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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Original Public Report

Report Issue Date June 3, 2022
Inspection Number 2022_1203_0002
Inspection Type
☒ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Golden Dawn Nursing Home

Long-Term Care Home and City
80 Main Street , Lion's Head ON N0H 1W0

Lead Inspector
Janet Evans #659

Inspector Digital Signature
Janet M Evans
2022.06.06 14:49:39 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 9 -13, 2022

The following intake(s) were inspected:
- Log # 002358-22 \Follow-up regarding Infection Prevention and Control
- Log # 007455-22 \ Related to alleged resident to resident abuse

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 229 (4)	2022_977754_0001	001	Janet Evans #659

The following **Inspection Protocols** were used during this inspection:

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Staffing, Training and Care Standards

INSPECTION RESULTS

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WRITTEN NOTIFICATION POLICE NOTIFICATION

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1

Non-compliance with: O. Reg. 246/22 *s. 105*

The licensee has failed to ensure that the appropriate police force was immediately notified of the witnessed and suspected incident of abuse of an identified resident by a co-resident that they suspected may constitute a criminal offence.

On a specified date, staff witnessed two incidents of suspected abuse of the identified resident by a co-resident. Staff notified management of the incidents.

The Administrator acknowledged an official report to the police had not been made.

Sources: CIS report, progress notes, interviews with DOC Support and Administrator

Janet Evans #659

WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO DIRECTOR

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 28 (1) 2*

The licensee has failed to ensure that the Director was notified immediately of the alleged incident of abuse.

Two incidents of alleged abuse occurred on a specified date.

A Critical Incident Summary report was not submitted until four days following these incidents.

Not immediately submitting the report meant the Director was not made aware and could not respond in a timely manner if it was required.

Sources:
CIS report, Interview with DOC support.

Janet Evans #659

WRITTEN NOTIFICATION POLICY TO PROMOTE ZERO TOLERANCE

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 25 (1)

The licensee has failed to ensure that staff complied with the home's policy of zero tolerance of abuse and neglect

The home's policy for zero tolerance of abuse and neglect directed staff who witnessed an incident of alleged abuse or neglect to complete written statements for the home. If there was reason to suspect abuse, the staff member was to request a full medical examination of the resident and not to the leave the resident alone.

There were no written statements from staff and no documented full medical examination of the identified resident.

Not complying with the home's policy of zero tolerance of abuse and neglect may have a potential risk of not capturing timely information or assessments related to the resident's health status and allow for timely interventions as needed.

Sources: Hard copy of resident's chart, progress note review, assessment review, interview with Administrator, DOC Support and staff.

Janet Evans #659

WRITTEN NOTIFICATION TRAINING

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 *s. 76.(7) 1*

The licensee has failed to ensure that all staff who provide direct care to residents, receive as a condition of continuing to have contact with residents, training in the areas set out in the following paragraph at times or at intervals provided for in the regulations: 1. Abuse recognition and prevention.

The home provided training on zero tolerance and abuse through Surge learning.

Review of 2021 Surge learning for zero tolerance of abuse showed 88.4% or 38/43 staff had completed training on abuse and neglect.

The DOC acknowledged not all staff had completed the required training.

There is a risk if staff are not trained on the home's policy of zero tolerance of abuse and neglect they will not recognize potential abuse or neglect and respond appropriately.

Sources: Surge learning, Policy Zero Tolerance of Abuse and Neglect , #70.140, last revised September 2020, interview with DOC

Janet Evans # 659

WRITTEN NOTIFICATION NOTIFICATION RE INCIDENTS

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 104 (1) a.*

The licensee has failed to ensure that Substitute Decision Makers (SDM) for two residents involved in incidents of abuse, were immediately notified of the incidents.

The SDMs of the residents involved, were notified of the incidents one day following their occurrence.

Delay in notifying the SDM meant that they were unable to provide support to the residents if required.

Sources: Progress notes, interview with DOC support

Janet Evans #659

WRITTEN NOTIFICATION RESPONSIVE BEHAVIOURS

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 58 (4) a, b and c

The licensee has failed to ensure that for an identified resident who was demonstrating responsive behaviours, behavioural triggers for the resident were identified, strategies were developed and implemented to respond to the behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented

The identified resident exhibited responsive behaviours towards a co-resident. Two staff said as a result of previous incidents they had been advised to have two persons provide the resident's care.

The identified resident's written plan of care at the time of the inspection did not include any triggers, strategies, assessments or interventions to manage or respond to the responsive behaviours.

The BSO RPN said they received the referral for the identified resident and were advised to complete an assessment. However, they did not assess the resident. The RPN acknowledged that there was no written plan of care for the resident related to this responsive behaviour.

Sources: Progress notes, care plan, BSO referral, interviews with DOC Support and staff.

Janet Evans #659

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 102 (7) 4*

The licensee has failed to ensure that the infection prevention and control lead designated under subsection (5) carried out the auditing of the infection prevention and control practices in the home.

A letter to the DOC Support/IPAC Lead from Grey Bruce Public Health unit, stated that the home must conduct regular IPAC self audits at a minimum every two weeks when the home was not in outbreak and once a week when the home was in outbreak to identify and address gaps in IPAC practices. As well they recommended implementing additional audits including PPE, hand hygiene, environmental and IPAC.

PHO Covid 19 Self Assessment audit tool was not completed for the week of May 7, 2022.

The DOC Support/IPAC lead acknowledged that they had not completed a PHO Covid 19 Self Assessment audit tool for May 2022.

Sources: Letter dated January 25, 2022, from Grey Bruce Public Health, PHO Covid 19 Self Assessment audit tool and interview with DOC Support/IPAC lead

Janet Evans #659

WRITTEN NOTIFICATION MUST BE R.N.

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 77 (2)*

The licensee has failed to ensure that the Director of Nursing and Personal Care was a Registered Nurse.

There was a new DOC at the home at the time of the inspection.

The DOC acknowledged they were a Registered Practical Nurse (RPN).

Sources: CNO, Interview with DOC and others

Janet Evans #659

WRITTEN NOTIFICATION DIRECTOR OF NURSING AND PERSONAL CARE

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 250 (1) 4.

The licensee has failed to ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.

The DOC was present in the home May 9-12, 2022.

A written contract between the home and the DOC indicated they would work onsite 32 hours per week and be available 24/7. The contract stated that they would allot 25 percent of their time or eight hours per week to the DOC role and the remaining to the RAI Coordinator role.

A payroll schedule for the DOC documented two days per week (16 hours/week) in the DOC role and two days in the RAI Coordinator role.

The DOC told Inspector #659 they spent 50 percent of their time on the DOC role and 50 percent of their time on the RAI Coordinator role.

Sources: Contract, Payroll schedule, interview with DOC and others

Janet Evans #659

COMPLIANCE ORDER [CO# 001] DUTY TO PROTECT

NC#010 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: FLTCA, 2021, s. 24.1

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

The Licensee will comply with s. 24.1

Specifically, the licensee shall protect the identified resident from abuse by their co-resident

The Licensee shall:
1. Develop, document and implement a written plan for monitoring the identified resident's whereabouts. Ensure the monitoring is documented and maintained at the home.
2. Ensure that identified resident and co-resident are not present in the same room unless supervised by staff.
3. Ensure that the co-resident is assessed and based on that assessment, triggers are identified and strategies developed and implemented to manage and monitor the resident's sexually responsive behavours.
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Grounds

The licensee has failed to protect an identified resident from abuse by a co-resident.

The identified resident had a moderate cognitive impairment and was known to wander about the home and enter other resident rooms.

The co-resident was known to exhibit specified responsive behaviours towards staff. They did not have a history of this behaviour towards other residents.

On a specified day the identified resident was found in the co-resident's room on two instances and the co-resident was exhibiting responsive behaviours towards the identified resident.

There were no documented measures or interventions to prevent future incidents, in either of the resident's plans of care immediately following the first incident.

Sources: CIS report**,** progress notes, plan of care, communication book. Interviews with Administrator, DOC support, staff and resident #001 and #002**.**

This order must be complied with by June 30, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

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Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

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