Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 7, 2019	2019_723606_0006	031949-18, 033286-18, 002748-19, 006071-19, 007255-19	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Halton Hills
9 Lindsay Court Georgetown ON L7G 6G9

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

JANET GROUX (606)

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): March 25, 26, 27, 28, April 2, 3, 4, 5, 8, and 12, 2019.

The following complaints were inspected:
Complaints regarding staffing issues affecting resident care; a complaint regarding injuries to a resident of unknown cause and the use of chemical restraints; and a complaint regarding an allegation of resident to resident abuse resulting in a transfer to the hospital.

The following Critical Incident System intakes were inspected during this Complaint Inspection:
Log #031949-18 regarding an allegation of staff to resident physical abuse.
PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 19.(1) was identified in this inspection and has been issued in Inspection Report # 2019_723606_0007 which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care (DOC), the Behavioural Support of Ontario (BSO) Nurse, the Minimum Data Set (MDS) and Point Click Care (PCC) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Director of Care Clerk, Clinical Consultant, Sheridan College Students, Sheridan College, Sheridan College Clinical Teacher, Georgetown Hospital Physician, A-Supreme Nursing Agency RNs, Substitute Decision Makers (SDM) and residents.

During the course of the inspection, the inspector(s) conducted observations of resident care, residents and staff interactions, completed interviews and reviewed residents' clinical records such as progress notes, assessments, physician orders, written care plans, reviewed relevant home's investigation records, home's meeting minutes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

9 WN(s)
3 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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Two complaints submitted to the Ministry of Health and Long Term Care (MOHLTC) reported allegations of resident to resident abuse.

The first complaint reported that resident #006 had wandered into resident #004's room and an altercation between the two residents resulted in resident #004 to fall.The second complaint reported that resident #006 had wandered into resident #020's room and an altercation between the two residents resulted in resident #020 to fall and sustain injuries.

Resident #006's progress notes were reviewed and showed documentation of the resident wandering into other residents' rooms and rummaging through their personal belongings.There were a number of entries in the progress notes that stated resident #006 had wandered into other residents' rooms.

The progress notes identified a number of incidents where resident #006 was physically aggressive towards another individual. Two of the incidents involved residents #004 and #020 as mentioned above and another incident that involved a staff member who sustained injuries from an incident with resident #006.

Documentation stated that resident #006 repeatedly wandered into resident #004 and #020's rooms prior to and after the incidents mentioned above. Several documentation in the progress notes identified a number of dates and times that resident #006 wandered in resident #004 and #020's rooms. There was no documentation to show that there were additions or changes to the current interventions put in place to prevent resident #006 from wandering again into room resident #020's room.

Review of resident #006's plan of care identified the resident to have a number of identified behaviours. The plan of care identified that the resident's behaviours increased during an identified time.The plan of care directed the staff to implement a number of interventions and included engaging the resident in a listed number of activities and/or

use other redirection tactics. If these interventions were ineffective, the registered staff were to be informed and they were directed to assess the resident for identified symptoms and administer medication as required. If behaviours continued to be unmanaged or worsen, the resident would be referred to an external service for additional support.

Resident #020 was admitted to the home on an identified date and documentation indicated that resident #006 was observed to wander into resident #020’s room prior to the incident and continued to wander in resident #020's after the incident. The progress notes stated resident #006 was redirected each time.
Further review stated a number of entries that identified other residents' rooms that resident #006 wandered in. The progress notes did not indicate that any follow up was initiated to manage resident #006 from wandering back into these rooms and the current interventions in place were not effective.

The progress notes indicated that the home identified that resident #006's wandering behaviours increased during an identified time. Documentation showed that the resident’s wandering behaviours were observed during identified times with a number of episodes in the progress notes.

Resident #006’s clinical records stated that resident #006 was referred to the Behavioural Support of Ontario (BSO) team and was on frequent monitoring for their identified behaviours.

Personal Support Worker (PSW) #137, #112 and RPN #139 stated that resident #006 frequently wandered in and out of other residents’ rooms and was managed with activities, redirection and medications. They stated that these interventions were not always effective. The BSO lead stated that the home had interventions in place to manage resident #006 and initiated additional interventions such as the one to one staff and referrals to external behavioural supports but not until after the incident with resident #020.

The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #006 and other residents by identifying and implementing interventions to manage resident #006’s wandering behaviours. [s. 54. (b)]

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 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 has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

A complaint submitted to the MOHLTC reported allegations of registered nurses (RN) staffing shortages.

The home's daily staffing complement for the nursing department was reviewed and showed documentation that the home had scheduled RNs from two nursing agencies to be In charge of the building. Further review stated that there was no RN on duty and present in the building on a number of identified dates.

The Director of Care Clerk who was responsible for staffing the nursing department acknowledged that the home had scheduled agency RNs to be in charge of the building. They confirmed that the home did not have a RN on duty and present in the home as mentioned above.

The licensee has 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 was on duty and present in the home at all times. [s. 8. (3)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 has failed to ensure that the person who had reasonable grounds to suspect that abuse and/or neglect of a resident by anyone was immediately reported to the Director.

Written complaints submitted to the home regarding allegations of staff to resident abuse and care concerns were reviewed.

a) Two written concerns regarding an incident on an identified date were submitted to the home that reported allegations of staff to resident abuse towards resident #010 causing injury.

b) A concern was submitted to the MOHLTC on an identified date and reported an allegation of a staff to resident abuse towards resident #003. The same concern was shared with the Inspector by an individual and stated they submitted a written letter to the home on an identified date.

c) A concern was shared with the Inspector by an individual that resident #008 was not provided competent care when the resident had a change in their condition. They stated that they submitted a written letter to the home.

The Administrator, and the Director of Care (DOC) acknowledged that the incidents identified above were not reported to the Director. [s. 24. (1)]

Additional Required Actions:

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

WN #4: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care provided to the resident was documented.

A concern was shared with the Inspector that resident #008 had a change in their condition and was not provided the appropriate care.

Resident #008's clinical records did not show any documentation regarding the assessment and care provided to resident #008 on an identified date.

PSW #102 stated that they were concerned with resident #008's well being when they observed the resident to have a change in their condition. They stated that they immediately brought the resident to the nursing station for RN #116 to assess.

RN #116 stated that they assessed resident #008 and that the information obtained from their assessment was within the resident's baseline. They stated that resident #008 was offered to go to the hospital but declined. RN #116 stated that they monitored resident #008 for the rest of the shift and did not see any further changes to their condition as reported by PSW #102. RN #116 stated that they did not document their assessment as required.

The licensee has failed to ensure that the care provided to resident #008 was documented. [s. 6. (9) 1.]

2. The licensee has failed to ensure that the resident's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change.

A written complaint received by the home reported observations of resident #002's skin impairments of unknown cause to areas of their body.

Review of resident #002's progress notes identified a number of skin integrity impairments.

RPN #106 stated that resident #002's skin integrity impairments may have been sustained during a responsive behaviour episode when the resident became physically aggressive. They stated that a number of identified interventions were to be added to their plan of care to prevent further incidents of skin integrity impairments.

Resident #002's plan of care did not show evidence that the care plan was updated to reflect interventions to prevent the resident from further skin integrity impairments.

The licensee has failed to ensure that resident #002's plan of care in relation to skin integrity was reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care provided to the resident was documented; and to ensure that the resident's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #5: 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 has failed to ensure the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

a) A concern was submitted to the MOHLTC regarding an allegation of staff to resident abuse.

The home's policy stated that anyone who witnesses or suspects abuse or neglect of a resident by another resident, staff, or other person, must report the incident. The report may be made to the home and/or external authorities. At minimum any individual who witnesses or suspects abuse or neglect of a resident must notify management immediately. Staff must complete an internal incident report and notify their supervisor (or during after hours the nurse on site).

The home's investigation documents for resident #003 stated that the date the complaint was received on an identified date the day after the incident occurred.

PSW #102 stated that they witnessed PSW #103 abuse resident #003 and but waited until the day after the incident to report it.

The Administrator acknowledged that PSW #102 did not follow the home's policy in relation to immediate reporting.

b) A concern submitted to the MOHLTC reported an allegation that a resident sustained injuries due to a staff member mishandling of the resident.

RPN #100 told the Inspector that they witnessed resident #010 sustain an injury due to the action of PSW #103 but RPN #100 said they did not report the incident until the following day.

The Acting DOC acknowledged that the incident was not reported immediately as per the home's prevention of abuse and neglect policy. [s. 20. (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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, 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 ensure that a written complaint concerning the care of a resident was immediately forwarded to the Director.

Complaints were brought to the attention of the Inspector during the home's inspection regarding concerns with resident care and allegations of resident abuse that involved resident #003, #010, #008.

The home's investigation documents were reviewed and did not show evidence that the home submitted a copy of the written complaints to the Director.

The Administrator acknowledged that the home did not submit the above mentioned written complaint letters to the Director. [s. 22. (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 written complaint concerning the care of a resident is immediately forwarded to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's personal health information within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential in accordance with that Act.

The Inspector observed resident #005's medical diagnosis and treatment posted on a sign on the resident's door that was visible to others. PSWs #103, #104, and RPN #105 were with the Inspector during the observation and acknowledged that posting resident #005's medical diagnosis and treatment information was considered a resident's health information and was confidential.

The licensee failed to ensure resident #005's personal health information was kept confidential. [s. 3. (1) 11. iv.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

Findings/Faits saillants :

1. The licensee failed to ensure that locks on bedrooms and washrooms were designed and maintained so they could be readily released from the outside in an emergency.

A complaint was submitted to the MOHLTC which reported resident to resident abuse. On an identified date, resident #006 entered resident #020's room which resulted in an altercation and caused resident #020 to fall and sustain injuries.

On an identified date, the Inspector observed that the door to enter resident #020's room was equipped with identified locks that were either inaccessible or prevented entry to their room during an emergency.

Resident #020 stated that the locks were installed to prevent resident #006 from entering their room again.

PSW #112 stated locks were installed on resident #020's room doors to keep resident #006 from wandering in their room. The PSW shared with the Inspector that they had difficulty unlocking the doors.

The licensee failed to ensure that the locks on resident #020's bedroom and washroom doors were designed and maintained so they could be readily released from the outside in an emergency. [s. 9. (1) 3.]

WN #9: 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 an investigation was commenced immediately in response to a complaint of alleged harm or risk of harm to a resident.

A written concern was received by the home on an identified date regarding concerns about the care provided to resident #008.

Review of the home's investigation documents stated the investigation was initiated on an identified date and the Administrator acknowledged that the investigation was not started immediately.

The licensee has failed to ensure that the concerns regarding the care provided to resident #008 were not investigated immediately. [s. 101. (1) 1.]

Issued on this 11th day of June, 2019

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

Ministère 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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANET GROUX (606)
Inspection No. / No de l'inspection :	2019_723606_0006
Log No. / No de registre :	031949-18, 033286-18, 002748-19, 006071-19, 007255-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 7, 2019
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Halton Hills 9 Lindsay Court, Georgetown, ON, L7G-6G9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Emily Bosma

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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

Ministère 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

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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee must be compliant with s. 54 O. Reg 79/10.

Specifically, the licensee must ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents #006, #004 and #020 and any other resident by identifying and implementing interventions.

Grounds / Motifs :

1. The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Two complaints submitted to the Ministry of Health and Long Term Care (MOHLTC) reported allegations of resident to resident abuse.

The first complaint reported that resident #006 had wandered into resident #004's room and an altercation between the two residents resulted in resident #004 to fall.The second complaint reported that resident #006 had wandered into resident #020's room and an altercation between the two residents resulted in resident #020 to fall and sustain injuries.

Resident #006's progress notes were reviewed and showed documentation of the resident wandering into other residents' rooms and rummaging through their

personal belongings.There were a number of entries in the progress notes that stated resident #006 had wandered into other residents' rooms.

The progress notes identified a number of incidents where resident #006 was physically aggressive towards another individual. Two of the incidents involved residents #004 and #020 as mentioned above and another incident that involved a staff member who sustained injuries from an incident with resident #006.

Documentation stated that resident #006 repeatedly wandered into resident #004 and #020's rooms prior to and after the incidents mentioned above. Several documentation in the progress notes identified a number of dates and times that resident #006 wandered in resident #004 and #020's rooms. There was no documentation to show that there were additions or changes to the current interventions put in place to prevent resident #006 from wandering again into room resident #020's room.

Review of resident #006's plan of care identified the resident to have a number of identified behaviours. The plan of care identified that the resident's behaviours increased during an identified time.The plan of care directed the staff to implement a number of interventions and included engaging the resident in a listed number of activities and/or use other redirection tactics. If these interventions were ineffective, the registered staff were to be informed and they were directed to assess the resident for identified symptoms and administer medication as required. If behaviours continued to be unmanaged or worsen, the resident would be referred to an external service for additional support.

Resident #020 was admitted to the home on an identified date and documentation indicated that resident #006 was observed to wander into resident #020's room prior to the incident and continued to wander in resident #020's after the incident. The progress notes stated resident #006 was redirected each time.

Further review stated a number of entries that identified other residents' rooms that resident #006 wandered in. The progress notes did not indicate that any follow up was initiated to manage resident #006 from wandering back into these rooms and the current interventions in place were not effective.

The progress notes indicated that the home identified that resident #006's wandering behaviours increased during an identified time. Documentation showed that the resident's wandering behaviours were observed during identified times with a number of episodes in the progress notes.

Resident #006's clinical records stated that resident #006 was referred to the Behavioural Support of Ontario (BSO) team and was on frequent monitoring for their identified behaviours.

Personal Support Worker (PSW) #137, #112 and RPN #139 stated that resident #006 frequently wandered in and out of other residents' rooms and was managed with activities, redirection and medications. They stated that these interventions were not always effective. The BSO lead stated that the home had interventions in place to manage resident #006 and initiated additional interventions such as the one to one staff and referrals to external behavioural supports but not until after the incident with resident #020.

The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #006 and other residents by identifying and implementing interventions to manage resident #006's wandering behaviours. [s. 54. (b)]

A compliance order (CO) was issued based on the following:
The severity of this issue was determined to be a level 2 as there was minimal harm or minimal risk.
The scope of the issue was a level 2, patterned and affected 2/3 of the residents inspected.
The home had a level 2 compliance history as they had a previous non-compliance to a different subsection of s. 54 of the Ontario Regulation (O. Reg) 79/10 that included a written Notification (WN) and Voluntary Plan of Correction (VPC) issued during inspection # 2018_728696_0008 dated September 18, 2018, for s. 54 (a).

(606)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 09, 2019

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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. 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 must be compliant with s. 8.(3) of the Long Term Care Homes Act (LTCHA).

Specifically, the licensee 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.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

A complaint submitted to the MOHLTC reported allegations of registered nurses (RN) staffing shortages.

The home's daily staffing complement for the nursing department was reviewed and showed documentation that the home had scheduled RNs from two nursing agencies to be In charge of the building. Further review stated that there was no RN on duty and present in the building on a number of identified dates.

The Director of Care Clerk who was responsible for staffing the nursing department acknowledged that the home had scheduled agency RNs to be in charge of the building. They confirmed that the home did not have a RN on duty and present in the home as mentioned above.

A compliance order (CO) was issued based on the following:
The severity of this issue was determined to be a level 1 as there was minimal harm or minimal risk.
The scope of the issue was a level 3, wide spread as more than 67% of the resident population had the potential to be affected by the NC.
The home had a level 2 compliance history as they had one or more non-compliance in a different section/subsection.
(606)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 09, 2019

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Order / Ordre :

The licensee must be compliant with s. 24. of the Long Term Care Homes Act (LTCHA).

Specifically, the licensee must ensure that the person who has reasonable grounds to suspect that abuse by anyone and/or neglect by the Licensee or staff is immediately reported to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse by anyone and/or neglect by the Licensee or staff by anyone was immediately reported to the Director.

Written complaints submitted to the home regarding allegations of staff to resident abuse and care concerns were reviewed.

a) Two written concerns regarding an incident on an identified date were submitted to the home that reported allegations of staff to resident abuse towards resident #010 causing injury.

b) A concern was submitted to the MOHLTC on an identified date and reported an allegation of a staff to resident abuse towards resident #003. The same concern was shared with the Inspector by an individual and stated they submitted a written letter to the home on an identified date.

c) A concern was shared with the Inspector by an individual that resident #008 was not provided competent care when the resident had a change in their condition. They stated that they submitted a written letter to the home.

The Administrator, and the Director of Care (DOC) acknowledged that the incidents identified above were not reported to the Director. [s. 24. (1)]

A CO was issued based on the following:
The severity of this issue was determined to be a level 1 as there was minimal harm or minimal risk.
The scope of the issue was a level 3, widespread as more than 67% of the residents in the home had the potential to be affected.
The home had a level 3 compliance history that included a written Notification (WN) during inspection # 2018_539120_0015 dated June 8, 2018, for s. 24(1).
(606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 09, 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

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:

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 7th day of June, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Janet Groux

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