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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
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Bureau régional de services de Centre Ouest
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Amended Public Copy/Copie modifiée 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 12, 2019	2018_580568_0016 (A4)	028934-17, 002261-18, 017981-18, 019694-18, 020637-18	Complaint

Licensee/Titulaire de permis

Corporation of the County of Bruce
30 Park Street WALKERTON ON N0G 2V0

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

Brucelea Haven Long Term Care Home - Corporation of the County of Bruce
41 McGivern Street West P.O. Box 1600 WALKERTON ON N0G 2V0

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

Amended by AMANDA OWEN (738) - (A4)

Amended Inspection Summary/Résumé de l'inspection modifié

The home accidentally requested a compliance due date change to December 16, 2019 for r. 230. They requested the due date to be changed back to the original due date of October 25, 2019.

Issued on this 12nd day of December, 2019 (A4)

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

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*

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

Amended by AMANDA OWEN (738) - (A4)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 28, 29, 30, 31, 2018; September 4, 5, 6, 7, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20, 21, 24, 25, 2018

Inspector #729 participated in this inspection.

The following intakes were completed during the inspection:

Log #02261-18, IL-55233-CW related to certification of nurses;

Log #019694-18, IL-58546-CW related to multiple care concerns including bathing, oral care, skin care, staffing standards and drug regimes;

Log #020637-18, IL-58546-CW related to resident neglect;

Log #028934-17, IL-IL-54586-LO re: verbal abuse and access to plan of care;

Log #017981-18, M507-000028-18 related to improper seating and reporting and complaints

Please Note: A Written Notification and Compliance order related to LTCHA, 2007, c.8, s. 6. (1) (c) plan of care; O. Reg 79/10, s. 50. (2) (a) (ii) and (b) (iv) skin and wound assessments; and s. 31 (3) sufficient staffing was identified in this inspection and has been issued in Inspection Report 2017_580568_0014, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Director of Health Services, Administrator, Director of Care, Administrative Assistant, RAI Coordinator, Dietary Manager, Ward Clerk, Recreation & Leisure Program Volunteer Coordinator, Environmental Services Supervisor, County of Bruce Human Resource Supervisor, Recreation & Leisure Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers,

Housekeepers, Recreation & Leisure Aides, Dietary Aides, Ward Clerk, Maintenance staff, a physician, residents and families.

The inspectors also reviewed relevant clinical records, policies and procedures, meeting minutes, staff schedules; observed the provision of resident care, resident-staff interactions, and

the safety of the home.

The following Inspection Protocols were used during this inspection:

Pain
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **6 WN(s)**
- **2 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

During an interview with a Registered Nurse (RN) they shared that on a specified date they received a phone call alerting them that there was an intruder in the home. A Registered Practical Nurse (RPN) said that on the same night they received a call from police saying they were at the front door. They explained that they were looking for a missing person and believed they may be on the premises.

The RN said that after letting police in the front doors they secured the doors so that they would not open from the inside or outside. The police wanted to search the first floor and while checking doors out to the patio they found that the door closest to the chapel that led to the patio area was not locked. They obtained the Allen Key and locked the door manually.

In interviews with two PSWs they shared that on the night in question they were working on 4 South and 4 West. When they finished doing rounds on 4 South and walked to 4 West they noted that the lights were on in the nursing station and there was a person sitting in the nursing station at the computer. They did not approach the person, went into a resident room and tried to call the RN and RPN phones. A call bell rang on 4 South so one of the PSWs went to answer it. While walking back to 4 West the staff member encountered an unknown person standing at the elevator. The person indicated that they were not okay and they were being apprehended. The PSW left and hid with their partner in the servery as the person got on the elevator.

During a search of the building by police and home staff, the RN encountered the intruder in the 3rd floor nursing station. The RN said they talked to the intruder who then slammed the door to the nursing station. Police arrived and the intruder was removed from the home.

During an interview with the PSW working on 3rd floor they shared that they were working alone on the specified date because they were short of staff. The RN was supposed to help with resident care in addition to completing their own duties. The PSW said that the RN was not on the floor when they started to do rounds so they started on their own. They were alone and could not leave the floor, so they just kept working because there were 48 residents that needed care. They explained that they had no idea there was an intruder on the floor until after the intruder had been removed.

The RN stated that they notified the Administrator of the incident on the night of the incident. They advised the Administrator that the door to the patio, closest to the chapel, was found unlocked. The RN said that when they worked the next night, they found the same door unlocked. They had a call from the Director of Health Services that night and shared with them that the door was found unlocked both nights. The RN stated that the door remained unlocked again the following night and they had to lock it manually. They then sent an email about this to the

ESS and the Administrator saying that the door closest to the chapel going out to the patio had been unlocked after 2100 hours since the incident with the intruder two nights prior. They also submitted a maintenance request regarding the door from the chapel to the patio not locking at 2100 hours.

During an interview with the ESS they shared that there were no audits done to ensure the timer on the doors leading to the patio were working and locking at programmed times. They said that the doors were not checked unless a maintenance request was submitted. They also shared that there was no set schedule to change any of the key padded doors and that no door codes had been changed since the intruder incident eleven days prior.

The Administrator stated they were the manager on call at time the intruder was in the building and that they got a call around 0430 hours from the RN reporting the incident. The Administrator did not recall if the RN told them about the unlocked door during the call or if they learned about it from the Director of Health Services the next day. The Administrator shared that the ESS was away at a conference the two days following the intruder incident so they said it was their intention to speak with them about the door not locking when they returned. The Administrator shared that in their view in terms of risk assessment and not knowing that the door closest to the chapel was the actual entrance point for the intruder, it seemed a low risk that it would occur again so they decided to wait until the ESS returned. The Administrator said it was the night nursing staff's responsibility to check the doors, however, there were no written job routines or shift routines noting this task.

During an interview with the Director of Health Services they said that they called the home the night after the intruder incident and spoke with the RN who informed them that the door closest to the chapel leading to the outside patio was unlocked the night the intruder entered the home and again that night. The Director of Health Services shared that they informed the Administrator the next morning that the door was unlocked. They indicated that their expectation was that the door would have been fixed once they reported it to the Administrator.

During an interview with a Maintenance Worker they said they received a maintenance request about the door not locking when they came to work three days after the intruder incident. The door was fixed that morning. Later that evening, the door was tested to ensure it was locked.

During interviews with six staff working the night of the intruder incident, they shared that they did not know how the intruder got into the home, but that the door codes on internal and external doors had not been changed since the incident.

An email sent from the RN to the ESS, Administrator and DOC three days after the incident, stated that the door closest to the chapel leading to the patio had been open since the incident and was still not locking at 2100 hours. The Administrator replied to the email saying the ESS was at a conference the last two days so they planned to meet with them that morning about the identified door and all other external doors.

During the inspection all the internal and external door codes were noted to remain the same as they were on the day of the incident.

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

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. 46. Every licensee of a long-term care home shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario. O. Reg. 79/10, s. 46.

Findings/Faits saillants :

1. The licensee failed to ensure that every member of the staff who performed duties in the capacity of a registered nurse, registered practical nurse or registered nurse in the extended class had the appropriate current certificate of registration with the College of Nurses of Ontario (CNO).

Registered nurse means a member of the CNO who holds a certificate of registration as a registered nurse under the Nursing Act, 1991.

An anonymous complaint was received by the MOHLTC indicating that the home had staff working in the capacity of registered nurses and/or registered practical nurses without having the proper credentials.

In a review of the CNO's document titled "Terms, Conditions and Limitations", a temporary class membership included: temporary members must be monitored and directed by a member in the general or extended class. Temporary members were not permitted to supervise, monitor or direct the practice of another member in any class. Nurses with a temporary registration use the designation “registered nurse (temporary). The employer is responsible for having sufficient resources to provide direct or indirect monitoring, consultation and collaboration to the temporary member. The level of supervision required would vary according to the member’s expertise and familiarity with the practice setting. The temporary member cannot monitor or direct the practice of another nurse in any category or class. Therefore, it was not appropriate for a temporary member to be solely “in-charge” or act in a formal leadership role.

a) A review of a Registered Nurse's (RN) CNOs profile found on the "find a nurse" website, showed that the RN was classified as a temporary status RN for a six month period.

A review of the RN's letter of hire revealed that the conditions of employment included obtaining a permanent registered nursing license on or before a specified date. Failure to provide proof of completion could result in immediate termination.

The home's employee schedule listing showed that the identified RN worked 15 night shifts in a charge nurse role without another registered nurse in the home while they held a temporary license.

In an interview with the identified RN they said they had worked alone in a charge

nurse role under the temporary license.

The DOC explained that the human resource consultant checks references and licenses and they could not recall if the identified RN provided validation of a temporary license. The DOC stated that they did not complete an evaluation of the RN's competencies or post orientation evaluation. The DOC confirmed that the RN worked 15 night shifts while having a temporary license and without a second RN in the building. Under the direction of the Director of Care, the RN worked in the capacity of a registered nurse without having the appropriate current certificate of registration with the CNO.

b) In a review of a RPN's College of Nurses profile, it revealed that the RPN was not registered with the CNO until a specific date.

Review of the employee file for the RPN showed a letter of employment for a casual position of Registered Practical Nurse effective 20 days earlier..

In an interview with the RPN they said they were not registered with the CNO prior to being hired and they had discussed this with the DOC and the Human Resources consultant during the interview process. The RPN shared that they booked their orientation shifts based on what they were available to work. The RPN reviewed the staffing schedule for a 19 day period and shared that they completed orientation shifts with another RPN or RN. The RPN stated that the RN or RPN would complete the first medication pass and they would complete the second and subsequent medication passes.

The DOC shared that they were not aware that the RPN was working during orientation without a license.

During an interview with the Human Resources Supervisor they said that it was up to the hiring manager to check the qualifications for the staff that they hire. They agreed that for RNs and RPNs these qualifications would need to be checked by the Director of Care.

Record review showed that the identified RPN administered medications to residents, some that included controlled substances, on four separate dates prior to being licensed with the CNO.

The licensee failed to ensure that every member of the staff who performs duties

in the capacity of a registered nurse, registered practical nurse or registered nurse in the extended class had the appropriate current certificate of registration with the College of Nurses of Ontario.

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(b) test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(c) conduct a planned evacuation at least once every three years; and O. Reg. 79/10, s. 230 (7).
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans. O. Reg. 79/10, s. 230 (7).

Findings/Faits saillants :

1. The licensee has failed to test the emergency plans related to the loss of essential services, situations involving a missing resident, medical emergencies and violent outburst on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency; conduct a planned evacuation at least once every three years; and keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans.

During interviews with an RN employed by the home for ten years; a RPN employed by the home for nine years; a PSW who worked in the home for more than thirty years; a PSW who worked in the home for thirteen years; and a PSW who worked in the home since February 2018, they all said they had not received training and had not participated in test scenarios / situations for any of the emergency codes other than fire drills. The staff members said they worked the night shift when an intruder was in the home, and were not sure what they were supposed to do because they had not received training in relation to this type of emergency situation. One of the PSWs working the night of the intruder incident shared that this was their first shift on their own as they had just completed their orientation. During orientation the different colored codes and what each meant was reviewed, but they did not recall any review of what they were to do if a code was called.

During an interview with the Administrator they shared that they had been employed by the home for almost two years and during that time there had not been any training, testing or annual review of training for any of the emergency codes except for fire drills. The Administrator said that the protocols with community agencies were reviewed and agreements signed last year.

The licensee has failed to test the emergency plans related to the loss of essential services, situations involving a missing resident, medical emergencies and violent outburst on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency; conduct a planned evacuation at least once every three years; and keep a written record of the

testing of the emergency plans and planned evacuation and of the changes made to improve the plans.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A4)
The following order(s) have been amended: CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately.

A Critical Incident System (CIS) report was submitted to the MOHLTC with regards to improper/incompetent treatment of a resident that resulted in harm or risk of harm to a resident. Under the section entitled "description of the incident, including events leading up to the incident" it stated that the complaint was not about a particular incident, but to a general experience of feeling that the family members requests and concerns had not been heard or addressed in relation to specific resident care issues.

A copy of an email from a RPN to the DOC and copied to the Administrator was included with the CIS report. The email outlined a complaint/concern that had been brought forward to the RPN by a resident's substitute decision maker (SDM). The RPN said in the email that they would forward their concerns to the DOC and Administrator for resolution.

In a letter from the home's Administrator to the resident's SDM almost two months later, the Administrator apologized for not resolving the concerns for the identified resident sooner and for not responding to the SDM's concerns in a more timely manner.

The home's policy titled Complaints Management Program stated that for written complaints the Administrator or designate would contact or arrange to meet with the complainant to obtain information about the areas of concern. They would conduct and document an internal investigation using the complaint record form and provide a written response to the complainant within ten business days of receipt.

The Administrator stated that the email was received by both himself and the DOC but they had not followed up with the complainant. Approximately one month after the initial complaint was received the Administrator said the complainant spoke with the Recreation and Leisure Manager and asked why no one had followed up. They then brought it to their attention at which point an investigation was initiated. A letter was sent to the complainant providing a response to their concern close to two months later.

The licensee failed to ensure that the written complaint submitted to the home by a resident's SDM concerning the care of a resident was investigated immediately, resolved where possible and response provided within ten business days of receipt of the complaint.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every written or verbal complaint made to the licensee or staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately, to be implemented voluntarily.

WN #5: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of an incident in

the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
An environmental hazard that affected the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including, a breakdown or failure of the security system or a breakdown of major equipment or a system in the home.

During an interview with a RN they shared that on a specified night shift they received a phone call alerting them that there was an intruder in the home. A RPN told the Inspector that on the same night shift they received a call from police saying they were at the front door of the home. They explained that they were looking for a missing person and they believed the individual was on the premises.

The RN let two police officers in the front doors and then secured the doors so that they would not open from the inside or outside. The police wanted to search the first floor and while checking doors out to the patio they found that the door closest to the chapel that leads to the patio area was not locked.

The RN said they notified the Administrator of the incident by phone at approximately 0400 hours on the specified date. They advised the Administrator that the door to the patio, closest to the chapel was found unlocked. The RN shared that when they worked night shift the next day, they checked the doors on first floor and found the same door unlocked. That night they had a call from the Director of Health Services and shared with them that the patio door was found unlocked both nights. The RN stated that the door remained unlocked again the following night, and they had to lock it manually. They sent an email about this to the Environmental Services Supervisor and the Administrator on the third day, saying that the door closest to the chapel going out to the patio had been unlocked after 2100 hours since the incident with the intruder in the early morning hours of the specified date.

The Administrator said they had reviewed their algorithms to see if the intruder incident was something that needed a Critical Incident System (CIS) report completed. The Administrator said that because there were no residents involved in the incident a CIS report was not filed.

The Director of Health Services told the Inspector that the Administrator notified them of the intruder incident the day it occurred. They shared that they spoke

about the incident and if they needed to file a CIS report. The Administrator said there was no disruption of residents, staff were okay, and they had reviewed the criteria and could not discern what to report as nothing pointed to resident safety or care.

The license failed to ensure that the Director was informed of an incident involving an intruder in the home and having knowledge of an unsecured exterior door that affected the provision of care or the safety, security or well-being of residents for a period greater than six hours.

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 Director was informed of an incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
An environmental hazard that affected the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including, a breakdown or failure of the security system or a breakdown of major equipment or a system in the home, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to immediately forward any written complaints that have been received concerning the care of a resident or the operation of the home to the Director.

a) Review of documentation related to a CIS report identified an email from a RPN to the DOC and copied to the Administrator. The email outlined a care concern brought forward by a resident's SDM.

The Administrator told the Inspector that both he and the DOC had received the email but somehow it got missed in terms of follow-up. The home did not submit the written complaint to the MOHLTC until six weeks later when they were reminded of the concern by another staff member.

b) A complaint and related CIS report was submitted to the MOHLTC to inform the Director of concerns involving general care, medication administration, and wound care.

A complaint email was submitted to the DOC and Administrator on a specified date, from a resident's SDM regarding care concerns related to a resident. The DOC's response one day later to the resident's SDM did not satisfy them. Additional concerns related to nutrition and falls prevention were submitted via email to the DOC. The licensee failed to report to the director the second complaint email.

In an interview with the DOC they acknowledged having received the emails, but said they did not forward the letters of complaint to the Director. The complaint was brought forward to the Director of Health Services at a later date as the resident's SDM did not receive a response from their second email.

The licensee has failed to immediately forward written complaints with regards to resident's care to the Director.

Issued on this 12nd day of December, 2019 (A4)

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AMANDA OWEN (738) - (A4)
Inspection No. / No de l'inspection :	2018_580568_0016 (A4)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	028934-17, 002261-18, 017981-18, 019694-18, 020637-18 (A4)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 12, 2019(A4)
Licensee / Titulaire de permis :	Corporation of the County of Bruce 30 Park Street, WALKERTON, ON, N0G-2V0
LTC Home / Foyer de SLD :	Brucelea Haven Long Term Care Home - Corporation of the County of Bruce 41 McGivern Street West, P.O. Box 1600, WALKERTON, ON, N0G-2V0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Willie VanKlooster

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

To Corporation of the County of Bruce, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5 of the LTCHA.

Specifically the licensee must:
a) Develop, document and implement a process for checking all external doors at specified intervals. The process should identify who is responsible; when it will be conducted; and if any deficiencies are found, the process for having them addressed.
b) Change all door codes on doors that lead to the exterior of the building, if not already done since the incident on September 9, 2018.
c) Develop and implement a process with respect to when door codes are to be changed and the frequency that they will be changed to ensure the home is a safe environment for residents.

Grounds / Motifs :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

During an interview with a Registered Nurse (RN) they shared that on a specified date they received a phone call alerting them that there was an intruder in the home. A Registered Practical Nurse (RPN) said that on the same night they received a call from police saying they were at the front door. They explained that they were looking for a missing person and believed they may be on the premises.

The RN said that after letting police in the front doors they secured the doors so that they would not open from the inside or outside. The police wanted to search the first

floor and while checking doors out to the patio they found that the door closest to the chapel that led to the patio area was not locked. They obtained the Allen Key and locked the door manually.

In interviews with two PSWs they shared that on the night in question they were working on 4 South and 4 West. When they finished doing rounds on 4 South and walked to 4 West they noted that the lights were on in the nursing station and there was a person sitting in the nursing station at the computer. They did not approach the person, went into a resident room and tried to call the RN and RPN phones. A call bell rang on 4 South so one of the PSWs went to answer it. While walking back to 4 West the staff member encountered an unknown person standing at the elevator. The person indicated that they were not okay and they were being apprehended. The PSW left and hid with their partner in the servery as the person got on the elevator.

During a search of the building by police and home staff, the RN encountered the intruder in the 3rd floor nursing station. The RN said they talked to the intruder who then slammed the door to the nursing station. Police arrived and the intruder was removed from the home.

During an interview with the PSW working on 3rd floor they shared that they were working alone on the specified date because they were short of staff. The RN was supposed to help with resident care in addition to completing their own duties. The PSW said that the RN was not on the floor when they started to do rounds so they started on their own. They were alone and could not leave the floor, so they just kept working because there were 48 residents that needed care. They explained that they had no idea there was an intruder on the floor until after the intruder had been removed.

The RN stated that they notified the Administrator of the incident on the night of the incident. They advised the Administrator that the door to the patio, closest to the chapel, was found unlocked. The RN said that when they worked the next night, they found the same door unlocked. They had a call from the Director of Health Services that night and shared with them that the door was found unlocked both nights. The RN stated that the door remained unlocked again the following night and they had to lock it manually. They then sent an email about this to the ESS and the Administrator saying that the door closest to the chapel going out to the patio had been unlocked

after 2100 hours since the incident with the intruder two nights prior. They also submitted a maintenance request regarding the door from the chapel to the patio not locking at 2100 hours.

During an interview with the ESS they shared that there were no audits done to ensure the timer on the doors leading to the patio were working and locking at programmed times. They said that the doors were not checked unless a maintenance request was submitted. They also shared that there was no set schedule to change any of the key padded doors and that no door codes had been changed since the intruder incident eleven days prior.

The Administrator stated they were the manager on call at time the intruder was in the building and that they got a call around 0430 hours from the RN reporting the incident. The Administrator did not recall if the RN told them about the unlocked door during the call or if they learned about it from the Director of Health Services the next day. The Administrator shared that the ESS was away at a conference the two days following the intruder incident so they said it was their intention to speak with them about the door not locking when they returned. The Administrator shared that in their view in terms of risk assessment and not knowing that the door closest to the chapel was the actual entrance point for the intruder, it seemed a low risk that it would occur again so they decided to wait until the ESS returned. The Administrator said it was the night nursing staff's responsibility to check the doors, however, there were no written job routines or shift routines noting this task.

During an interview with the Director of Health Services they said that they called the home the night after the intruder incident and spoke with the RN who informed them that the door closest to the chapel leading to the outside patio was unlocked the night the intruder entered the home and again that night. The Director of Health Services shared that they informed the Administrator the next morning that the door was unlocked. They indicated that their expectation was that the door would have been fixed once they reported it to the Administrator.

During an interview with a Maintenance Worker they said they received a maintenance request about the door not locking when they came to work three days after the intruder incident. The door was fixed that morning. Later that evening, the door was tested to ensure it was locked.

During interviews with six staff working the night of the intruder incident, they shared that they did not know how the intruder got into the home, but that the door codes on internal and external doors had not been changed since the incident.

An email sent from the RN to the ESS, Administrator and DOC three days after the incident, stated that the door closest to the chapel leading to the patio had been open since the incident and was still not locking at 2100 hours. The Administrator replied to the email saying the ESS was at a conference the last two days so they planned to meet with them that morning about the identified door and all other external doors.

During the inspection all the internal and external door codes were noted to remain the same as they were on the day of the incident.

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

The severity of this issue was determined to be a level 2, potential for actual harm / risk of harm. The scope was a level 3, widespread, as all residents in the home were potentially affected. The home had a level 2 history with one or more unrelated non-compliance in the last 36 months. (155)

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

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 46. Every licensee of a long-term care home shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario. O. Reg. 79/10, s. 46.

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 46.

Specifically the licensee must:
1. Develop and implement a process that identifies who will be responsible for ensuring that every member of the staff who performs duties in the capacity of a registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario.
2. That the licensee ensure that this check is done before the employee performs any of their duties in the capacity of a registered nurse, registered practical nurse or registered nurse in the extended class and that there is documentation kept in the home which identifies who completed the check and the date the check was completed.

Grounds / Motifs :

1. The licensee failed to ensure that every member of the staff who performed duties in the capacity of a registered nurse, registered practical nurse or registered nurse in the extended class had the appropriate current certificate of registration with the College of Nurses of Ontario (CNO).

Registered nurse means a member of the CNO who holds a certificate of registration as a registered nurse under the Nursing Act, 1991.

An anonymous complaint was received by the MOHLTC indicating that the home had staff working in the capacity of registered nurses and/or registered practical nurses without having the proper credentials. In a review of the CNO's document titled "Terms, Conditions and Limitations", a temporary class membership included: temporary members must be monitored and directed by a member in the general or extended class. Temporary members were not permitted to supervise, monitor or direct the practice of another member in any class. Nurses with a temporary registration use the designation registered nurse (temporary). The employer is responsible for having sufficient resources to provide direct or indirect monitoring, consultation and collaboration to the temporary member. The level of supervision required would vary according to the member's expertise and familiarity with the practice setting. The temporary member cannot monitor or direct the practice of another nurse in any category or class. Therefore, it was not appropriate for a temporary member to be solely in-charge or act in a formal leadership role.

a A review of a Registered Nurse's (RN) CNOs profile found on the "find a nurse" website, showed that the RN was classified as a temporary status RN for a six month period.

A review of the RN's letter of hire revealed that the conditions of employment included obtaining a permanent registered nursing license on or before a specified date. Failure to provide proof of completion could result in immediate termination.

The home's employee schedule listing showed that the identified RN worked 15 night shifts in a charge nurse role without another registered nurse in the home while they held a temporary license.

In an interview with the identified RN they said they had worked alone in a charge nurse role under the temporary license.

The DOC explained that the human resource consultant checks references and licenses and they could not recall if the identified RN provided validation of a temporary license. The DOC stated that they did not complete an evaluation of the RN's competencies or post orientation evaluation. The DOC confirmed that the RN worked 15 night shifts while having a temporary license and without a second RN in the building. Under the direction of the Director of Care, the RN worked in the capacity of a registered nurse without having the appropriate current certificate of

registration with the CNO.

b In a review of a RPN's College of Nurses profile, it revealed that the RPN was not registered with the CNO until a specific date.

Review of the employee file for the RPN showed a letter of employment for a casual position of Registered Practical Nurse effective 20 days earlier. In an interview with the RPN they said they were not registered with the CNO prior to being hired and they had discussed this with the DOC and the Human Resources consultant during the interview process. The RPN shared that they booked their orientation shifts based on what they were available to work. The RPN reviewed the staffing schedule for a 19 day period and shared that they completed orientation shifts with another RPN or RN. The RPN stated that the RN or RPN would complete the first medication pass and they would complete the second and subsequent medication passes.

The DOC shared that they were not aware that the RPN was working during orientation without a license.

During an interview with the Human Resources Supervisor they said that it was up to the hiring manager to check the qualifications for the staff that they hire. They agreed that for RNs and RPNs these qualifications would need to be checked by the Director of Care.

Record review showed that the identified RPN administered medications to residents, some that included controlled substances, on four separate dates prior to being licensed with the CNO.

The Licensee failed to ensure that every member of the staff who performs duties in the capacity of a registered nurse, registered practical nurse or registered nurse in the extended class had the appropriate current certificate of registration with the College of Nurses of Ontario.

The severity of harm for this issue was determined to be a level 2, potential risk of harm. The scope was a level 2, pattern, two out of three staff reviewed. The home had a level 2 history, one or more unrelated non-compliance in the last 36 months. (155)

Ontario

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Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 21, 2019(A2)

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency;
(b) test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency;
(c) conduct a planned evacuation at least once every three years; and
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans. O. Reg. 79/10, s. 230 (7).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 230 (7).

Specifically the licensee must:
a) Develop and implement testing / training for the emergency plans related to the loss of essential services, situations involving a missing resident, medical emergencies and violent outburst.
b) Ensure that all staff attend the training and that records are kept in the home of their attendance and the training provided.

Grounds / Motifs :

1. The licensee has failed to test the emergency plans related to the loss of essential services, situations involving a missing resident, medical emergencies and violent outburst on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; test all other emergency plans at least once every three years, including

arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency; conduct a planned evacuation at least once every three years; and keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans.

During interviews with an RN employed by the home for ten years; a RPN employed by the home for nine years; a PSW who worked in the home for more than thirty years; a PSW who worked in the home for thirteen years; and a PSW who worked in the home since February 2018; they all said they had not received training and had not participated in test scenarios / situations for any of the emergency codes other than fire drills. The staff members said they worked the night shift when an intruder was in the home and were not sure what they were supposed to do because they had not received training in relation to this type of emergency situation. One of the PSWs working the night of the intruder incident shared that this was their first shift on their own as they had just completed their orientation. During orientation the different colored codes and what each meant was reviewed, but they did not recall any review of what they were to do if a code was called.

During an interview with the Administrator they shared that they had been employed by the home for almost two years and during that time there had not been any training, testing or annual review of training for any of the emergency codes except for fire drills. The Administrator said that the protocols with community agencies were reviewed and agreements signed last year.

The licensee has failed to test the emergency plans related to the loss of essential services, situations involving a missing resident, medical emergencies and violent outburst on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency; conduct a planned evacuation at least once every three years; and keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans.

The severity of harm for this issue was determined to be a level 2, potential for actual harm. The scope of the issue was a level 3, widespread, as it impacted all staff in the home and all emergency codes except fire. The home had a level 2 history, one

or more unrelated non-compliances in the last 36 months.
(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 25, 2019(A4)

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:

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

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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

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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 12nd day of December, 2019 (A4)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by AMANDA OWEN (738) - (A4)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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