pressures are not recorded.

On September 5, 2012 staff member # S107 and the inspector reviewed Resident # 001's "Admission Summary – CC." On the bottom of page one of this document, Resident # 001"s vital signs are handwritten indicating a blood pressure of 89/50. This handwritten entry does not indicate the date or time that the vital signs were taken nor the position of Resident # 001 when her/his blood pressure was taken.

The licensee failed to comply with O. Reg 79/10 s. 6 (1) (c) in that a resident's plan of care did not set out clear directions to staff and others who provide direct care to the resident.

Resident # 001 was admitted to hospital in July 2012 and transferred to Valley Stream Manor eight days later. According to the Hospital Discharge Summary of July 2012, Resident # 001 experienced multiple falls during the previous six months with a rapid progression of postural instability. On the date of her/his admission to Valley Stream Manor, Resident # 001 underwent a Falls Risk Assessment whereby multiple risk factors for falls were identified. The staff interventions in Resident # 001's care plan were to reinforce the resident's need to call for assistance, call bell in reach when in bed, encourage resident to use handrails or assistive devices properly and to put up one bed rail when resident in bed.

On the date of admission to the home in July 2012 Physiotherapy assessment indicates Resident # 001 has very poor balance, poor endurance and postural hypotension hence staff must allow time for resident to change position. The Physiotherapy assessment also indicates that resident ambulates with 4 wheeled walker and requires stand by assistance. Resident # 001's plan of care does not reflect the physiotherapy fall risk interventions.

***Additional Required Actions:***

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

***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 (1) the provision of care set out in the plan of care is documented and (2) that a resident's plan of care sets out clear directions to staff and others who provide direct care to the resident., to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

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Findings/Faits saillants :

The licensee failed to comply with O. Reg 79/10 s. 26 (3) (10) in that a resident's plan of care is not based on an interdisciplinary assessment with respect to the resident's risk of falls.

Resident # 001 was admitted to hospital in July 2012 and transferred to Valley Stream Manor eight days later. According to the Hospital Discharge Summary of July 2012, Resident # 001 experienced multiple falls during the previous six months with a rapid progression of postural instability. On the date of her/his admission to Valley Stream Manor, Resident # 001 underwent a Falls Risk Assessment whereby multiple risk factors for falls were identified. The staff interventions in Resident # 001's care plan were to reinforce the resident's need to call for assistance, call bell in reach when in bed, encourage resident to use handrails or assistive devices properly and to put up one bed rail when resident in bed.

On a date in July 2012 an Admission Summary was completed by home's Admission Coordinator indicates that Resident # 001 will sometimes attempt to get up on her/his own and to provide a bed alarm if possible for the resident. This information is not contained in resident's plan of care nor was the resident provided a bed alarm.

On a date in July 2012 Progress notes indicate that the resident has a history of falls ++ and would benefit from a bed alarm as son states that the resident often will try to get up on her/his own. This information is not contained in resident's plan of care.

On September 5, 2012 the Director of Care indicated to the inspector that the home has bed alarms and personal alarms available to residents when required. The Director of Care acknowledged to the inspector that a mistake had been made in not providing a bed/ personal alarm for Resident # 001.

On a date in July 2012 Physiotherapy assessment indicates Resident # 001 has very poor balance and postural hypotension hence staff must allow time for resident to change position. The Physiotherapy assessment also indicates that resident ambulates with 4 wheeled walker and requires stand by assistance. This information is not contained in resident's plan of care.

On a date in July 2012 Occupational Therapist assessment indicates that Resident # 001 experiences dizziness, blurred vision when going from lie to sit or sit to stand and that she is concerned regarding Resident # 001's impulsiveness and falls risk. She indicates that Resident # 001's family member stated to her that the resident thinks she/he can get up on her/his own, but is "gradually learning" that she/he needs to ring the call bell. This information is not contained in Resident # 001's plan of care.

***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 that all residents plan of care are based on an interdisciplinary assessment with respect to the resident's risk of falls, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff**

**Specifically failed to comply with the following subsections:**

**s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:**
**1. Falls prevention and management.**
**2. Skin and wound care.**
**3. Continence care and bowel management.**
**4. Pain management, including pain recognition of specific and non-specific signs of pain.**
**5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.**
**6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).**

**Findings/Faits saillants :**

The licensee failed to comply with O. Reg 79/10 s. 221 (1) (1) in that the licensee did not ensure that direct care staff are provided training in falls prevention and management.

On September 13, 2012 the Director of Care indicated that the home's Fall Prevention and Management Policy # VII-G-60.00 is part of the home's interdisciplinary Falls Prevention and Management Program.

On September 13, 2012 four direct care staff members #S102, #S103, #S104, #S105 indicated to the inspector that they have not been provided training in the home's Fall Prevention and Management Policy # VII-G-60.00.

On September 13, 2012 the Director of Care indicated to the inspector that direct care staff has not been provided training in the home's Falls Prevention and Management Policy # V11-G-60.00 as the policy has not been implemented in the home.

***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 all direct care staff are provided training in falls prevention and management which includes the home's Fall Prevention and Management Policy # VII-G-60.00, to be implemented voluntarily.***

**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following subsections:**

**s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,**
**(a) shall provide that abuse and neglect are not to be tolerated;**
**(b) shall clearly set out what constitutes abuse and neglect;**
**(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;**
**(d) shall contain an explanation of the duty under section 24 to make mandatory reports;**
**(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;**
**(f) shall set out the consequences for those who abuse or neglect residents;**
**(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and**
**(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).**

**Findings/Faits saillants :**

The licensee has failed to comply with LTCHA 2007 c. 8, s. 20(2) (b) in that the home's written policy to promote zero tolerance of abuse and neglect of residents does not clearly set out what constitutes abuse and neglect.

On September 18, 2012 the General Manager/Administrator of the home provided the inspector with a copy of the home's written policy # V11-G-10.00 "Abuse and Neglect of a Resident – Actual or Suspected."

A review of the home's written policy # V11-G-10.00 "Abuse and Neglect of a Resident – Actual or Suspected" does not clearly set out what constitutes physical, emotional, verbal, sexual abuse and neglect.

***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 that the home's written policy to promote zero tolerance of abuse and neglect of residents clearly set out what constitutes abuse and neglect, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance**
**Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,**
**(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;**
**(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;**
**(c) identifies measures and strategies to prevent abuse and neglect;**
**(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and**
**(e) identifies the training and retraining requirements for all staff, including,**
**(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and**
**(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.**

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**Findings/Faits saillants :**

The licensee has failed to comply with O. Reg 79/10 s. 96 ( e ) in that the home's written policy to promote zero tolerance of abuse and neglect of residents does not identify the training and retraining requirements for all staff including:

i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations.

On September 18, 2012 the General Manager/Administrator of the home provided the inspector with a copy of the home's written policy # V11-G-10.00 "Abuse and Neglect of a Resident – Actual or Suspected."

A review of the home's written policy # V11-G-10.00 "Abuse and Neglect of a Resident – Actual or Suspected" does not identify the training and retraining requirements for all staff including:

i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations.
2. The licensee has failed to comply with O. Reg 79/10 s. 96 (c) in that the home's written policy to promote zero tolerance of abuse and neglect of residents does not identify measures and strategies to prevent abuse and neglect.

On September 18, 2012 the General Manager/Administrator of the home provided the inspector with a copy of the home's written policy # V11-G-10.00 "Abuse and Neglect of a Resident – Actual or Suspected."

A review of the home's written policy # V11-G-10.00 "Abuse and Neglect of a Resident – Actual of Suspected" does not identify measures and strategies to prevent abuse and neglect.

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs**

**Specifically failed to comply with the following subsections:**

**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).**

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**Findings/Faits saillants :**

The licensee failed to comply with O. Reg 79/10 s. 48 (1) in that the licensee did not ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury is implemented in the home.

On September 13, 2012 the Director of Care indicated that the home's Fall Prevention and Management Policy # VII-G-60.00 is part of the home's interdisciplinary Falls Prevention and Management Program.

On September 13, 2012 the Director of Care indicated that the home's Fall Prevention and Management Policy # VII-G-60.00 has not been implemented in the home.

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

**Specifically failed to comply with the following subsections:**

**s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).**

**Findings/Faits saillants :**

The licensee failed to comply with O. Reg 79/10 s. 49 (2) in that when an identified resident fell, a post-fall assessment was not conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

On a date in July 2012 two staff members heard Resident # 001 moan and a thump noise. She/He was found lying on her/his right side on the floor by the foot of her/his bed. A post-fall assessment of Resident # 001 was not conducted.

Seven days later following the first fall in July 2012 Resident # 001 was found on floor of her/his room in the doorway. A post-fall assessment of Resident # 001 was not conducted.

The day following fall #2, fall #3 occurred. Resident # 001 was observed by staff member # S106 unsteady on her/his feet. As she/he was falling, Resident # 001 landed partially on her/his bed with staff member # S106 catching her/him and lowering her/him to the floor so that she/he would not hit her/his head. A post-fall assessment of Resident # 001 was not conducted.

The day following fall #3, fall #4 occurred. Resident # 001 stood up with her/his walker and lost her/his balance. A health care aide was at her/his side and was able to stop her/his fall. A post-fall assessment of Resident # 001 was not conducted.

The day following fall #4, fall #5 occurred. Resident # 001 was found in her/his room lying on her/his back with a laceration to her/his head. A post-fall assessment of Resident # 001 was not conducted.

Discussion on September 5, 2012 with the Director of Care who confirmed that post fall assessments of Resident # 001 were not done.

**Issued on this 28th day of September, 2012**

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

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

**Public Copy/Copie du public**

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | KATHLEEN SMID (161) |
| **Inspection No. / No de l'inspection :** | 2012_044161_0036 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident |
| **Date of Inspection / Date de l'inspection :** | Sep 5, 6, 7, 11, 13, 18, 19, 20, 21, 24, 25, 26, 2012 |
| **Licensee / Titulaire de permis :** | VALLEY STREAM MANOR INC.<br>1433 York Mills Drive, Orleans, ON, K4A-2N9 |
| **LTC Home / Foyer de SLD :** | VALLEY STREAM MANOR<br>2 Valley Stream Drive, OTTAWA, ON, K2H-0A5 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | FRANCES DE BEAUMONT |

To VALLEY STREAM MANOR INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

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**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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).

**Order / Ordre :**

The licensee will prepare, submit and implement a plan to ensure that action is taken to protect resident from neglect by the staff as well as a plan including staff training to ensure the home's Head Injury policies and procedures are followed.

This plan must be submitted in writing to inspector Kathleen Smid at 347 Preston Street, 4th Floor, Ottawa, ON K1S 3J4 or by fax at 613-569-9670 on or before October 8, 2012

**Grounds / Motifs :**

1. The licensee failed to comply with LTCHA 2007 S.O. 2007, c.8, s. 19(1) in that the home did not protect a resident from neglect by a staff member(s).

Ontario Regulation 79/10, made under the Long Term Care Homes Act 2007, defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The following occurrence demonstrates a pattern of inaction that jeopardized the health, safety and well-being of Resident # 001 who died unexpectedly in August 2012 as a result of a head injury sustained on a date in July 2012 at the home.

Resident # 001's progress notes indicate that during the 16 days she/he resided at Valley Stream Manor, she/he experienced 5 falls. A review of Resident # 001's health record indicated that she/he was not reassessed for falls risk nor was her/his plan of care reviewed and revised.

The home's Fall Prevention and Management Policy # VII-G-60.00 Post Falls Assessment indicates that when a resident has fallen and if a head injury is suspected, Registered Nursing staff will initiate a head injury monitoring routine for 48 hours post fall for signs of neurological changes.

The home's Head Injury Policy # VII-G-10.22 indicates that for any resident who has sustained a head injury following a fall, the resident will have a head injury assessment routine initiated for 48 hours. The Registered Nursing staff will document their assessments and all interventions taken on the progress notes and the vital sign recordings on VII-G-10.22 (a) Head Injury Routine Monitoring Record every 30 minutes for two hours, every hour for six hours, every 4 hours for 8 hours and every 8 hours for 56 hours.

Resident # 001 was admitted to hospital in July 2012 and transferred to Valley Stream Manor eight days later. According to the Hospital Discharge Summary of July 2012, Resident # 001 experienced multiple falls during the previous six months with a rapid progression of postural instability. On the date of her/his admission to Valley Stream Manor, Resident # 001 underwent a Falls Risk Assessment whereby multiple risk factors for falls were identified.

On a date in July 2012 Resident # 001 was found in her/his room lying on her/his back with a laceration to her/his head. She/He was not wearing footwear nor was a wheelchair or walker close to her/him. An ambulance was called and Resident # 001 was transferred to hospital. Three and one-half hours later, Resident # 001 was transferred from the hospital back to the home.

Upon Resident # 001's return to the home Registered Nurse #S108 initiated the home's Head Injury Policy # VII-G-10.22 at 01:00 hours which was 25 minutes after Resident # 001 returned to the home.

A review of Resident # 001's Head Injury Routine Record of August 2012 indicated that Registered Nurse #S108 assessed the resident using the Head Injury assessment monitoring tool at 01:00 hours and 06:00 hours. Registered Nurse #S108 did not assess Resident # 001 at 01:30, 02:00, 02:30, 03:30, 04:30, 05:30, 06:30, nor was she/he assessed at 07:30 by the Registered Nurse #S109 on the day shift in August 2012. The home's Head Injury Policy # VII-G-10.22 frequency of assessments was not followed.

On the same day shift in August 2012 at 08:05, a Health Care Aide reported to Registered Nurse #S109 that Resident # 001 did not respond to the Health Care Aide attempts to wake her/him up and get her/him ready for breakfast. Registered Nurse #S109 immediately assessed Resident # 001 and found her/him unresponsive to verbal or tactile stimuli. An ambulance was immediately called and Resident # 001 was transferred to hospital where a CAT Scan of Resident # 001's head showed an subdural haemorrhage with herniation. She/He passed away several hours later in the emergency room.

On September 5, 2012 the Director of Care indicated to the inspector that on the night that Resident # 001 had fallen and returned from the hospital, Registered Nurse #S108 "only did 2 sets of head injury assessments." In the morning the resident was found unresponsive, sent to hospital where she/he died as a result of a head injury sustained due to the fall the day before (161)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 05, 2012

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**Order # /**
**Ordre no :** 002

**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. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

**Order / Ordre :**

The licensee shall ensure that residents are reassessed and the plan of care reviewed and revised at any time when care set out in the plan has not been effective.

**Grounds / Motifs :**

1. The licensee failed to comply with LTCHA 2007 c. 8, s. 6 (10) (c) in that the licensee did not ensure that a resident was reassessed and the plan of care reviewed and revised at any time when care set out in the plan has not been effective.

Resident # 001 was admitted to hospital in July 2012 and transferred to Valley Stream Manor eight days later. According to the Hospital Discharge Summary of July 2012, Resident # 001 experienced multiple falls during the previous six months with a rapid progression of postural instability. On the date of her/his admission to Valley Stream Manor, Resident # 001 underwent a Falls Risk Assessment whereby multiple risk factors for falls were identified. The staff interventions in Resident # 001's care plan were to reinforce the resident's need to call for assistance, call bell in reach when in bed, encourage resident to use handrails or assistive devices properly and to put up one bed rail when resident in bed.

Resident # 001's progress notes indicate that during the 16 days she/he resided at Valley Stream Manor, she/he experienced 5 falls the details of which are as follows:

On a date in July 2012 two staff members heard Resident # 001 moan and a thump noise. She/He was found lying on her/his right side on the floor by the foot of her/his bed. A review of Resident # 001's health record indicated that she/he was not reassessed for falls risk nor her/his plan of care reviewed and revised.

Seven days later following the first fall in July 2012 Resident # 001 was found on floor of her/his room in the doorway. . A review of Resident # 001's health record indicated that she/he was not reassessed for falls risk nor her/his plan of care reviewed and revised.

The day following fall #2, fall #3 occurred. Resident # 001 was observed by staff member # S106 unsteady on her/his feet. As she/he was falling, Resident # 001 landed partially on her/his bed with staff member # S106 catching her/him and lowering her/him to the floor so that she/he would not hit her/his head. A review of Resident # 001's health record indicated that she/he was not reassessed for falls risk nor her/his plan of care reviewed and revised.

The day following fall #3, fall #4 occurred. Resident # 001 stood up with her/his walker and lost her/his balance. A health care aide was at her/his side and was able to stop her/his fall. A review of Resident # 001's health record indicated that she/he was not reassessed for falls risk nor her/his plan of care reviewed and revised.

The day following fall #4, fall #5 occurred. Resident # 001 was found in her/his room lying on her/his back with a laceration to her/his head. A review of Resident # 001's health record indicated that she/he was not reassessed for falls risk nor her/his plan of care reviewed and revised.

Resident # 001's Head Injury Routine Record on a date in August 2012 was reviewed. It is documented by Registered Nurse # S108, that she conducted Head Injury assessments on Resident # 001 at 01:00 and 06:00 hours.

Resident # 001's Progress notes on the same date in August 2012 at 05:51 states "resident slept quietly through the night, neuro status remains unchanged and vitals remain stable." There is no documentation to indicate that Resident # 001's neurological status and vital signs were reassessed after 01:00 and before 06:00 hours during the night of the same date in August 2012.

Discussion on September 5, 2012 with the Director of Care who confirmed that Resident # 001 was not reassessed for falls risk and the plan of care was not reviewed and revised.

Discussion on September 5, 2012 with the Director of Care who confirmed that on the night of the date in August 2012 Resident # 001 returned from hospital whereby Registered Nurse #S108 "only did 2 sets of head injury assessments." In the morning the resident was found unresponsive, sent to hospital where she/he died as a result of her/his head injury sustained due to her/his last fall on a date in July 2012. (161)

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 05, 2012

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

**Issued on this 26th day of September, 2012**

**Signature of Inspector / Signature de l'inspecteur :** Kathleen Smid

**Name of Inspector / Nom de l'inspecteur :** KATHLEEN SMID

**Service Area Office / Bureau régional de services :** Ottawa Service Area Office

Ontario

**Ministry of Health and Long-Term Care**
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

**Ministère de la Santé et des Soins de longue durée**
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

# Amended Order of the Inspector

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

| | Licensee Copy/Copie du Titulaire | X Public Copy/Copie Public | |
|---|---|---|---|
| **Name of Inspector:** | Kathleen Smid | **Inspector ID #** | 161 |
| **Log #:** | O-001807-12 | | |
| **Inspection Report #:** | 2012-044161-36 | | |
| **Type of Inspection:** | Critical Incident | | |
| **Date of Inspection:** | September 5, 6, 7, 11, 13, 18, 19, 20, 21, 24, 25, 26, 2012 | | |
| **Licensee:** | VALLEY STREAM MANOR INC.<br>1433 York Mills Drive, Orleans, ON, K4A-2N9 | | |
| **LTC Home:** | VALLEY STREAM MANOR<br>2 Valley Stream Drive, OTTAWA, ON, K2H-0A5 | | |
| **Name of Administrator:** | Frances de Beaumont | | |

To Valley Stream Manor Inc, you are hereby required to comply with the following order(s) by the AMENDED date(s) set out below:

| **Order #:** | 001 | **Order Type:** | Compliance Orders, s. 153. (1) (b) |
|---|---|---|---|

**Pursuant to:**
LTCHA, 2007 S.O. 2007, c. 8, 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.

**Order:** The licensee will prepare, submit and implement a plan to ensure that action is taken to protect resident from neglect by the staff as well as a plan including staff training to ensure the home's Head Injury policies and procedures are followed.

This plan must be submitted in writing to inspector Kathleen Smid at 347 Preston Street, 4th Floor, Ottawa, ON K1S 3J4 or by fax at 613-569-9670 on or before October 8, 2012

**Grounds:**
The licensee failed to comply with LTCHA 2007 S.O. 2007, c.8, s. 19(1) in that the home did not protect a resident from neglect by a staff member(s).

Ontario Regulation 79/10, made under the Long Term Care Homes Act 2007, defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The following occurrence demonstrates a pattern of inaction that jeopardized the health, safety and well-being of Resident # 001 who died unexpectedly in August 2012 as a result of a head injury sustained on a date in July 2012 at the home.

Resident # 001's progress notes indicate that during the 16 days she/he resided at Valley Stream Manor, she/he experienced 5 falls. A review of Resident # 001's health record indicated that she/he was not reassessed for falls risk nor was her/his plan of care reviewed and revised.

The home's Fall Prevention and Management Policy # VII-G-60.00 Post Falls Assessment indicates that when a resident has fallen and if a head injury is suspected, Registered Nursing staff will initiate a head injury monitoring routine for 48 hours post fall for signs of neurological changes.

The home's Head Injury Policy # VII-G-10.22 indicates that for any resident who has sustained a head injury following a fall, the resident will have a head injury assessment routine initiated for 48 hours. The Registered Nursing staff will document their assessments and all interventions taken on the progress notes and the vital sign recordings on VII-G-10.22 (a) Head Injury Routine Monitoring Record every 30 minutes for two hours, every hour for six hours, every 4 hours for 8 hours and every 8 hours for 56 hours.

Resident # 001 was admitted to hospital in July 2012 and transferred to Valley Stream Manor eight days later. According to the Hospital Discharge Summary of July 2012, Resident # 001 experienced multiple falls during the previous six months with a rapid progression of postural instability. On the date of her/his admission to Valley Stream Manor, Resident # 001 underwent a Falls Risk Assessment whereby multiple risk factors for falls were identified.

On a date in July 2012 Resident # 001 was found in her/his room lying on her/his back with a laceration to her/his head. She/He was not wearing footwear nor was a wheelchair or walker close to her/him. An ambulance was called and Resident # 001 was transferred to hospital. Three and one-half hours later, Resident # 001 was transferred from the hospital back to the home.

Upon Resident # 001's return to the home Registered Nurse #S108 initiated the home's Head Injury Policy # VII-G-10.22 at 01:00 hours which was 25 minutes after Resident # 001 returned to the home.

A review of Resident # 001's Head Injury Routine Record of August 2012 indicated that Registered Nurse #S108 assessed the resident using the Head Injury assessment monitoring tool at 01:00 hours and 06:00 hours. Registered Nurse #S108 did not assess Resident # 001 at 01:30, 02:00, 02:30, 03:30, 04:30, 05:30, 06:30, nor was she/he assessed at 07:30 by the Registered Nurse #S109 on the day shift in August 2012. The home's Head Injury Policy # VII-G-10.22 frequency of assessments was not followed.

On the same day shift in August 2012 at 08:05, a Health Care Aide reported to Registered Nurse #S109 that Resident # 001 did not respond to the Health Care Aide attempts to wake her/him up and get her/him ready for breakfast. Registered Nurse #S109 immediately assessed Resident # 001 and found her/him unresponsive to verbal or tactile stimuli. An ambulance was immediately called and Resident # 001 was

transferred to hospital where a CAT Scan of Resident # 001's head showed a subdural haemorrhage with herniation. She/He passed away several hours later in the emergency room.

On September 5, 2012 the Director of Care indicated to the inspector that on the night that Resident # 001 had fallen and returned from the hospital, Registered Nurse #S108 "only did 2 sets of head injury assessments." In the morning the resident was found unresponsive, sent to hospital where she/he died as a result of a head injury sustained due to the fall the day before.

| **This order must be complied with by:** | **November 24, 2012** |
|---|---|

## 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 service for the Licensee.

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

**Director**
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

**Health Services Appeal and Review Board and the**
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

**Director**
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

| | |
|---|---|
| Issued on this 28th day of September 2012 | |
| Signature of Inspector: | Kathleen Smid |
| Name of Inspector: | Kathleen Smid |
| Service Area Office: | Ottawa Service Area Office |