Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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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
Aug 3, 2021	2021_822613_0017	009362-21, 009896-21, 010069-21	Critical Incident System

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 Van Daele
39 Van Daele Street Sault Ste. Marie ON P6B 4V3

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

LISA MOORE (613)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 28-30 and July 2, 5-9, 2021.

The following intakes were inspected during this Inspection:

Two Critical Incident (CI) reports that were submitted to the Director regarding staff towards resident abuse;

One CI report regarding a resident fall resulting with an injury and transfer to the hospital and unexpected death.

A concurrent Complaint Inspection #2021_822613_0016 was also conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Service Manager (ESM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping and screening staff and residents.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, investigation files, personal files and reviewed relevant policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Sexual abuse is defined within Ontario Regulation 79/10 as, any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

A Critical Incident System (CIS) report was submitted to the Director, identifying allegations of abuse towards a resident by a PSW.

A PSW observed another PSW inappropriately touching a resident during care.

The home's internal investigation substantiated the abuse and a PSW was terminated from their employment.

A PSW had provided improper care to a resident by confirming they had touched them inappropriately.

2. A CIS report was submitted to the Director, identifying allegations of abuse towards another resident by a PSW.

A resident reported to a staff member that a PSW had inappropriately touched them and that they had reported to a nurse that they did not want the PSW providing further care to them.

The home's internal investigation substantiated the abuse and a PSW was terminated from their employment.

A PSW verified they had inappropriately touched a resident during care without consent.

There was a pattern of inaction on the part of the licensee to ensure that residents were protected from abuse and neglect.

Sources: CIS reports; Zero Tolerance of Resident Abuse and Neglect Program, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy; Commitment to Resident-Centred Care and Resident Rights policy; the home's investigation file; resident's health care record; PSW's termination letter; and interviews with DOC and other staff. [s. 19. (1)]

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. 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 that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

See WN #1 for details.

The Inspector reviewed the home's Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy and Zero Tolerance of Abuse and Neglect Program.

A) The home's policy identified staff were to immediately respond to any form of abuse;

intervene and ensure the safety of the resident. A PSW who had witnessed the abuse to a resident by another PSW did not stop the other PSW's actions, nor did the PSW ask the other PSW to leave a resident's room, while they completed their care. Both PSWs proceeded to complete care rounds for the remainder of the residents on the unit.

B) The home's policy identified that anyone who witnesses, or suspects abuse of a resident must report the incident immediately to the Senior Supervisor/Manger. After witnessing the abuse incident involving a resident, a PSW did not report the witnessed abuse immediately.

C) After the abuse incident involving another resident, a PSW did not report to a RN Charge Nurse, when a resident stated to them that they were uncomfortable by their actions and they did not want a PSW providing further care for them. Furthermore, the staff member that a resident had reported the incident to had not taken appropriate action to protect the resident, nor had the other co-workers that continued to answer the resident's call bells and provide the resident care, after the resident had stated they no longer wanted a PSW to provide their care.

D) The home's policy identified that staff members were to ensure the safety of the abused resident through completion of a full assessment. A RN Charge Nurse did not complete a full assessment on a resident after being notified of the abuse. An assessment was not completed until several hours after the abuse had occurred and was not completed until they were directed by the DOC.

The failure of staff not following their Zero Tolerance of Abuse and Neglect policy put residents at risk of harm and caused actual harm to residents.

Sources: CIS reports; Zero Tolerance of Resident Abuse and Neglect Program, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy; Commitment to Resident-Centred Care and Resident Rights policy; the home's investigation file; resident's health care record; and interviews with the DOC, PSW and RN Charge Nurse . [s. 20. (1)]

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for a resident that set out clear direction to staff and others who provide direct care to the resident.

A resident’s plan of care identified two different interventions for their continence care.

PSW's stated that the plan of care was unclear and should be updated.

There was a risk that the wrong care would be provided to a resident as their plan of care was unclear and provided two different interventions for their continence care.

Sources: Observations of a resident; review of their care plan; and interviews with PSW's. [s. 6. (1) (c)]

2. The licensee has failed to ensure that a PSW provided care to a resident as set out in the resident’s plan of care.

A PSW provided care to a resident alone when their plan of care identified in different areas that specific staff were not to provide care to the resident.

A specific PSW had awoken a resident to complete their care even though their care plan intervention identified different direction. The PSW had not reviewed the resident’s plan of care and they were unaware of this intervention. A Charge Nurse was unaware that the resident’s plan of care identified that specific staff were not to provide their care.

The failure of PSW and RN Charge Nurse being aware of a resident's plan of care interventions resulted in care not being provided as set out in the plan of care and caused harm to the resident.

Sources: CIS reports; Zero Tolerance of Resident Abuse and Neglect Program, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy; Commitment to Resident-Centred Care and Resident Rights policy; the home's investigation file; resident's plan of care; PSW's termination letter; and interviews with DOC and RN Charge Nurse. [s. 6. (7)]

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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 79/10, s. 24 (6).

Findings/Faits saillants :

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

A resident's progress notes identified that they were at risk for falls and required safety devices to be applied to their mobility aid and bed related to prior self transferring and falls. Two safety devices were brought to the unit by an Activity Aide and provided to a RPN. The progress notes identified that two RPN's were aware that the safety devices were received on the unit and that a resident's care plan had been updated with the safety intervention; however, they failed to apply the safety device to the resident's bed, while they were sleeping.

Approximately one hour after the safety devices were received on the unit, a resident suffered an injury because of a fall, resulting in a transfer to the hospital. Staff was aware a resident was at risk for falls and failed to apply the safety device to the resident's bed.

Both the DOC and ADOC stated that the staff should have applied the safety device to the resident's bed immediately after it was received as they were aware of the resident's risk for falls.

Sources: CIS report; Resident's progress notes and previous LTCH health care records, care plan; Investigation file and interviews with DOC, ADOC and other staff. [s. 24. (6)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the air temperatures were measured and documented in writing, at a minimum in two resident bedrooms in different parts of the home, one resident common area on every floor of the home and every designated cooling area.

According to the amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007, related to enhanced cooling requirements, which was sent April 1, 2021, with an effective date of May 15, 2021, Long-Term Care Home's were required to measure and document the air temperature, at a minimum, in certain specified areas in the Long Term Care home at specified intervals.

The DOC identified that air temperatures were monitored daily in different locations in the home, which included a resident room, a common area or cooling area, but each area did not always have the air temperature monitored daily. The DOC verified that the registered nursing staff did not obtain temperature readings in all of the required areas outlined in the Ontario Regulation 79/10.

Sources: April 1, 2021 memo regarding amendments to Ontario Regulation 79/10 related to enhanced cooling requirements; Indoor Temperature Tracking Record, Humidex Tracking Record and Daily Log For Week Ending; interviews with the Director and Assistant Director of Care and registered staff. [s. 21. (2)]

2. The licensee has failed to ensure that the temperature required to be measured under subsection (2) was documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

A review of the licensee's documents titled, "Indoor Temperature Tracking Record," "Humidex tracking Record," and "Daily Log for Week Ending" failed to demonstrate that air temperatures were being taken three times daily. The DOC verified that the registered staff did not obtain temperature readings at the required specified times as outlined in the Ontario Regulation 79/10.

Sources: April 1, 2021 memo regarding amendments to Ontario Regulation 79/10 related to enhanced cooling requirements; Indoor Temperature Tracking Record, Humidex Tracking Record and Daily Log For Week Ending; interviews with the Director and Assistant Director of Care and registered staff. [s. 21. (3)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any 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. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director with respect to the incident that caused an injury to a resident and their unexpected death, that a description of the individuals involved in the incident, including the names of any staff members or other persons who were present or discovered the incident were included.

A Critical Incident Systems (CIS) report was submitted to the Director, identifying that a resident had a fall resulting in an injury and transfer to the hospital. Another CIS report submitted to the Director, identified the resident had passed away.

The PSWs names were not identified on the submitted CIS reports, despite being present at the time of the incident's occurrence.

Sources: CIS reports; and an interview with the ADOC who submitted both CIS reports. [s. 107. (4) 2. ii.]

Issued on this 11th day of August, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA MOORE (613)
Inspection No. / No de l'inspection :	2021_822613_0017
Log No. / No de registre :	009362-21, 009896-21, 010069-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 3, 2021
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Van Daele 39 Van Daele Street, Sault Ste. Marie, ON, P6B-4V3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mary Deschene

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 19. (1) of the LTCH Act, 2007.

Specifically, the licensee must ensure that residents are protected from abuse by anyone.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Sexual abuse is defined within Ontario Regulation 79/10 as, any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

A Critical Incident System (CIS) report was submitted to the Director, identifying allegations of abuse towards a resident by a PSW.

A PSW observed another PSW inappropriately touching a resident during care.

The home's internal investigation substantiated the abuse and a PSW was terminated from their employment.

A PSW had provided improper care to a resident by confirming they had touched them inappropriately.

2. A CIS report was submitted to the Director, identifying allegations of abuse towards another resident by a PSW.

A resident reported to a staff member that a PSW had inappropriately touched them and that they had reported to a nurse that they did not want the PSW providing further care to them.

The home's internal investigation substantiated the abuse and a PSW was terminated from their employment.

A PSW verified they had inappropriately touched a resident during care without consent.

There was a pattern of inaction on the part of the licensee to ensure that residents were protected from abuse and neglect.

Sources: CIS reports; Zero Tolerance of Resident Abuse and Neglect Program, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy; Commitment to Resident-Centred Care and Resident Rights policy; the home's investigation file; resident's health care record; PSW's termination letter; and interviews with DOC and other staff.

An order was made by taking the following factors into account:

Severity: There was actual harm to two residents, with findings of two distinct abuse incidents by a PSW.

Scope: The scope of non-compliance was a pattern involving two residents.

Compliance History: There was no previous history in the past 36 months.
(613)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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).

Order / Ordre :

The licensee must be compliant with s. 20. (1) of the LTCH Act, 2007.

Specifically the licensee must ensure:

A) Refresher training is provided to a PSW and all staff that cared for a resident during specified dates, on immediately responding to any form of abuse, intervening and ensuring the safety of the residents and reporting any form of abuse immediately to their Senior Supervisor/Manager;

B) Refresher training is provided to a RN Charge Nurse on ensuring the safety of abused residents through a completion and documentation of a full assessment immediately after becoming aware of any form of abuse.

C) Keep a record of the training, date occurred, who provided the training and the resource material used.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

See WN #1 for details.

The Inspector reviewed the home's Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy and Zero Tolerance of Abuse and Neglect Program.

A) The home's policy identified staff were to immediately respond to any form of abuse; intervene and ensure the safety of the resident. A PSW who had witnessed the abuse to a resident by another PSW did not stop the other PSW's actions, nor did the PSW ask the other PSW to leave a resident's room, while they completed their care. Both PSWs proceeded to complete care rounds for the remainder of the residents on the unit.

B) The home's policy identified that anyone who witnesses, or suspects abuse of a resident must report the incident immediately to the Senior Supervisor/Manger. After witnessing the abuse incident involving a resident, a PSW did not report the witnessed abuse immediately.

C) After the abuse incident involving another resident, a PSW did not report to a RN Charge Nurse, when a resident stated to them that they were uncomfortable by their actions and they did not want a PSW providing further care for them. Furthermore, the staff member that a resident had reported the incident to had not taken appropriate action to protect the resident, nor had the other co-workers that continued to answer the resident's call bells and provide the resident care, after the resident had stated they no longer wanted a PSW to provide their care.

D) The home's policy identified that staff members were to ensure the safety of the abused resident through completion of a full assessment. A RN Charge Nurse did not complete a full assessment on a resident after being notified of the abuse. An assessment was not completed until several hours after the abuse had occurred and was not completed until they were directed by the DOC.

The failure of staff not following their Zero Tolerance of Abuse and Neglect policy put residents at risk of harm and caused actual harm to residents.

Sources: CIS reports; Zero Tolerance of Resident Abuse and Neglect Program, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy; Commitment to Resident-Centred Care and Resident Rights policy; the home's investigation file; resident's health care record; and interviews with the DOC, PSW and RN Charge Nurse.

An order was made by taking the following factors into account:

Severity: There was actual harm to two residents, with findings of two distinct abuse incidents by a PSW. Other staff members inactions to comply with the home's zero tolerance of resident abuse policy put two residents and other resident's at risk of further harm.

Scope: The scope of non-compliance was a pattern of several staff members not following the home's zero tolerance of resident abuse involving two residents.

Compliance History: In the past 36 months, the licensee was found to be noncompliant with O. Reg. 79/10 s. 20 (1). Two previous Voluntary Plan of Correction (VPC) and a Compliance Order (CO), which was complied, was issued to the home. (613)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 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. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6. (7) of the LTCH Act, 2007.

Specifically, the licensee must ensure that:

A) Interventions in a resident's plan of care are implemented and followed by all direct care staff as it relates to their continence care and preference.

B) All staff who provide care to a resident review their plan of care prior to starting their next scheduled shift.

C) A record is kept of the plan of care review, including date and staff's signature.

Grounds / Motifs :

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

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

A PSW provided care to a resident alone when their plan of care identified in different areas that specific staff were not to provide care to the resident.

A specific PSW had awoken a resident to complete their care even though their care plan intervention identified different direction. The PSW had not reviewed the resident's plan of care and they were unaware of this intervention. A Charge Nurse was unaware that the resident's plan of care identified that specific staff were not to provide their care.

The failure of PSW and RN Charge Nurse being aware of a resident's plan of care interventions resulted in care not being provided as set out in the plan of care and caused harm to the resident.

Sources: CIS reports; Zero Tolerance of Resident Abuse and Neglect Program, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy; Commitment to Resident-Centred Care and Resident Rights policy; the home's investigation file; resident's plan of care; PSW's termination letter; and interviews with DOC and RN Charge Nurse.

An order was made by taking the following factors into account:

Severity: There was actual harm to a resident as a result of a PSW not following the resident's interventions as per their plan of care.

Scope: The scope of non-compliance was isolated to a resident. Two other resident's plans of care were reviewed during this inspection, interventions listed in their plans of care had been implemented.

Compliance History: In the past 36 months, the licensee was found to be noncompliant with O. Reg. 79/10 s. 6 (7). A previous Voluntary Plan of Correction (VPC) was issued to the home. (613)

Ontario

Ministry of Long-Term Care

Ministère 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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 30, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 79/10, s. 24 (6).

Order / Ordre :

The licensee must be compliant with s. 24. (6) of the LTCH Act, 2007.

Specifically, the licensee must ensure that;

A) Interventions in residents' 24-Hour plans of care are implemented immediately when received and followed by all direct care staff as it relates to their falls prevention interventions.

B) Refresher training is provided to the two RPN's involved with this incident on immediately implementing fall prevention interventions when received.

C) A record is kept of training, including date, who attended and resource material used.

Grounds / Motifs :

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

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

A resident's progress notes identified that they were at risk for falls and required safety devices to be applied to their mobility aid and bed related to prior self transferring and falls. Two safety devices were brought to the unit by an Activity Aide and provided to a RPN. The progress notes identified that two RPN's were aware that the safety devices were received on the unit and that a resident's care plan had been updated with the safety intervention; however, they failed to apply the safety device to the resident’s bed, while they were sleeping.

Approximately one hour after the safety devices were received on the unit, a resident suffered an injury because of a fall, resulting in a transfer to the hospital. Staff was aware a resident was at risk for falls and failed to apply the safety device to the resident’s bed.

Both the DOC and ADOC stated that the staff should have applied the safety device to the resident’s bed immediately after it was received as they were aware of the resident's risk for falls.

Sources: CIS report; Resident’s progress notes and previous LTCH health care records, care plan; Investigation file and interviews with DOC, ADOC and other staff.

An order was made by taking the following factors into account:

Severity: A resident sustained a fall that resulted in actual harm as a result of direct care staff not following the resident's fall prevention interventions as per their 24-Hour care plan.

Scope: The scope of non-compliance was isolated to a resident.

Compliance History: There was no previous history in the past 36 months. (613)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 30, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

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

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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 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 3rd day of August, 2021

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Lisa Moore

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