Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 9, 2019	2019_633577_0033	019915-19, 019969-19, 021554-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 2) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Birchwood Terrace
237 Lakeview Drive, R.R. #1 KENORA ON P9N 4J7

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

DEBBIE WARPULA (577), MELISSA HAMILTON (693)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 25-28, 2019.

The following Critical Incident System (CIS) intakes were inspected during this CIS Inspection:
- One intake related to a fall with injury;
- Two intakes related to resident to resident abuse.

Additionally, Complaint Inspection #2019_633577_0032 was conducted concurrently with this CIS Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), Registered Nurse (RN), Extendicare Regional Director, Nurse Practitioner (NP), Registered Practical Nurses (RPNs), Resident Assessment Instrument (RAI) Coordinator, Personal Support Workers (PSWs), Physiotherapist (PT), Physiotherapist Assistant (PTA), Behavioural Supports Ontario (BSO) Outreach Personal Support Worker and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health care records, and reviewed licensee policy procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Responsive Behaviours
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,
(a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration; O. Reg. 79/10, s. 212 (4).
(b) has at least three years working experience,
(i) in a managerial or supervisory capacity in the health or social services sector, or
(ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d); O. Reg. 79/10, s. 212 (4).
(c) has demonstrated leadership and communications skills; and O. Reg. 79/10, s. 212 (4).
(d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time. O. Reg. 79/10, s. 212 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that everyone hired as an Administrator after coming into force of this section, had a post-secondary degree from a program that was a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that was a minimum of two years in duration; had at least three years working experience in a managerial or supervisory capacity in the health or social services sector, or in another managerial or supervisory capacity, if he or she had already successfully completed a program in long-term care home administration or long-term care home management.

During an interview with the Administrator, they reported to Inspector #577 that they had been hired into the role of Administrator, did not have a degree or diploma to meet the legislative requirement, and had not worked in a managerial or supervisory capacity in the health or social services sector.

During an interview with Extendicare Regional Director #103, together with Inspector #577, a review of the legislation related to Administrator qualifications was conducted. They were in agreement and confirmed that the Administrator was not qualified for the position as the home's Administrator, as per the legislation. [s. 212. (4)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to make a report in writing to the Director under subsection 23 (2) of the Act, failing to include a description of the incident, individuals involved, actions taken concerning the outcome or current status of the individual who was involved in the incident, with respect to the alleged, suspected or witnessed incident of abuse of a

resident by anyone or neglect of a resident by the licensee or staff that led to the report.

A Critical Incident System (CIS) report was submitted to the Director on an identified date, concerning resident to resident abuse. The report indicated that resident #002 was the aggressor.

Inspector #577 reviewed the amended CIS report and found that there was not a clear description of the incident; the documented outcome/current status of the individual(s) indicated that a resident required specific assistance by staff to stand up and was transferred to the hospital to rule out an injury; the immediate actions indicated that "the resident remains injured and unable to care for them; they have been transferred to another facility".

A review of resident #003's progress notes indicated that resident #002 had punched them and they suffered an injury on an identified area of their body.

A physician progress note indicated that following resident #003's specific injury, they had suffered a specific medical impairment.

During an interview with the Administrator, together with Inspector #577, the CIS report was reviewed. The Administrator confirmed that the description of the incident, the current status, and the outcome did not contain sufficient information. They further confirmed that they had not conducted an investigation related to resident to resident abuse. [s. 104. (1)]

2. A report was received by the Ministry of Long-Term Care Action Line on an identified date, related to resident to resident abuse. The report indicated that resident #004 had followed resident #002 down the hallway and had an unwitnessed altercation. Resident #002 was found with a bodily substance on a specific area of their body and reported that resident #004 had attacked them. Resident #004 was found with specific injuries on identified areas of their body.

Inspector #577 could not find an associated Critical Incident System (CIS) report related to the incident of resident to resident abuse submitted to the Director by the home.

A review of the home's policy, "Critical Incident Reporting – RC-09-01-06" revised June 2019, indicated that the home was to inform the MOH Director immediately, in as much detail as was possible where there was an incident of abuse of a resident by anyone that

resulted in harm or a risk of harm to the resident. They were required to amend the Critical Incident report with new or additional information as it became available and were to submit it to the MOHLTC within the established time frames.

A review of the home's policy, "Zero Tolerance of Resident Abuse and Neglect - RC-02-01-01", revised June 2019, indicated that the Administrator was required to promptly investigate resident-to-resident altercations, complaints and unexplained bruising or injuries to determine the root cause and put in place measures to prevent recurrence.

During an interview with the Administrator, they reported that they had not submitted a CIS report to the Director and had not initiated an investigation related to resident to resident abuse. [s. 104. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the care set out in the plan had not been effective.

A Critical Incident System (CIS) report was submitted to the Director on an identified date, concerning resident #005 who had fallen and suffered a specific injury. The report indicated that the resident had been ambulating with their mobility aid and had fallen.

Inspector #577 reviewed resident #005's most current care plan which identified the following interventions specifically related to certain care activities:

- specific assistance with a mobility aid, offer a different mobility aid and related assistance when needed;
- transfer with specific assistance for a particular care routine, using a mobility aid;
- walks independently to and from meals and activities with use of a mobility aid; tends to walk on unit and in room without the mobility aid despite encouragement to use the mobility aid at all times; always remind the resident to use their mobility aid while walking;
- remind and redirect the resident to use their mobility aid at all times;
- resident performs a specific activity independently; and
- encourage and remind resident to wear specific aid when walking in their room or within the home.

A review of the most recent Physiotherapy assessment progress note on an identified date, indicated that resident #005 required specific assistance for a specific care activity and a mobility device due to a specific medical condition.

During an interview with RPN #104, they reported that resident #005 used a specific mobility aid and their care plan had not been updated to reflect their current needs.

During an interview with Physiotherapist (PT) #105 they reported that the resident required specific assistance and mobilized with a mobility aid.

A review of the home's policy, "Resident Assessment and Care Planning - RV-02-01-01", revised April 2019, indicated that the resident care plan would be reviewed when there was a significant change in the resident's condition. A review of the home's policy, "Critical Incident Reporting - RC-09-01-06, revised June 2019, indicated that staff were to update the resident care plan where necessary to reflect the current care needs and inform care staff of changes.

During an interview with Resident Assessment Instrument (RAI) Coordinator they reported that all registered staff were responsible for updating care plans.

During an interview with Acting Director of Care (ADOC), together with Inspector #577, resident #005's care plan was reviewed. They confirmed that the current care plan had not been updated to reflect their current needs. [s. 6. (10) (b)]

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 resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the care set out in the plan had not been effective, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, behavioural triggers were identified, strategies were developed and implemented to respond to those behaviours and actions were taken to respond to those needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A Critical Incident System (CIS) report was submitted to the Director on a specified date, concerning resident to resident abuse. The report indicated that resident #002 punched resident #003 and they had suffered a specific injury.

Refer to WN #2 for further details.

Inspector #577 conducted a record review of resident #002's progress notes and found the following:

-on a day in July 2019- resident was banging on the glass window; a co-resident became frustrated and hit them over the left upper back;
-on a day in October 2019- resident was demonstrating aggressive behaviour using their mobility aid to run into residents; appeared to be seeking out particular residents;
-on that same day in October 2019- very aggressive behaviour this shift, following residents around in threatening manner; followed a co-resident and attempted to hit them on the back;
-on another day in October 2019- very aggressive and threatening; targeting particular residents, staring at them and standing in front of them, intimidating them;
-on another day in October 2019- resident standing in front of a resident at the table and had attempted to get physical;
-on another day in October 2019- resident punched resident #003 and suffered a specific injury;
-on another day in October- resident had escalating aggression and agitation over past two weeks, often banging doors, chasing multiple residents on unit, difficult to redirect and had recently pushed another resident which resulted in a specific injury;
-on another day in October 2019- resident kept banging on west side exit door and woke up all the residents;
-on a day in November 2019- resident had unwitnessed altercation with resident #004; found with a bodily substance on a specific area of their body .

Inspector #577 reviewed resident #002's current care plan and noted there were no documented triggers for their responsive behaviour or indication of physical altercations with other residents.

A review of the home's policy, "Responsive Behaviours – 17-01-04", revised February 2017, indicated that all new or escalated instances of responsive behaviours would be reported, recorded and investigated on an ongoing basis. The home would implement and evaluate strategies and interventions to prevent, minimize and address responsive behaviours. They were to have ensured that the care plan included a description of the behavior, triggers to the behavior, preventative measures to minimize risk of the behavior developing or escalating, resident specific interventions to address behaviours and strategies that staff were to have followed if the interventions were not effective.

A review of the home's policy, "Zero Tolerance of Resident Abuse and Neglect - RC-02-01-01", revised June 2019, indicated that the home was required to have developed a comprehensive plan of care on admission, readmission, and at a minimum quarterly thereafter, for residents with needs and behaviours that may lead to altercations, victimization or aggression and ensure that all caregivers were aware of and compliant with it's contents.

During observations through-out inspection, the inspector observed the resident to be frequently pacing with their mobility aid back and forth in the hallways.

During an interview with Behavioural Supports Ontario (BSO) Outreach Personal Support Worker, they reported that the resident was referred to them on a specified date, for specific behaviours. They had identified a particular trigger for their responsive behaviours and tried to keep them busy with specific activities. They further reported that they were unaware of any altercations with other residents and had never witnessed the resident being aggressive or angry or having had responsive behaviours with other residents.

During an interview with PSW #107 they reported that resident #002 had altercations with resident #003 and #004; they wandered back and forth in the hallway and banged on the exit doors; they wandered into other resident rooms and they were unaware of any triggers for their responsive behaviour.

During an interview with PSW #108 they reported that there were times when resident #002 had been aggressive with other residents, would exit seek, wandered and shook the exit doors. They went on to indicate that the resident had physical altercations with other residents, and identified a particular trigger which caused physical altercations with other residents. They described that a month previous they had approached other residents and rammed their mobility aid into them.

During an interview with ADOC they reported that there had been altercations with resident #002 toward other residents. They further reported that the resident could be resistive and unpredictable and was often exit seeking.

During an interview with the Nurse Practitioner (NP), they reported that staff had not implemented the interventions recommended by BSO, and the resident was constantly pacing up and down the hallway and banging on the exit doors. [s. 53. (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 for each resident demonstrating responsive behaviours, behavioural triggers are identified, strategies are developed and implemented to respond to those behaviours and actions are taken to respond to those needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that there was, at least quarterly, a documented reassessment of each resident's drug regime.

Inspector #577 conducted a record review of resident #002's physician's orders and identified that resident #002 did not have a current quarterly reassessment of their drug regime. A review of the previous quarterly medication review was signed by the physician on an identified date, and the authorization period was over a specified time period. The previous quarterly medication review with an authorization period over a specified time

period, and current quarterly medication review with an authorization period over a specified time period, had not been signed by the physician. A review of the Electronic Medication Administration Record (MAR) for resident #002 confirmed that staff had been administering resident #002's prescribed medication over a specified time period until present.

A review of the home's policy, "Medication Review - RC-16-01-12", revised February 2017, indicated that the three month medication review was to be prepared and forwarded to the home by the contracted pharmacy. The physician/NP would review all orders quarterly or as per regulatory requirements.

A review of the last signed quarterly medication review with an authorization period over a specified time period, indicated that a total of three residents were missing physician signatures authorizing the administration of the residents' medications for the period over a specified time period.

A review of the last signed quarterly medication review with an authorization period over a specified time period, indicated that a total of four residents were missing physician signatures authorizing the administration of the residents' medications over a specified time period.

A review of the last signed quarterly medication review with an authorization period over a specified time period, indicated that a total of 17 residents were missing physician signatures authorizing the administration of the residents' medications over a specified time period.

In total, 23/44 or 52 per cent of the residents did not have a current and valid prescription for administration of their medications that had been administered over a specified time period, and were currently being administered.

During an interview with the Regional Manager of Clinical Pharmacy Services, they reported that the quarterly medication reviews were to be completed every 90 days.

During an interview with the ADOC and the Administrator, Inspector #577, reviewed the expired quarterly medication reviews and they confirmed that staff had administered medication without a current order, and 23 residents had expired authorization for the administration of their medication. [s. 134. (c)]

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 there is, at least quarterly, a documented reassessment of each resident's drug regime, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to inform the Director of an incident under subsection (1), (3) or (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: Analysis and follow-up action, including, the immediate actions taken to prevent recurrence and the long-term actions planned to correct the situation and prevent recurrence.

A Critical Incident System (CIS) report was submitted to the Director on a specified date, concerning resident #005 who had fallen and suffered a specific injury. The report indicated that the resident had ambulated with their mobility aid and had fallen.

Inspector #577 reviewed the amended CIS report and found that the documented responses were inaccurate and insufficient. The immediate actions taken to prevent recurrence/interventions in place prior to Critical Incident indicated "fall assessments have been performed several times over the past six months". The long-term actions planned to correct the situation and prevent recurrence indicated information on a different resident.

A record review of the home's policy, "Critical Incident Reporting – RC-09-01-06", revised June 2019, indicated that the Critical Incident report was to be amended with new or additional information as it became available and were to submit it to the Ministry of Health and Long-Term Care (MOHLTC) within established time frames.

During an interview with the Administrator, the amended CIS report was reviewed. They confirmed that the documentation for immediate actions did not contain sufficient information and they had documented information for a different resident under the long-term actions. They further confirmed that they had not conducted an investigation related to resident #005's fall. [s. 107. (4) 4.]

Issued on this 11th day of December, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère 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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	DEBBIE WARPULA (577), MELISSA HAMILTON (693)
Inspection No. / No de l’inspection :	2019_633577_0033
Log No. / No de registre :	019915-19, 019969-19, 021554-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 9, 2019
Licensee / Titulaire de permis :	CVH (No. 2) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Birchwood Terrace 237 Lakeview Drive, R.R. #1, KENORA, ON, P9N-4J7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Natalie Rogers

To CVH (No. 2) LP, 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

Ministère 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 212. (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,
(a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration;
(b) has at least three years working experience,
(i) in a managerial or supervisory capacity in the health or social services sector, or
(ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d);
(c) has demonstrated leadership and communications skills; and
(d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time. O. Reg. 79/10, s. 212 (4).

Order / Ordre :

The licensee must be in compliance with r. 212. (4) of O. Reg. 79/10. Specifically the licensee must:

Ensure that the person hired as the Administrator meets the following qualifications:
a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration,
b) has at least three years working experience in a managerial or supervisory capacity in the health or social services sector, or in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d),
c) has demonstrated leadership and communications skills; and
d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Grounds / Motifs :

1. The licensee has failed to ensure that everyone hired as an Administrator after coming into force of this section, had a post-secondary degree from a program that was a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that was a minimum of two years in duration; had at least three years working experience in a managerial or supervisory capacity in the health or social services sector, or in another managerial or supervisory capacity, if he or she had already successfully completed a program in long-term care home administration or long-term care home management.

During an interview with the Administrator, they reported to Inspector #577 that they had been hired into the role of Administrator, did not have a degree or diploma to meet the legislative requirement, and had not worked in a managerial or supervisory capacity in the health or social services sector.

During an interview with Extendicare Regional Director #103, together with Inspector #577, a review of the legislation related to Administrator qualifications was conducted. They were in agreement and confirmed that the Administrator was not qualified for the position as the home's Administrator, as per the legislation.

The decision to issue this Compliance Order (CO) was based on the scope which was widespread, the severity which was minimal harm/minimal risk. In addition, the home's compliance history of previous on-going unrelated non compliance.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 03, 2020

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

2. A description of the individuals involved in the incident, including,

i. names of all residents involved in the incident,

ii. names of any staff members or other persons who were present at or discovered the incident, and

iii. names of staff members who responded or are responding to the incident.

3. Actions taken in response to the incident, including,

i. what care was given or action taken as a result of the incident, and by whom,

ii. whether a physician or registered nurse in the extended class was contacted,

iii. what other authorities were contacted about the incident, if any,

iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and

v. the outcome or current status of the individual or individuals who were involved in the incident.

4. Analysis and follow-up action, including,

i. the immediate actions that have been taken to prevent recurrence, and

ii. the long-term actions planned to correct the situation and prevent recurrence.

5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Order / Ordre :

The licensee must be in compliance with r. 104 (1) of O. Reg. 79/10. Specifically the licensee must:

a) Ensure that all alleged, suspected or witnessed incidents of abuse of a resident by anyone or neglect of a resident by the licensee or staff is investigated and reported to the Director,
b) Ensure that the report to the Director contains the following:
-a description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident,
-a description of the individuals involved in the incident, including the names of all residents involved in the incident, the names of any staff members or other persons who were present at or discovered the incident,
-the names of any staff members or other persons who were present at or discovered the incident, and the names of staff members who responded or are responding to the incident,
- actions taken in response to the incident, including, what care was given or action taken as a result of the incident, and by whom; whether a physician or registered nurse in the extended class was contacted; what other authorities were contacted about the incident, if any, and whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons,
-the outcome or current status of the individual or individuals who were involved in the incident,
-analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence,
-the name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.

Grounds / Motifs :

1. The licensee failed to make a report in writing to the Director under subsection 23 (2) of the Act, failing to include a description of the incident, individuals involved, actions taken concerning the outcome or current status of the individual who was involved in the incident, with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a

resident by the licensee or staff that led to the report.

A Critical Incident System (CIS) report was submitted to the Director on an identified date, concerning resident to resident abuse. The report indicated that resident #002 was the aggressor.

Inspector #577 reviewed the amended CIS report and found that there was not a clear description of the incident; the documented outcome/current status of the individual(s) indicated that a resident required specific assistance by staff to stand up and was transferred to the hospital to rule out an injury; the immediate actions indicated that "the resident remains injured and unable to care for them; they have been transferred to another facility".

A review of resident #003's progress notes indicated that resident #002 had punched them and they suffered an injury on an identified area of their body.

A physician progress note indicated that following resident #003's specific injury, they had suffered a specific medical impairment.

During an interview with the Administrator, together with Inspector #577, the CIS report was reviewed. The Administrator confirmed that the description of the incident, the current status, and the outcome did not contain sufficient information. They further confirmed that they had not conducted an investigation related to resident to resident abuse. (577)

2. A report was received by the Ministry of Long-Term Care Action Line on an identified date, related to resident to resident abuse. The report indicated that resident #004 had followed resident #002 down the hallway and had an unwitnessed altercation. Resident #002 was found with a bodily substance on a specific area of their body and reported that resident #004 had attacked them. Resident #004 was found with specific injuries on identified areas of their body.

Inspector #577 could not find an associated Critical Incident System (CIS) report related to the incident of resident to resident abuse submitted to the Director by the home.

A review of the home's policy, "Critical Incident Reporting – RC-09-01-06"

revised June 2019, indicated that the home was to inform the MOH Director immediately, in as much detail as was possible where there was an incident of abuse of a resident by anyone that resulted in harm or a risk of harm to the resident. They were required to amend the Critical Incident report with new or additional information as it became available and were to submit it to the MOHLTC within the established time frames.

A review of the home's policy, "Zero Tolerance of Resident Abuse and Neglect - RC-02-01-01", revised June 2019, indicated that the Administrator was required to promptly investigate resident-to-resident altercations, complaints and unexplained bruising or injuries to determine the root cause and put in place measures to prevent recurrence.

During an interview with the Administrator, they reported that they had not submitted a CIS report to the Director and had not initiated an investigation related to resident to resident abuse.

The decision to issue this Compliance Order (CO) was based on the scope which was a pattern, the severity which was minimal harm/minimal risk. In addition, the home's compliance history of previous on-going unrelated non compliance.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 03, 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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 9th day of December, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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