Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 6, 2016	2016_178624_0008	020560-15	Follow up

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE HALIBURTON
167 PARK STREET P.O. BOX 780 HALIBURTON ON K0M 1S0

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

BAIYE OROCK (624), CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 15, 16, 17, & 18, 2016

During this inspection, several complaints and Critical Incidents were inspected as indicated by the following log numbers :006943-16 & 006746-16(Complaint and Critical Incident re: the same staff to resident allegation of Abuse), 001454-16(Complaint re: staff to resident Abuse), 006750-16 (Critical Incident re: staff to resident abuse) 028948-15 (Complaint re: Care concerns and cleanliness of the Home), & 034279-15 (complaint re: multiple care areas).

During the course of the inspection, the inspector(s) spoke with The Administrator/Director of Care, the Program Manager, Registered Nurses(RNs), Registered Practical Nurses (RPNs), the Physiotherapist, the Dietitian, a Laundry Aide, a Health Care Aide (HCA), and Personal Support Workers (PSWs). Documentation review was also completed for relevant policies and procedures, licensee’s internal investigations related to critical incidents, plan on dealing with emergency nursing staff shortages, registered nursing schedules, staff training records on the homes abuse policy, the complaint binder and clinical health records. Observations were also made of several meal services, provision of resident care by staff and overall staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
9 WN(s)
4 VPC(s)
2 CO(s)
2 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	Legendé 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The Licensee failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

During a specified period, a second follow up inspection was conducted in this 60 bed facility between regarding the legislative requirement to have a registered nurse on duty and present in the home at all times, with legislative exceptions during an emergency.

According to Ontario Regulations 79/10 s. 45 (2), an "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home. O. Reg. 79/10, s. 45 (2).

Exceptions to the requirement to have a registered nurse on duty and present in the home at all times can be found in Ontario Regulations section 45 (1) (1) (ii) b which states that: For homes with a licensed bed capacity of 64 beds or fewer, in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered practical nurse who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone.

A review of the registered nurses'(RN) schedules from October 2015 and March 2016 revealed that there were twelve (12) 8-hour shifts, one (1) 4-hour shift, one (1) 2-hour shift and one (1) 1.5-hour shift were there was no RN on duty and present in the home.

In an interview with the Administrator/DOC she reported that registered practical nurses (RPNs) were used for the above shifts with either herself or a registered nurse being on call. She stated that the Home's RN backup plan is to have registered nurses extend from eight hours to 12 hour shifts if there are sick calls and then if that fails, to have RPNs cover the shift while herself or another RN is put on call.

After reviewing the definition of emergency as specified in the legislature in comparison to the Home's definition of emergency, the Administrator/DOC acknowledged that the identified unplanned absences would not be considered "emergency situations" but "sick calls." As such, there was no RN on duty and present in the home during the shifts

identified above over the six month period.

Additional Required Actions:

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

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 failed to protect two residents from abuse by two staff members.

According to the LTCHA, 2007, section 2.(1) a, emotional abuse is defined as follows: Emotional abuse means "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

On a given date in 2016, the Ministry received two critical incident reports from the Home alleging that two staff members had abused two different residents.

According to the critical incidents, during a resident meeting with the Program Manager on specified date, a resident had reported to the Program Manager that two PSWs had abused another resident while transferring the resident to bed.

During the same resident meeting with the Program Manager on the same specified date, a third resident also stated that the same two PSWs had emotionally abused him/her and two of his/her roommates on two different occasions.

A review of the investigative package notes of both incidents, provided to the inspector by the Administrator/DOC, and in interviews with the Administrator/DOC both during and after the inspection, she confirmed that an investigation of the incidents was not started until three days after the alleged incidents were reported to the Program Manager. Both PSWs continued working with the residents for three and two consecutive shifts and were only suspended from work three days after the Program Manager informed the acting DOC of the abuse allegations. The Program Manager therefore did not immediately report, did not immediately start an investigation and did not immediately put in place measures to protect the residents from further abuse. At the end of the investigation, one of the PSW was suspended for one day and the other resigned.

The Licensee therefore failed to protect residents from abuse as both PSWs continued working for three and two consecutive shifts respectively with both residents despite the Licensee becoming aware of the allegation of staff to resident abuse, by not reporting the allegation of abuse immediately to the Director, by not immediately beginning an investigation into the allegation of abuse and as such not following their own Resident Abuse Prevention Policy.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

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

Specifically failed to comply with the following:

s. 6. (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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 6(7) when the care set out in the plan of care for resident #002 related to mobility/ambulation; transferring and falls were not provided to the resident as specified in the plan.

Regarding resident # 002:

Plan of care for resident #002 for Mobility/ambulation, for the period of October 2015 to

March 2016 outlined a range of interventions to prevent resident from falling.

Review of the progress notes for resident #002 for the period of October 2015 to March 2016 was completed and indicated that during the said period, resident sustained multiple falls as a result of staff not providing the interventions as specified in the resident's plan of care.

Staff therefore failed to provide care as set out in the plan of care for resident #002 related to transferring , mobility and falls during the period of October 2015 to February 2016. [s. 6. (7)]

2. The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the care set out in the plan of care for personal hygiene and responsive behaviours had not been effective.

Resident # 002 was admitted to the home in a specified year with a diagnosis that required one staff to provide cuing and encouragements with personal hygiene care. Over time, the staff realized that the resident had experienced further decline. A number of staff interviewed provided inconsistent responses to the level of care the resident needed. Some staff members blamed the resident’s behavior for the increased level of care while others attributed the increased level of care to the decline in condition.

Reviews of resident’s health records indicated a level of care that was inconsistent and lower than what interviewed staff reported they were providing to the resident. Health records review also indicated no identified strategies that were developed and implemented to deal with the alleged behaviours that staff had suggested was the cause of the increase in the level of care required by the resident.

A review of the clinical health record therefore did not provide evidence that the resident was reassessed when the resident’s level of care and responsive behaviours needs had changed. The plan of care was not revised to reflect the increased level of care required by the resident as documented in the progress notes and as identified by staff during interviews with inspector.

3.The licensee failed to review and revise the plan of care for residents when the care set out in the plan was not effective.

Regarding resident # 002, a review of the resident's plan of care with regards to the specified task in this care area outlined several interventions between two specified dates.

A Review of the health record for the resident over a seven month period directs that the resident requires total assistance with task performance/needs extensive encouragement to perform the said task. During interview with a staff member who had written the above health record, it was clarified to the inspector that the expectations with comments "resident requires total assistance for performing task/needs extensive encouragement to perform the task" was that staff would be providing total assistance in a monitoring capacity during the task and providing physical assistance if the resident was not able to complete the task.

A review of the progress notes for the resident identify on numerous occasions between January and March 2016 where the resident had required total assistance with performing the task.

During Interviews with inspector PSW's #101, #104, #105, RPN # 102 and RN # 115 all indicated that resident requires total assistance with performing the said task.

The plan of care for resident was only changed to reflect the resident's needs related to the said task on March 10, 2016.

Regarding the second resident (resident #001)

Resident # 001 was admitted to the home on a specified date and identified as being at high risk of falls that was related to unsteady gait and visual problems but with no previous history of fall prior to admission.

Review of the clinical health records for resident #001 over a specified one month period was conducted related to falls and included several interventions to prevent falls.

The resident's admission assessment does not indicate a history of falls prior to admission to the home though the Morse falls assessment completed on admission resulted in a High risk score.

Resident #001 is however noted to have had multiple unwitnessed falls over a specified one month period with Post Fall Assessments having been completed for all the falls.

The post fall assessments completed for resident #001 identified several activities of daily living as causes of falls. The plan of care for resident #001 was not reviewed and revised to include different approaches in the revision of the plan of care as identified in the post fall assessments.

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: (1)the plan of care set out clear directions to staff and others who provide direct care to resident # 002 related to assistance with care needs, (2)the care set out in the plan of care
is provided to resident #002 as specified in the plan,specifically related to mobility and ambulation, and (3)residents are reassessed and the plan of care revised when residents' care needs have changed related to falls for resident #001 and ADLs for resident #002, to be implemented voluntarily.

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.As regulated under O.Reg. s 8(1)(b) 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, is complied with.

-The Falls prevention program is an identified program under O. Reg 79/10 s. 48(1)1

The licensee has failed to ensure compliance related to the its "Falls Prevention Program" .

The "Falls Prevention Program" Policy # RESI-10-02-01 dated April 2013 directs;
- a Morse Falls Assessment to be completed within 24 hours of admission, newly triggered RAP and with significant change in status
-Post Falls Assessment to be completed within 24 hours of a fall
-Incident Report to be completed within 24 hours of a fall
-Progress note to be completed each shift updating resident status for 72 hours following a fall
-care plan to be updated within 24 hours of a fall.

Regarding resident #002

Review of the clinical health records "progress notes" for resident #002 was completed and indicated that over a two month period in 2016, resident # 002 had multiple incidents of falls that did not have completed documentation of resident status for 72 hours following each of the fall incidents.

Regarding resident # 001

Review of the clinical health records "progress notes" for resident #001 was also completed and indicated that a specified one month period in 2015, resident # 001 had multiple fall incidents that did not have completed documentation of resident status for 72 hours following each of the fall incidents.

The Licensee therefore failed to comply with its "Falls Prevention Program" Policy # RESI-10-02-0" as specified by the legislature.

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 the Home complies with its Falls Prevention Program by documenting resident's status updates every shift for 72 hours following incidents of falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to immediately investigate a reported allegation of abuse of two residents

According to the LTCHA, 2007 s. 23 (1) (a) (i) (ii), every licensee of a long-term care home shall ensure that every alleged, suspected or witnessed incident of abuse or neglect that the licensee knows of, or that is reported to the licensee, is immediately investigated.

On a given date in 2016, the Ministry received two critical incident reports from the Home alleging that two staff members had abused two different residents.

According to the critical incidents, during a resident meeting with the Program Manager on a specified date, a resident had reported to the Program Manager that two PSWs had abused another resident while transferring the resident to bed.

During the same resident meeting with the Program Manager on the same specified date, a third resident also stated that the same two PSWs had emotionally abused him/her and two of his/her roommates on two different occasions.

A review of the investigative package notes of both incidents and in interviews with the Administrator/DOC both during and after the inspection, she confirmed that an investigation of the incidents was not started until three days after the alleged incidents were reported to the Program Manager. Both PSWs continued working with the residents for three and two consecutive shifts and were suspended from work three days after the Program Manager informed the acting DOC of the abuse allegations. At the end of the investigation, one of the PSW was suspended for one day and the other resigned.

The Licensee therefore failed to immediately investigate an allegation of abuse as specified in the Legislature.

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 alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that an allegation of abuse brought to their attention was immediately reported to the Director.

According to the LTCHA 2007 s. 24 (1) (2), a person who has reasonable grounds to suspect that an Abuse of a resident by anyone or neglect of a resident by the licensee or staff has occurred, or may occur, they shall immediately report the suspicion and the information upon which it is based to the Director.

On a given date in 2016, the Ministry received two critical incident reports from the Home alleging that two staff members had abused two different residents.

According to the critical incidents, during a resident meeting with the Program Manager on specified date, a resident had reported to the Program Manager that two PSWs had abused another resident while transferring the resident to bed.

During the same resident meeting with the Program Manager on the same specified date, a third resident also stated that the same two PSWs had emotionally abused him/her and two of his/her roommates on two different occasions.

According to the submited Critical Incident Reports, both allegations of abuse were not reported to the Director until three days after the residents spoke to the Program Manager.

In an interview with the Program Manager and the Administrator/DOC, both stated that the expectation is to immediately report any allegation of abuse to the Director. Both acknowledged that the home failed to immediately report the allegation of abuse for both incidents to the Director. The Program Manager reported that she was not aware of the fact that she can and should have reported directly to the Ministry. [s. 24. (1)]

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 a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff has occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to comply with its Resident Abuse Policy No: RESI-02-06-01

According to the Resident Abuse Policy No: RESI-02-06-01 dated October 6, 2011, Under reporting an allegation,it states: "All employees and volunteers - Immediately report any suspected or witnessed acts of Abuse to the Administrator, Director of Care, or their designate"

"Administrator or Desinate - During an investigation, responsible for ensuring all reports of Abuse are made immediately to authorities (i.e. police, professional regulatory body) Note: In Ontario, the home must notify the Ministry of Health and Long-Term Care of all investigated reports of Abuse."

According to the same policy emotional abuse is defined as "any action of behaviour towards a resident that includes, but not limited to: verbal threats, verbal insults, intimidation, humiliation, patronizing, and actions and/or behaviours by a resident that makes another resident fearful."

On a given date in 2016, the Ministry received two critical incident reports from the Home alleging that two staff members had abused two different residents.

According to the critical incidents, during a resident meeting with the Program Manager on specified date, a resident had reported to the Program Manager that two PSWs had abused another resident while transferring the resident to bed.

During the same resident meeting with the Program Manager on the same specified date, a third resident also stated that the same two PSWs had emotionally abused him/her and two of his/her roommates on two different occasions.

Both allegations were not reported to the Acting DOC and the Ministry of Health and Long-Term Care until three days later. The Program Manager therefore failed to comply with the Licensee's policy to immediately report any allegation of abuse to the required authorities. [s. 20. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to immediately notify the substitute decision maker upon become aware of an allegation of abuse of resident # 004.

According to Ontario Regulations79/10 s. 97(1) (a), every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

On a given date in 2016, the Ministry received a critical incident reports from the Home alleging that two staff members had abused two a resident.

According to the critical incident report, during a resident meeting with the Program Manager on specified date, a resident had reported to the Program Manager that two PSWs had abused another resident while transferring the resident to bed.

A review of the health records for the allegedly abused resident indicated that the substitute decision maker of resident was not notified of the incident until three days after the incident was reported to the Program Manager.

In an interview with the Administrator/DOC, she acknowledged that the reviewed health records were correct and that the SDM was not notified immediately. [s. 97. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to include the names of two staff members who were present at or discovered an incident of abuse.

According to Ontario Regulations 79/10 s. 104 (1) (2), in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include in writing, the names of any staff members or other persons who were present at or discovered an alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report.

On a specified date, the Licensee submitted two Critical Incident Reports of alleged abuse of two residents by two staff members. A review of the investigative package notes revealed the names of both staff members who allegedly abused the residents. However, the licensee, in the written report submitted to the Ministry, failed to include the names of the two staff members as required in the legislation.

Issued on this 13th day of May, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BAIYE OROCK (624), CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2016_178624_0008
Log No. / Registre no:	020560-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 6, 2016
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE HALIBURTON 167 PARK STREET, P.O. BOX 780, HALIBURTON, ON, K0M-1S0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JANE ROSENBERG

To EXTENDICARE (CANADA) INC., 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) (b)

Linked to Existing Order / Lien vers ordre existant: 2015_365194_0018, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall prepare and implement a system to address unplanned registered nurses' absences and ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Grounds / Motifs :

1. The Licensee failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

During a specified period, a second follow up inspection was conducted in this 60 bed facility regarding the legislative requirement to have a registered nurse on duty and present in the home at all times, with legislative exceptions during an emergency.

According to Ontario Regulations 79/10 s. 45 (2), an "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home. O. Reg. 79/10, s. 45 (2).

Exceptions to the requirement to have a registered nurse on duty and present in the home at all times can be found in Ontario Regulations section 45 (1) (1) (ii) b

which states that: For homes with a licensed bed capacity of 64 beds or fewer, in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered practical nurse who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone.

A review of the registered nurses'(RN) schedules from October 2015 and March 2016 revealed that there were twelve (12) 8-hour shifts, one (1) 4-hour shift, one (1) 2-hour shift and one (1) 1.5-hour shift were there was no RN on duty and present in the home.

In an interview with the Administrator/DOC she reported that registered practical nurses (RPNs) were used for the above shifts with either herself or a registered nurse being on call. She stated that the Home's RN backup plan is to have registered nurses extend from eight hours to 12 hour shifts if there are sick calls and then if that fails, to have RPNs cover the shift while herself or another RN is put on call.

After reviewing the definition of emergency as specified in the legislature in comparison to the Home's definition of emergency, the Administrator/DOC acknowledged that the identified unplanned absences would not be considered "emergency situations" but "sick calls." As such, there was no RN on duty and present in the home during the shifts identified above over the six month period. (624)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 shall ensure that every time a suspected, reported or witnessed incident and/or allegation of abuse of a resident by a staff member is brought to the Licensee's attention, the Licensee shall ensure that:
1.) Immediate action is taken to protect the concerned resident from any further abuse by the suspected staff member,
2.) An investigation into the abuse allegation is commenced immediately,
3.) The allegation of abuse is reported to the Director immediately, and
4.) The Home complies with all applicable sections of its Abuse Policy.

Grounds / Motifs :

1. The Licensee failed to protect two residents from abuse by two staff members.

According to the LTCHA, 2007, section 2.(1) a, emotional abuse is defined as follows:
Emotional abuse means "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

On a given date in 2016, the Ministry received two critical incident reports from the Home alleging that two staff members had abused two different residents.

According to the critical incidents, during a resident meeting with the Program Manager on specified date, a resident had reported to the Program Manager that two PSWs had abused another resident while transferring the resident to bed.

During the same resident meeting with the Program Manager on the same specified date, a third resident also stated that the same two PSWs had emotionally abused him/her and two of his/her roommates on two different occasions.

A review of the investigative package notes of both incidents, provided to the inspector by the Administrator/DOC, and in interviews with the Administrator/DOC both during and after the inspection, she confirmed that an investigation of the incidents was not started until three days after the alleged incidents were reported to the Program Manager. Both PSWs continued working with the residents for three and two consecutive shifts and were only suspended from work three days after the Program Manager informed the acting DOC of the abuse allegations. The Program Manager therefore did not immediately report, did not immediately start an investigation and did not immediately put in place measures to protect the residents from further abuse. At the end of the investigation, one of the PSW was suspended for one day and the other resigned.

The Licensee therefore failed to protect residents from abuse as both PSWs continued working for three and two consecutive shifts respectively with both residents despite the Licensee becoming aware of the allegation of staff to resident abuse, by not reporting the allegation of abuse immediately to the Director, by not immediately beginning an investigation into the allegation of abuse and as such not following their own Resident Abuse Prevention Policy.

Also, as per a previous order that was issued and complied less than 12 months ago, the Licensee has similar history related to not protecting residents from abuse, not immediately notifying the Director of allegations of abuse, not immediately investigating (624)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

À l'attention du registraire Commission d'appel et de révision des services de santé 151, rue Bloor Ouest, 9e étage Toronto (Ontario) M5S 2T5	Directeur a/s Coordinateur des appels Inspection de sions de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Ontario, ON M5S-2B1 Fax: 416-327-7603

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

Issued on this 6th day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Baiye Orock

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