Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 12, 2022	2022_868561_0001 (A2)	002123-22, 002757-22	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Burloak
5959 New Street Burlington ON L7L 6W5

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

Amended by DARIA TRZOS (561) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Completed.

Issued on this 12 th day of May, 2022 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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Burloak
5959 New Street Burlington ON L7L 6W5

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

Amended by DARIA TRZOS (561) - (A2)

Amended 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): February 23, 24, 25, 28, March 1, 2, 3, 4, 7, 9, 10, 2022.

The following Critical Incident (CI) inspections with the following log numbers (#) were completed during this inspection:

log #002757-22, CI #2857-000007-22 - related to unexpected death of a resident,

log #002123-22, CI #2857-000006-22 - related to a medication incident.

A Complaint inspection #2022_868561_0002 was also conducted concurrently with this inspection.

Long Term Care Consultant and Environmental Inspector #120 was being consulted offsite during the course of this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Regional Manager at Revera Inc, Interim Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Services Manager (ESM), Police Constable, Resident Assessment Instrument (RAI) Coordinator, Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

During the course of the inspection, the inspector(s) toured the home, observed provision of care, observed medication administration, and reviewed relevant documentation, policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Hospitalization and Change in Condition
Medication
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.
- **8 WN(s)**
- **4 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

A resident had a plan of care with specific intervention to ensure their safety due to their condition and their behaviours.
An incident involving the resident occurred in the home. The home's investigation notes and interviews with staff during the inspection identified that the plan of care was not followed in relation to their safety.

Staff not following the resident's plan of care may have increased the risk to the resident's safety.

Sources: CI; plan of care; investigation notes; interviews with staff and management. [s. 6. (7)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from neglect.

Section 2 (1) of the Ontario Regulation 79/10, defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

An incident occurred in the home involving a resident. The resident had a plan of care specific to their condition and behaviours which involved an intervention to ensure their safety. The staff in the home failed to follow the resident's plan of care. The staff also failed to follow the home's policy.

The home did not have a process in place for preventive maintenance of a specific door type in the home. A maintenance request was submitted related to this door type not functioning properly. Based on the description on the request, thorough maintenance of the door did not occur.

The inaction of not following the resident's plan of care and policies and procedures, resulted in actual harm.

Sources: CI; investigation notes; maintenance request form; resident's plan of care; Emergency Response policy (March 31, 2021); interviews with staff and management. [s. 19. (1)]

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 / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

During the inspection the inspector observed the specific door type in the home that had recently had the alarm system repaired and had been equipped with a new lock to restrict unsupervised access. This was not completed as part of routine maintenance or the result of the maintenance requisition.

Sources: observations; email communication from KR Communication; investigation notes; interview with staff [s. 9. (1) 1.1.]

2. The licensee has failed to ensure that a written policy that dealt with permitting or restricting unsupervised access to secure outdoor areas was developed, specifically patio areas.

A CI was submitted to the Director related to an unexpected death of a resident. According to registered staff, no one was assigned to check the specific door to determine if they were locked or unlocked to permit or restrict residents from accessing it by residents. The licensee did not assign anyone to check the door alarm for function, which was a back up system to alert staff as to when someone opened the specific door. Staff interviews indicated that there was no written policy that dealt with permitting or restricting unsupervised access to secure areas.

Sources: CI; interviews with staff. [s. 9. (2)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

WN #4: 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 the Medication Administration and the Narcotics and Controlled Drugs Management policies were complied with.

O. Reg 79/10, s. 114 (2) requires licensees to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A) The home's policy titled "Medication Administration", reviewed on March 31, 2021, stated medications will not be left unattended for the resident to self-administer unless the resident performs self-medication administration in adherence to the self medication administration of medication procedure.

During the inspection, medication administration by registered staff was observed at lunch time. Medications from the morning administration schedule were observed left in a resident's room on the side table in a medication cap. Registered staff stated that the resident refused to take the medications initially

and they had left them in the room for the family member to try and administer. The Interim DOC confirmed that the policy was not to leave any medications unattended in the resident's room or for family to administer.

Leaving medications unattended may have posed a risk for misuse, omission and adverse drug reactions for residents.

Sources: observation of medication pass; home's "Medication Administration" policy (March 31, 2021); interviews with staff.

B) The home's policy titled "Narcotics and Controlled Drugs Management", reviewed March 31, 2021, stated under the title 'Drug Counts' that all entries must be made on the Narcotic count sheet at the time the drug is removed from the container/pack for administration.

During the inspection, registered staff was observed administering a narcotic to a resident at lunch time. The registered staff had signed the electronic medication administration record (EMAR) that it was given; however, they had not accounted for it on the Narcotic and Controlled Drug Administration Record (NCDAR). The count was also not documented on the NCDAR at the morning administration. The Interim DOC confirmed that the narcotics needed to be counted and recorded after each administration.

Failing to account for narcotics and controlled substances after each administration may have increased the risk for medication errors.

Sources: observation of medication administration; home's policy "Narcotics and Controlled Drugs Management" (March 31, 2021); Narcotic and Controlled Drug Administration Record; interviews with staff. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policies and procedures are complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, the licensee has failed to ensure that, schedules and procedures were in place for routine, preventive and remedial maintenance.

An incident involving a resident occurred in the home. The licensee was not able to determine how the incident occurred; however, they acknowledged that the alarm system was in disrepair and not functioning. The licensee brought in a company to inspect the door after the incident, and they determined that a part was not functioning.

The ESM stated that there were no written procedures explaining how and when exit doors, door hardware, self-closing devices and associated alarm systems were to be routinely checked for condition and function. There had not been any documented routine or preventive maintenance.

Sources: CI; observations; email confirming the doors were inspected and fixed by KR Communications; interview with ESM and the ED. [s. 90. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that schedules and procedures are in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead - housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated lead for housekeeping, laundry, and maintenance had a minimum of two years experience in a managerial or supervisory capacity.

The licensee had employed a designated lead for housekeeping, laundry and maintenance that did not have a minimum of two years experience in a managerial or supervisory capacity. The ESM confirmed that previous to this position as an ESM, they had not held a position in any supervisory capacity.

Sources: interview with the ESM. [s. 92. (2)]

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 designated lead for housekeeping, laundry, and maintenance has a minimum of two years experience in a managerial or supervisory capacity, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1.The licensee has failed to ensure that the drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Registered staff administered medications to a resident that were prescribed for another resident. The registered staff had not checked the resident using correct identifiers; they had followed the dining room seating plan instead. The resident's health condition deteriorated later that day and they were sent to the hospital for further assessment.

Failing to administer correct medications to the correct resident as prescribed by the physician may have led to the deterioration in the resident's health condition.

Sources: CI; resident's progress notes, investigation notes; interviews with staff. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The quarterly evaluation of the effectiveness of the medication management system in the home was not completed in the last quarter of 2021. The last quarterly evaluation was done in September 2021. The ED confirmed that the interdisciplinary team had not met in the last quarter of 2021 which had been scheduled for December 2021 to evaluate the effectiveness of the medication management system in the home.

Sources: binder with PAC meeting minutes for year 2021; home's Medication Incidents policy (March 31, 2021); interview with ED. [s. 115. (1)]

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Issued on this 12th day of May, 2022 (A2)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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Inspection de soins de longue durée

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DARIA TRZOS (561) - (A2)
Inspection No. / No de l'inspection :	2022_868561_0001 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	002123-22, 002757-22 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 12, 2022 (A2)
Licensee / Titulaire de permis :	AXR Operating (National) LP, by its general partners c/o Revera Long Term Care Inc., 5015 Spectrum W
LTC Home / Foyer de SLD :	Burloak 5959 New Street, Burlington, ON, L7L-6W5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sharon Bailey

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 AXR Operating (National) LP, by its general partners, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

Specifically, the licensee must:

1. Ensure that all residents in the home that require an intervention to ensure their safety, receive this intervention as indicated in their plan of care.

2. The home shall ensure that they complete the following:
   - Identify which residents in the home require an intervention to ensure their safety.
   - Develop an audit to ensure the intervention is provided as indicated in the residents' plans of care. The home shall keep a record of the audit that was completed, the name of the staff completing the audit and corrective actions taken if required. The audit will continue until the compliance due date.

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

Grounds / Motifs :

(A2)
1. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

A resident had a plan of care with specific intervention to ensure their safety due to their condition and their behaviours.

An incident involving the resident occurred in the home. The home's investigation notes and interviews with staff during the inspection identified that the plan of care was not followed in relation to their safety.

Staff not following the resident's plan of care may have increased the risk to the resident's safety.

Sources: CI; plan of care; investigation notes; interviews with staff and management. [s. 6. (7)]

An order was made by taking the following factors into account:
Severity: There was actual harm to the resident, therefore the severity was actual harm.
Scope: The scope was isolated and involved one resident.
Compliance History: One written notification (WN) was issued to the same section on June 22, 2020 (inspection 2020_543561_0005), and one WN was issued on July 15, 2020 (inspection 2020_543561_0006). (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 18, 2022

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 19(1) of the LTCHA.

Specifically, the licensee must ensure the following:

1. All residents are protected from neglect by the licensee or staff in the home.

2. The home will hold an educational session with all PSW and registered staff in the home to review the incident involving the resident and what corrective action was taken to ensure future incidents can be prevented. The session should be an educational session, considered as a case study, and not include any personal health information of staff or the resident.

3. All registered staff shall review the policy for missing residents. The review shall be documented and shall include the content of the review, the name of the staff members who completed the review and the date completed.

Grounds / Motifs :

(A2)

1. The licensee has failed to ensure that a resident was protected from neglect.

Section 2 (1) of the Ontario Regulation 79/10, defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

An incident occurred in the home involving a resident. The resident had a plan of care specific to their condition and behaviours which involved an intervention to ensure their safety. The staff in the home failed to follow the resident's plan of care. The staff also failed to follow the home's policy.

The home did not have a process in place for preventive maintenance of a specific door type in the home. A maintenance request was submitted related to this door type not functioning properly. Based on the description on the request, thorough maintenance of the door did not occur.

The inaction of not following the resident's plan of care and policies and procedures, resulted in actual harm.

Sources: CI; investigation notes; maintenance request form; resident's plan of care; Emergency Response policy (March 31, 2021); interviews with staff and management. [s. 19. (1)]

An order was made by taking the following factors into account:
Severity: There was actual harm to the resident, therefore the severity was actual harm.
Scope: The scope was isolated and involved one resident.
Compliance History: A voluntary plan of correction (VPCs) was issued to the home related to s. 19(1) of the LTCHA, on December 28, 2018 (inspection 2018_689586_0027), a written notification (WN) was issued to the same section on February 3, 2020 (inspection 2020_820130_0004), a compliance order (CO) was issued to the same section on June 22, 2020 (inspection 2020_543561_0005) and later complied on December 15, 2020. (561)

This order must be complied with by / Aug 18, 2022
Vous devez vous conformer à cet ordre d'ici le :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Order / Ordre :

The licensee must be compliant with s. 9 (2) of O. Reg. 79/10.

Specifically, the licensee shall:
1. Develop and implement a written policy that deals with when doors leading to secure areas, must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

The policy must include but is not limited to:
- When doors will be open for use by residents (times of the day and time of of the year).
- If specific home areas can be used by residents while unsupervised or if certain residents will require supervision.
- Which staff members will have access to the door keys, who will be accountable for ensuring the doors are locked when not open for use by residents.
- How often doors will be checked to ensure that they are locked when not open for resident use.

2. All maintenance staff, nursing staff, management staff and any other staff identified as having a role in the above-mentioned policy, shall be trained on the written policy. The home shall keep a record of the attendees and the dates the training was provided.

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

Grounds / Motifs :

1. The licensee has failed to ensure that a written policy that dealt with permitting or restricting unsupervised access to secure outdoor areas was developed.

A CI was submitted to the Director related to an unexpected death of a resident. According to registered staff, no one was assigned to check the specific door to determine if they were locked or unlocked to permit or restrict residents from accessing it by residents. The licensee did not assign anyone to check the door alarm for function, which was a backup system to alert staff as to when someone opened the specific door. Staff interviews indicated that there was no written policy that dealt with permitting or restricting unsupervised access to secure areas.

Sources: CI; interviews with staff. [s. 9. (2)]

An order was made by taking the following factors into account:
Severity: There was actual harm to the resident, therefore the severity was actual harm.
Scope: The scope was isolated as it related to one policy in the home.
Compliance History: several written notifications (WNs) and voluntary plans of correction (VPCs), and one compliance order (CO) were issued to the home related to different sections of the legislation in the past 36 months. (561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 18, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch Ministry of
Long-Term Care
438 University Avenue, 8th Floor Toronto, ON M7A
1N3
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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board 151
Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère des Soins de longue durée
438, rue University, 8e étage Toronto ON
M7A 1N3 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.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3 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 12 th day of May, 2022 (A2)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by DARIA TRZOS (561) - (A2)

Service Area Office / Bureau régional de services :

Hamilton Service Area Office