Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 8, 2019	2019_627138_0020	019355-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Renfrew
9 International Drive PEMBROKE ON K8A 6W5

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

Bonnechere Manor
470 Albert Street RENFREW ON K7V 4L5

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

PAULA MACDONALD (138)

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): October 7, 8, 9, 16, 17, and 18, 2019.

The following Critical Incident System (CIS) intake was completed during the inspection:
- log 019355-19 relating to a missing resident.

During the course of the inspection, the inspector(s) spoke with an administrative assistant - administration, an administrative assistant - finance, director of care, the director of long-term care, a driver for a transportation service, the environmental services supervisor, a significant other of the resident, a substitute decision maker for the resident, a laundry aide, the RAI MDS coordinator, a personal support worker, a physician, registered practical nurses (RPNs), registered nurses (RNs), and a unit clerk.

The inspector toured a resident home area as well as resident commons areas and non residential areas, toured the grounds of the home, observed a resident drop off via a transportation service, reviewed a health care record, reviewed internal investigation documents, reviewed resident sign out/in records, reviewed communication records, and reviewed the home's written plan relating to missing residents.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **1 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put any plan in place, the plan was complied with.

In accordance with LTCHA 2007, s. 87 (1) (a), and in reference to O. Reg. 79/10, s. 230. (4) 1. vii, the licensee is required to have an emergency plan that provides for situations involving a missing resident.

Specifically, staff did not comply with the licensee's emergency plan, "Missing Resident – Code Yellow" (EP-023, revised August 9, 2019), that directs staff to take specific actions when a resident has been identified as absent from their usual area.

The Ministry of Long-Term Care was made aware via emergency after hours procedures that resident #001 had been out, accompanied by a significant other, and was to be returned to the home by a transportation service at a specific time. Instead, resident #001 was found outside of the home approximately 11 hours later by a passer by who contacted the police.

In follow up, the licensee submitted a critical incident report in relation to a missing resident, resident #001, who had been found on the grounds of the home. The critical incident report stated that the resident had injuries. The resident was transferred via ambulance to the hospital.

The inspector commenced an inspection in response to the above and reviewed the health care record for resident #001. According to the health care record, resident #001 was admitted to the home several years ago and had multiple diagnoses.

On the day that the resident was first identified as absent from the home, according to the significant other of resident #001, the resident and the significant other took part in a regular planned outing. The resident's significant other stated that they both left the home at a specific time via a transportation service and were later picked up at a specific time by the same transportation service. The resident's significant other further stated that the transportation service first dropped off the significant other at their residence and then proceeded to the home to drop off the resident at a specific time.

The inspector spoke with driver #104 of the transportation service who drove resident #001 and the resident's significant other on the day the resident was first identified as absent from the home. The driver stated that they picked up resident #001 and the resident's significant other at the home at a specific time and returned to pick them up at a specific time, first dropping off the resident's significant other at their residence and then returning resident #001 to the home at a specific time. The driver further added that, upon return to the home, they observed the resident proceed through both sets of doors at the front entrance of the home with the inner secure door closing fully behind the resident as the resident went into the lobby of the home.

Approximately 11 hours later, resident #001 was found in the field on the grounds of the home. According to the resident's significant other, who spoke with the resident immediately after the incident, the resident had reported that they tried to go to their home area after returning to the home. The resident's significant other stated that the resident reported that the door, referring to the internal door to the home area, was closed and so the resident returned to the lobby to sit in their usual chair. The resident reported that they were unable to find the usual chair and then found themselves outside on the paved walkway at the front of the home. The resident's significant other stated that the resident reported that they followed the paved walkway until the walkway ended at the side of the home where the resident sustained an injury. The resident's significant other stated that the resident eventually continued in search of a specific landmark near their room. The resident's significant other surmised that the resident was looking for this landmark for a specific reason. The resident's significant other added that once the resident found the landmark, that it had prompted a specific response by the resident resulting in the resident laying down on the ground.

Inspector spoke with Director of Care #100 who stated that the internal doors to resident #001's home area had been closed for specific reasons. The Director of Care also stated that there were modifications to the appearance of the lobby area for specific reasons.

RPN #102, who was the RPN working on resident #001's home area the day the resident was first identified as absent from the home, stated that resident #001 had gone out with their significant other as planned but that the resident did not return to the home area as expected. The RPN stated that it was assumed that the resident was still out with their significant other and had directed staff to check the resident's room throughout the remainder of the shift for the resident's return. The RPN also stated that staff prepared the resident's care supplies and the resident's medication in anticipation of the resident's return. However, in accordance with O .Reg 131(2), the resident's medication had not been administered as indicated in the plan of care as it was believed that the resident had not returned to the home. The RPN stated that they were not too concerned that the resident had not returned to the home area. The RPN added that it was assumed the resident was still out with their significant other as there had been times in the past when the resident returned late from such outing outings, though the resident would usually be back within an identified timeframe.

RN #116 was the charge nurse working at the same time as RPN #102 and according to RN #116, they were aware a half hour after the resident's usual return time that resident #001 had not returned. RN #116 had asked if any staff had seen the resident and reported that no one had but that it was not unusual for the resident to stay out with their significant other. No further actions were taken by RN #116 to locate the resident during the shift.

RPN #102 and RN #116's shift ended and a report was provided to the oncoming charge nurse, RN #101. RN #101 stated that they were told at the beginning of the shift that resident #001 had not returned from the outing with their significant other and that the resident had not had their medications. RN #101 stated that they were not concerned by the resident's absence as they had assumed that the resident was still out with their significant other. RN #101 did further state that though the resident could be out late, the resident usually would arrive within an identified timeframe. RN #101 further added that the resident had stayed out for extended periods in the past but acknowledged this was not a recent routine. RN #101 stated that they were aware that resident #001 was absent from the home and assumed that the resident had remained out with their significant other. RN #101 stated that, because of this assumption, the only actions taken in response to the resident's absence were to have staff continue to monitor for the resident's return throughout the shift.

RN #101 stated that resident #001 did not return during the shift and this was

communicated to the oncoming charge nurse, RN #103. RN #103 stated that they started this shift with a report from RN #101 and then called the resident's significant other as soon a possible. RN #103 stated that the resident's significant other reported that the resident was returned to the home approximately 11 hours previously at the usual time. RN #103 stated that they had realized while speaking with the resident's significant other that resident #001 was missing. RN #103 further stated that they had received a call from the police just as the call with the resident's significant other was disconnected. RN #103 stated that the police were inquiring if there was a missing resident as the police had received a report that there was a person laying in the field of the home. RN #103 stated that the police had arranged for an ambulance and they had met the the ambulance in the field on the grounds of the home to assist. RN #103 stated that the ambulance attendants were providing care to the resident by the time they arrived and that resident #001 presented poorly. RN #103 stated that the resident was then taken to the hospital.

Physician #115 provided care to the resident in hospital and stated that the resident suffered injuries. The physician further stated that the resident was treated but experienced complications requiring further treatment. The physician stated resident #001 suffered a long-term change in health status as a result of the incident.

The inspector requested the licensee's emergency plan for addressing situations involving a missing resident and was provided a copy of a standard operating procedure titled "Missing Resident – Code Yellow" with a review date of August 9, 2019. The inspector reviewed this document and noted that it directs the charge nurse to call a code yellow as soon as a resident was identified absent from their usual area. This would be followed by providing team members information about the missing resident, conducting a search, other actions as required, and contacting the next of kin, the administrator or designate and the police. Director of Care #100 stated that "Missing Resident -Code Yellow" was never initiated for resident #001 from the time the resident had been identified first by RPN #102 and RN #116 as not returning as planned from an outing with their significant other and then by RN #101 who was also aware that the resident had not returned to their home area on a subsequent shift.

RPN #102, RN #101, and RN #116 all stated that resident #001 was identified as absent from the home. However, all assumed that resident #001 was still out with their significant other as all reported a history in which the resident would sometimes stay out later than planned.

Contrary, the inspector was able to determine, as outlined below, that there were no concerns in recent history with the resident failing to return to the home as planned.

The resident's significant other stated that the usual routine for that specific day and time each week is for both of them, the resident and the resident's significant other, to leave the home via a transportation service at a specific and routine time and then both are picked up later at a specific and routine time with the resident returning to the home at a specific and routine time. The resident's significant other stated this has been the usual routine for some time now. The resident's significant other further stated that there was a time when the resident would stay out later if there was a special occasion but reiterated that was in the past and has not happened in years because of specific reasons. The resident's significant other also stated that they knew it was important to have the resident back to the home at a specific time because the resident needed to have important time sensitive medications.

Driver #104 for the transportation service also stated that they have been driving resident #001 on these routine outings for several years and that there was a usual and consistent routine in place in which the driver picks up the resident and the resident's significant other at the home at a specific time and returns to pick them up at a specific time, returning the resident back to the home a specific time.

In addition to reports from the resident's significant other and the driver of the transportation service that the resident was routinely back in the home at a specific time following a routine outing, the inspector also spoke to PSW #117 who worked on resident #001's home area. PSW #117 stated that the resident was always back in the home after outings with the resident's significant other. PSW #117 stated that they were unable to recall the exact time the resident usually returned but did state that the resident was in the home area by the time staff completed a specific task on the home area.

The inspector spoke with the resident #001's substitute decision maker. The substitute decision maker stated that the licensee had never communicated to them any concerns that resident #001 was not returning as planned from their outings.

Resident #001's health care record was reviewed including the progress notes and the last interdisciplinary care conference. There was no recent documentation in the progress notes or the last interdisciplinary care conference notes about any concerns related to resident #001's outings, specifically no concerns relating to the late return of the resident.

The inspector further reviewed the Location of Administration Report, a sub-report of the electronic medication administration record, from February 2019 until October 2019 and it was noted that resident #001 commenced a specific medication in February 2019. The resident received this specific medication daily including after each routine outing with their significant other. The administration times of this specific daily medication were documented as being administered no later than a half hour after the resident's routine return time from their outing with their significant other. This indicates that the resident was routinely in the home as planned after such outings.

The Daily 24 Hour Report forms filled out daily by all shifts of RPNs for a specific period of time and the Charge RN forms filled out daily by all shifts of RNs for a specific period of time were also reviewed for concerns related to the late arrival of resident #001 after their routine outings. The only concern documented about late arrivals was of this incident in which the resident had not returned from the outing.

As such, resident #001's usual place was in the home after returning from routine planned outings with the resident's significant other at a specific time. The licensee failed to comply with the licensee's emergency plan dealing with situations of missing residents, "Missing Resident – Code Yellow" (EP-023, revised August 9, 2019), when multiple staff identified resident #001 as absent from the home for a period of approximately 11 hours.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 1 as it was isolated. The home had a level 3 compliance history as there was a previous non compliance to the same subsection that included:
- A voluntary plan of corrective action (VPC) issued March 4, 2019 (Inspection #2019_593573_0006). [s. 8. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 28th day of November, 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) :	PAULA MACDONALD (138)
Inspection No. / No de l'inspection :	2019_627138_0020
Log No. / No de registre :	019355-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 8, 2019
Licensee / Titulaire de permis :	The Corporation of the County of Renfrew 9 International Drive, PEMBROKE, ON, K8A-6W5
LTC Home / Foyer de SLD :	Bonnechere Manor 470 Albert Street, RENFREW, ON, K7V-4L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shelley Sheedy

To The Corporation of the County of Renfrew, 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. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8. (1) (b) of O. Reg 79/10.

Specifically the licensee shall:

1) Reassess the needs of resident #001 related to outings and revise the plan of care to ensure that the licensee is aware of the return of resident #001 after outings.

2) Ensure the plan that deals with situations of missing residents provides direction to staff in dealing with situations when a resident does not return from an outing as expected.

3) Ensure the emergency plan that deals with situations of missing residents provides direction to staff in conducting searches in non residential areas and the grounds of the home.

4) Train all charge nurses on the emergency plan that deals with situations of missing residents. This training will be documented.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put any plan in place, the plan was complied with.

In accordance with LTCHA 2007, s. 87 (1) (a), and in reference to O. Reg. 79/10, s. 230. (4) 1. vii, the licensee is required to have an emergency plan that provides for situations involving a missing resident.

Specifically, staff did not comply with the licensee's emergency plan, "Missing Resident – Code Yellow" (EP-023, revised August 9, 2019), that directs staff to take specific actions when a resident has been identified as absent from their usual area.

The Ministry of Long-Term Care was made aware via emergency after hours procedures that resident #001 had been out, accompanied by a significant other, and was to be returned to the home by a transportation service at a specific time. Instead, resident #001 was found outside of the home approximately 11 hours later by a passer by who contacted the police.

In follow up, the licensee submitted a critical incident report in relation to a missing resident, resident #001, who had been found on the grounds of the home. The critical incident report stated that the resident had injuries. The resident was transferred via ambulance to the hospital.

The inspector commenced an inspection in response to the above and reviewed the health care record for resident #001. According to the health care record, resident #001 was admitted to the home several years ago and had multiple diagnoses.

On the day that the resident was first identified as absent from the home, according to the significant other of resident #001, the resident and the significant other took part in a regular planned outing. The resident's significant other stated that they both left the home at a specific time via a transportation service and were later picked up at a specific time by the same transportation service. The resident's significant other further stated that the transportation service first dropped off the significant other at their residence and then proceeded to the home to drop off the resident at a specific time.

The inspector spoke with driver #104 of the transportation service who drove resident #001 and the resident's significant other on the day the resident was

first identified as absent from the home. The driver stated that they picked up resident #001 and the resident's significant other at the home at a specific time and returned to pick them up at a specific time, first dropping off the resident's significant other at their residence and then returning resident #001 to the home at a specific time. The driver further added that, upon return to the home, they observed the resident proceed through both sets of doors at the front entrance of the home with the inner secure door closing fully behind the resident as the resident went into the lobby of the home.

Approximately 11 hours later, resident #001 was found in the field on the grounds of the home. According to the resident's significant other, who spoke with the resident immediately after the incident, the resident had reported that they tried to go to their home area after returning to the home. The resident's significant other stated that the resident reported that the door, referring to the internal door to the home area, was closed and so the resident returned to the lobby to sit in their usual chair. The resident reported that they were unable to find the usual chair and then found themselves outside on the paved walkway at the front of the home. The resident's significant other stated that the resident reported that they followed the paved walkway until the walkway ended at the side of the home where the resident sustained an injury. The resident's significant other stated that the resident eventually continued in search of a specific landmark near their room. The resident's significant other surmised that the resident was looking for this landmark for a specific reason. The resident's significant other added that once the resident found the landmark, that it had prompted a specific response by the resident resulting in the resident laying down on the ground.

Inspector spoke with Director of Care #100 who stated that the internal doors to resident #001's home area had been closed for specific reasons. The Director of Care also stated that there were modifications to the appearance of the lobby area for specific reasons.

RPN #102, who was the RPN working on resident #001's home area the day the resident was first identified as absent from the home, stated that resident #001 had gone out with their significant other as planned but that the resident did not return to the home area as expected. The RPN stated that it was assumed that the resident was still out with their significant other and had directed staff to

check the resident's room throughout the remainder of the shift for the resident's return. The RPN also stated that staff prepared the resident's care supplies and the resident's medication in anticipation of the resident's return. However, in accordance with O .Reg 131(2), the resident's medication had not been administered as indicated in the plan of care as it was believed that the resident had not returned to the home. The RPN stated that they were not too concerned that the resident had not returned to the home area. The RPN added that it was assumed the resident was still out with their significant other as there had been times in the past when the resident returned late from such outing outings, though the resident would usually be back within an identified timeframe.

RN #116 was the charge nurse working at the same time as RPN #102 and according to RN #116, they were aware a half hour after the resident's usual return time that resident #001 had not returned. RN #116 had asked if any staff had seen the resident and reported that no one had but that it was not unusual for the resident to stay out with their significant other. No further actions were taken by RN #116 to locate the resident during the shift.

RPN #102 and RN #116's shift ended and a report was provided to the oncoming charge nurse, RN #101. RN #101 stated that they were told at the beginning of the shift that resident #001 had not returned from the outing with their significant other and that the resident had not had their medications. RN #101 stated that they were not concerned by the resident's absence as they had assumed that the resident was still out with their significant other. RN #101 did further state that though the resident could be out late, the resident usually would arrive within an identified timeframe. RN #101 further added that the resident had stayed out for extended periods in the past but acknowledged this was not a recent routine. RN #101 stated that they were aware that resident #001 was absent from the home and assumed that the resident had remained out with their significant other. RN #101 stated that, because of this assumption, the only actions taken in response to the resident's absence were to have staff continue to monitor for the resident's return throughout the shift.

RN #101 stated that resident #001 did not return during the shift and this was communicated to the oncoming charge nurse, RN #103. RN #103 stated that they started this shift with a report from RN #101 and then called the resident's significant other as soon a possible. RN #103 stated that the resident's

significant other reported that the resident was returned to the home approximately 11 hours previously at the usual time. RN #103 stated that they had realized while speaking with the resident's significant other that resident #001 was missing. RN #103 further stated that they had received a call from the police just as the call with the resident's significant other was disconnected. RN #103 stated that the police were inquiring if there was a missing resident as the police had received a report that there was a person laying in the field of the home. RN #103 stated that the police had arranged for an ambulance and they had met the the ambulance in the field on the grounds of the home to assist. RN #103 stated that the ambulance attendants were providing care to the resident by the time they arrived and that resident #001 presented poorly. RN #103 stated that the resident was then taken to the hospital.

Physician #115 provided care to the resident in hospital and stated that the resident suffered injuries. The physician further stated that the resident was treated but experienced complications requiring further treatment. The physician stated resident #001 suffered a long-term change in health status as a result of the incident.

The inspector requested the licensee's emergency plan for addressing situations involving a missing resident and was provided a copy of a standard operating procedure titled "Missing Resident – Code Yellow" with a review date of August 9, 2019. The inspector reviewed this document and noted that it directs the charge nurse to call a code yellow as soon as a resident was identified absent from their usual area. This would be followed by providing team members information about the missing resident, conducting a search, other actions as required, and contacting the next of kin, the administrator or designate and the police. Director of Care #100 stated that "Missing Resident -Code Yellow" was never initiated for resident #001 from the time the resident had been identified first by RPN #102 and RN #116 as not returning as planned from an outing with their significant other and then by RN #101 who was also aware that the resident had not returned to their home area on a subsequent shift.

RPN #102, RN #101, and RN #116 all stated that resident #001 was identified as absent from the home. However, all assumed that resident #001 was still out with their significant other as all reported a history in which the resident would sometimes stay out later than planned.

Contrary, the inspector was able to determine, as outlined below, that there were no concerns in recent history with the resident failing to return to the home as planned.

The resident's significant other stated that the usual routine for that specific day and time each week is for both of them, the resident and the resident's significant other, to leave the home via a transportation service at a specific and routine time and then both are picked up later at a specific and routine time with the resident returning to the home at a specific and routine time. The resident's significant other stated this has been the usual routine for some time now. The resident's significant other further stated that there was a time when the resident would stay out later if there was a special occasion but reiterated that was in the past and has not happened in years because of specific reasons. The resident's significant other also stated that they knew it was important to have the resident back to the home at a specific time because the resident needed to have important time sensitive medications.

Driver #104 for the transportation service also stated that they have been driving resident #001 on these routine outings for several years and that there was a usual and consistent routine in place in which the driver picks up the resident and the resident's significant other at the home at a specific time and returns to pick them up at a specific time, returning the resident back to the home a specific time.

In addition to reports from the resident's significant other and the driver of the transportation service that the resident was routinely back in the home at a specific time following a routine outing, the inspector also spoke to PSW #117 who worked on resident #001's home area. PSW #117 stated that the resident was always back in the home after outings with the resident's significant other. PSW #117 stated that they were unable to recall the exact time the resident usually returned but did state that the resident was in the home area by the time staff completed a specific task on the home area.

The inspector spoke with the resident #001's substitute decision maker. The substitute decision maker stated that the licensee had never communicated to them any concerns that resident #001 was not returning as planned from their

outings.

Resident #001's health care record was reviewed including the progress notes and the last interdisciplinary care conference. There was no recent documentation in the progress notes or the last interdisciplinary care conference notes about any concerns related to resident #001's outings, specifically no concerns relating to the late return of the resident.

The inspector further reviewed the Location of Administration Report, a sub-report of the electronic medication administration record, from February 2019 until October 2019 and it was noted that resident #001 commenced a specific medication in February 2019. The resident received this specific medication daily including after each routine outing with their significant other. The administration times of this specific daily medication were documented as being administered no later than a half hour after the resident's routine return time from their outing with their significant other. This indicates that the resident was routinely in the home as planned after such outings.

The Daily 24 Hour Report forms filled out daily by all shifts of RPNs for a specific period of time and the Charge RN forms filled out daily by all shifts of RNs for a specific period of time were also reviewed for concerns related to the late arrival of resident #001 after their routine outings. The only concern documented about late arrivals was of this incident in which the resident had not returned from the outing.

As such, resident #001's usual place was in the home after returning from routine planned outings with the resident's significant other at a specific time. The licensee failed to comply with the licensee's emergency plan dealing with situations of missing residents, "Missing Resident – Code Yellow" (EP-023, revised August 9, 2019), when multiple staff identified resident #001 as absent from the home for a period of approximately 11 hours.

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 1 as it was isolated. The home had a level 3 compliance history as there was a previous non compliance to the same subsection that included:
- A voluntary plan of corrective action (VPC) issued March 4, 2019 (Inspection

#2019_593573_0006). [s. 8. (1)]
(138)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 03, 2019

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 8th day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PAULA MACDONALD

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