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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 1, 2020	2020_771609_0015	010039-20, 010253-20	Critical Incident System

Licensee/Titulaire de permis

Anson General Hospital
58 Anson Drive IROQUOIS FALLS ON P0K 1E0

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

South Centennial Manor
240 Fyfe Street IROQUOIS FALLS ON P0K 1E0

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

CHAD CAMPS (609)

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): on-site August 10-14 and off-site August 17-19, 2020.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:

-One intake related to allegations of resident to resident abuse; and

-One intake related to allegations of staff to resident abuse.

A Complaint inspection #2020_771609_0014 was conducted along with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Buildings Maintenance Manager, Maintenance staff, Dietitian, Food Services Workers (FSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Laundry staff, residents and their families.

The Inspector(s) also did a daily tour of resident care areas, observed the care and services provided to residents, observed staff to resident and resident to resident interactions, reviewed health care records, internal investigation notes, Human Resources (HR) files, maintenance records, Purchase Orders (POs), training logs, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

- **6 WN(s)**
- **2 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.

Physical abuse, as defined in Ontario Regulation (O. Reg.) 79/10, means the use of physical force by anyone other than a resident that causes physical injury or pain.

Verbal abuse, as defined in O. Reg. 79/10, means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Neglect, as defined in O. Reg. 79/10, means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #609 reviewed the home’s Zero Tolerance of Abuse and Neglect policy (February 2018), which defined physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain and described rough handling of residents as an example of physical abuse. The policy defined verbal abuse as any form of verbal communication of a belittling or degrading nature which may diminish a resident's sense of well-being and described inappropriate manner of speaking which was upsetting to the resident as an example. The policy further defined neglect as the failure to provide a resident with the care or assistance they required for health, safety or well-being and described failing to provide care as set out in their plan of care as an example.

The policy indicated that all residents in the home had the right to be free from abuse and neglect and that employees who were reporting witnessed or suspected incidents of abuse or neglect of a resident would immediately report the allegations to the DOC/delegate or Chief Executive Officer.

The home's Zero Tolerance of Abuse and Neglect policy required the home to immediately notify the Substitute Decision-Maker (SDM) of incidents where residents were harmed and within 12 hours for all other situations of alleged or witnessed abuse or neglect.

The policy further required the DOC/delegate to determine the appropriate management action(s) to be taken as a result of the findings of the investigation into allegations of abuse or neglect of residents.

a) A Critical Incident System (CIS) report was submitted by the home to the Director, which outlined how Personal Support Worker (PSW) #100 responded to a resident's call for assistance and verbally and physically abused them.

A review of the resident's health care records found in a progress note that the resident was injured by the PSW.

During an interview with the resident, they described being injured by the PSW when they assisted them. The resident stated that the PSW would verbally abuse them as well.

b) A review the home's internal investigation notes found that while the DOC was conducting their investigation, multiple additional allegations of abuse of other residents were reported to them by staff and residents.

The internal investigation outlined how another resident reported to the DOC, that PSW #100 had injured them while providing care. The resident had previously reported the incident to PSW #111.

During an interview with the PSW #111, they verified that the resident had told them about the incident and injury prior to the DOC conducting their internal investigation. The PSW denied reporting the allegations of abuse to the home.

A review of the resident's health care records found no mention of the incident nor the resident's injury.

During an interview with the DOC, they verified that they had become aware of the allegations of abuse by the PSW during their internal investigation.

c) A review the home's internal investigation notes found that PSW #100 had an incident with another resident where they verbally and physically abused them which caused injury.

A review of the resident's health care records found in a progress note that the PSW had verbally and physically abused them.

During an interview with the resident, they recalled the incident and stated they had been verbally abused and physically injured by the PSW while they provided care.

During an interview with PSW #111, they verified that they observed the resident being verbally and physically abused by the PSW.

PSW #111 further verified that they did not report the witnessed abuse of the resident to the home.

d) A review of the home's internal investigation notes found that the DOC observed via video footage that PSW #100 provided abusive and improper care to another resident.

During an interview with the DOC, they described observing through the video footage, that the PSW provided abusive and improper care to the resident.

A review of the resident's health care records found no mention of the abusive and improper care provided to the resident by the PSW.

During the same interview with the DOC, they denied notifying the resident's SDM of the allegations of abusive and improper care that they observed.

e) A review of the home's internal investigation notes found that PSW #100 had completed all care for their assigned residents in an improper manner.

During an interview with PSW #111, they verified that they were aware that the PSW had completed the care for their assigned residents in the improper manner.

PSW #111 acknowledged that it would be considered neglect to provide the care in the improper manner. The PSW also acknowledged that they did not report the allegations of neglect to the home until the DOC was conducting their investigation.

During an interview with the DOC, a review of the care needs for PSW #100's assigned residents was conducted. The DOC indicated that some of the residents were neglected when the PSW provided their care in the improper manner.

The DOC denied reporting the allegations of neglect to the SDMs of the residents after becoming aware of the allegations of neglect.

f) During an interview with PSW #111, they verified that they considered it neglect to provide care in an improper manner, yet did just that after they found out that PSW #100 had done the same.

During an interview with the DOC, a review of the care needs of the PSW's assigned residents was conducted. The DOC indicated that some of the residents were neglected when the PSW provided their care in the improper manner.

The DOC indicated that they were unaware that the PSW had neglected residents until the Inspector notified them of the allegations.

g) During an interview with the DOC, allegations of potential verbal abuse of another resident by PSW #100, that was not reported to the home by an RPN was reviewed. The allegations of physical abuse and neglect of residents by PSW #100, that were not reported to the home by a PSW were also reviewed.

Despite the multiple allegations of abuse and neglect not reported to the home by the RPN or the PSW, the DOC denied taking any management actions to correct their lack of reporting, such as education or discipline as outlined in the home's Zero Tolerance of Abuse and Neglect policy.

h) A review of PSW #100's Human Resources (HR) file found:

-A document which substantiated how the PSW had neglected a resident;
-A document which outlined that they would be verbally abusive and neglectful of residents; and
-A written letter of complaint by a family member of a resident who described verbal

abuse and neglect by the PSW.

During an interview with the DOC, they verified that they were provided a letter of complaint by a resident's family member, which they acknowledged was not forwarded to the Director. After receiving the letter of complaint, they denied taking any other actions to protect residents from the PSW.

i) The DOC described that staff had concerns about working with PSW #100. The DOC described how residents had ongoing concerns with the care the PSW provided. The DOC denied any heightened awareness or monitoring of the PSW's performance to ensure the residents safety despite the multiple and ongoing concerns they identified with the PSW's performance.

A review of a document outlined how the home's investigation had found that PSW #100 had physically abused multiple residents. [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. 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 any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was 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; and
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.

Inspector #609 reviewed the home's Duty to Report policy (August 2017), which indicated the duty to report, and that the licensee or person managing the home was guilty of an offense if they failed to make a report as required.

The policy outlined that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident and 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 were to be immediately reported to the [Director].

a) A CIS report was submitted by the home to the Director, which outlined allegations of physical and verbal abuse of a resident by PSW #100, that occurred a number of days previously.

During an interview with the DOC, they described being informed by the resident of the allegations of verbal and physical abuse the day after the incident occurred.

During the same interview with the DOC, a review of critical incident was conducted. The DOC verified that they submitted the report a number of days after they became aware of the allegations of abuse of the resident. They further verified that they should have immediately reported the allegations of abuse to the Director.

b) A review the home's internal investigation for the CIS, found that the DOC had reviewed video footage, which showed PSW #100 providing abusive and improper care to another resident.

During an interview with the DOC, they outlined seeing the PSW providing abusive and improper care to the resident, while conducting the home's internal investigation.

The DOC verified that the potential abuse of the resident by the PSW that they saw on video was not reported to the Director.

c) A review of the home's internal investigation notes for the CIS found that the DOC was informed by other residents of allegations that PSW #100 had physically abused them.

During an interview with the DOC, they outlined how while conducting the home's internal investigation, they were informed by other residents of allegations that the PSW physically abused them while providing care.

The DOC verified that the potential abuse of the other residents that they became aware was not reported to the Director.

d) A review of the home's internal investigation for the CIS found a letter which described how a family member of a resident observed PSW #100 neglect residents.

During an interview with the DOC, they described receiving the written letter from a resident's family member. The DOC verified that the letter, which contained allegations of neglect by the PSW was not reported to the Director. [s. 24. (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 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:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were

kept closed and locked when they were not being supervised by staff.

a) During a tour of the home, Inspector #609 observed that the door leading to the home's staff entrance in the D-wing had the access code posted beside the keypad. Using the posted code, the Inspector was able open the door and enter:

-The home's unlocked and unattended storage room (labeled conference room) which housed numerous chemicals, that included bleach and concentrated broad-spectrum sanitizer;
-The home's unlocked and unattended receiving area and exit outside of the home via the receiving door;
-The home's unlocked and unattended laundry room where chemicals were noted; and
-The home's unlocked and unattended maintenance room which was filled with tools and chemicals and exit outside of the home via the maintenance door.

During an interview with a Food Services Worker (FSW), they indicated that the access code to the D-wing had been posted above the keypad for over two weeks because it was a new code.

During an interview with a Laundry Services staff member, they verified that residents would have been able to pass through the staff entrance door into D-wing via the posted access code.

During an interview with the DOC, they verified the Inspector's observations and indicated that the access code to D-wing had been posted above the keypad for a minimum for two weeks and that it should not have been.

When asked for the policy on doors in the home, the DOC indicated that they were unable to locate one.

b) During a tour of the home, the Inspector observed:

-Linen Room #221 unlocked and unattended. The door had a sign which indicated that the door was to remain locked;
-Utility Room #90A unlocked and unattended;
-Tub Room #90 unlocked and unattended;
-Lift Room #93 was closed using a barrel-bolt latch accessible to anyone on the outside of the door;

-Storage Room #180 unlocked and unattended, which housed medical equipment and supplies which included oxygen concentrators;
-The Nursing Office open and unattended, with a sign on the door which indicated that it was to be kept shut; and
-Dining Room #117 open, unattended with a lab cart noted just inside the door. The lab cart was unlocked with the key left in the lock. The Inspector was able to open the cart and observed numerous needles and vials for blood specimen collection inside.

During an interview with an RPN, they verified that Storage Room #180 should have been locked and that the automatic door closer was not working properly. The RPN further verified that the lab cart should not have been left unlocked in the dining room and proceeded to take the lab cart to the medical storage area.

c) During a tour of the home, the Inspector observed the door to the home's Kitchen (Room 54) was unlocked and the Kitchen was unattended. A sign on the door stated, "Please don't lock door".

During an interview with a FSW, they indicated that the keypad to the Kitchen door had been broken since June 29, 2020, and that they did not lock the door, even when the Kitchen was unattended by staff.

During an interview with a Maintenance Staff member, they indicated that they were unaware of the sign stating to not lock the Kitchen door and thought that the FSWs were using the secondary key lock on the door.

During an interview with a FSW, they indicated that until a new keypad was installed, they were keeping the Kitchen door unlocked, even when unattended and throughout the night.

During a tour of the home, the Inspector observed an ambulatory resident sitting directly outside the unlocked door leading into an unattended Kitchen.

d) During a tour of the home, the Inspector observed for the second time that Linen Room #221 was unlocked and unattended.

During an interview with a PSW, they verified the Inspector's observations and verified that the door should have been locked when not attended by staff.

e) During a tour of the home, the Inspector observed the home's Nursing Station unattended and that the two doors to either side of the Nursing Station had been removed. The Inspector was able to pass through the Nursing Station and enter:

-An open Storage Room, which was so full of equipment and supplies (which included chemicals) that the door could not close;
-A second open Storage Room, which housed supplies and equipment which included scissors; and
-A Staff Kitchen/Locker Room, which had a full, hot pot of coffee percolating in the coffee machine.

During an interview with a Maintenance Staff member, they verified that the Nursing Station doors had been removed at the request of the home's Joint Health and Safety Committee on June 9, 2020. They acknowledged that at the time they removed the Nursing Station doors they were concerned that residents would be able to enter the Nursing Station, Storage Rooms as well as the Staff Kitchen/Locker Room but had removed them anyway.

During an interview with the DOC, they indicated that the two Storage Rooms and the Staff Kitchen/Locker Room had "old locks" and that staff were unable to lock them. The DOC indicated that they would have to either replace the doors or the locks and would have a Locksmith assess them.

During another interview with the DOC, they stated that "there was no excuse for the doors to be open". [s. 9. (1) 2.]

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. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

Inspector #609 reviewed email correspondence between the DOC and the Buildings Maintenance Manager which identified that there were missing call bells in resident accessible areas.

A review of the home's Call Bell Response Time policy (September 2017), required the home to have a resident-staff communication and response system as specified under section 17 of the Regulation.

During a tour of the home the Inspector found no call bells located in the following five resident accessible areas:

-Family Room;
-Chapel;
-Craft Room;
-TV Room; and
-Physiotherapy Room.

During an interview with the Building Maintenance Manager, they verified that the identified resident accessible areas were without call bells and that the replacement resident-staff communication and response system would have them installed. [s. 17. (1) (e)]

2. The licensee has failed to ensure that the resident-staff communication and response system clearly indicated when activated where the signal was coming from.

During a tour of the home, a staff member described to Inspector #609 how the resident-staff communication and response system had a "ghost" bell that had been going off for weeks.

During an interview with a resident, they indicated that call bell system had been constantly ringing for two months which was affecting their sleep.

A review of the home’s maintenance work orders, found that on June 28, 2020, the resident-staff communication and response system began ringing when no bells were being pulled.

During an interview with the a Maintenance Staff member, they verified that the system continued to alarm non-stop, about one week after they attempted to fix the system on June 29, 2020.

During an interview with the Buildings Maintenance Manager, they described assessing the resident-staff communication and response system, together, with an outside technician and determined on July 6, 2020, that the system required replacement.

A review of correspondence from the staff to the home dated July 22, 2020, indicated that the resident-staff communication and response system continued to malfunction, that the “ghost bell is driving the staff and residents close to insanity” and that the ringing was non-stop 24 hours a day.

The Inspector observed that the resident-staff communication and response system did not stop ringing for the entire duration of the on-site inspection from August 10-14, 2020.

During an interview with an RN, they described how the call bell system had been ringing without someone activating the system for weeks. They gave the example of providing

care to residents in their rooms and not knowing if the call bell system had been activated by another resident over the continuously ringing false alarm. They further described how they would have to leave the room and check the central panel at the nursing station to know if a resident had called or not.

During an interview with the Administrator on August 12, 2020, they denied being made aware that the resident-staff communication and response system had been malfunctioning for over eight weeks. They indicated that there was a proposal for a new $60000 system, that the home did not have the money for, but would purchase it.

A review of the home's purchase order found that the replacement resident-staff communication and response system was approved on August 12, 2020, or 37 days after the home determined that the system required replacing.

During an interview with the DOC, they indicated that the malfunctioning resident-staff communication and response system was a "major" concern. They described that if staff were providing care in another room, they would not be able to distinguish the ghost bell from a bell being pulled and would have to check the central panel at the nursing station to see if there was an actual call.

The DOC nor Buildings Maintenance Manager were able to provide the Inspector with an estimated time for the resident-staff communication and response system to be replaced. [s. 17. (1) (f)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents.

Inspector #609 reviewed a letter, which described allegations of verbal abuse by a PSW. The letter outlined how the allegations of abuse was reported and RN, who did not immediately report the allegations of abuse to the home.

A review of the home’s Zero Tolerance of Abuse and Neglect policy (February 2018) indicated that the home would provide annual and ongoing education on the home’s zero tolerance of abuse and neglect policy.

a) During an interview with the RN, verified that they were not provided with training on the home’s zero tolerance of abuse and neglect policy in 2019, nor 2020.

A review of correspondence from the DOC verified that the RN did not receive training in the home’s zero tolerance of abuse and neglect policy in 2019 nor in 2020.

b) A review of the course completion record for the home’s retraining of staff in the home’s zero tolerance of abuse and neglect policy found that 3 of 39 or almost eight per cent of all staff did not complete the required training for the 2019 year. [s. 76. (4)]

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 all staff receives retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

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

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director under subsection 23 (2) of the Act included the following description of the individuals involved in the incident:
(i) names of all residents involved in the incident,
(ii) names of any staff members or other persons who were present at or discovered the incident, and
(iii) names of staff members who responded or were responding to the incident.

Inspector #609 reviewed the home's Zero Tolerance of Abuse and Neglect policy (February 2018) which indicated that the report to the Director must contain all the information required under section 104 of the Regulation.

During an interview with the DOC, a review of the home's internal investigation was conducted. The DOC verified that during their investigation, additional residents were identified as being potentially abused by a PSW in other incidents, where during some of the incidents additional staff were present.

During the same interview with the DOC, a review of CIS report was conducted. The DOC verified that they became aware of the additional incidents, residents/staff and did not include this information in the report to the Director; but should have. [s. 104. (1) 2.]

2. The licensee has failed to ensure that the report to the Director under subsection 23 (2) of the Act included, the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.

During an interview with the DOC, a review of the home's internal investigation was conducted. The DOC verified that they conducted the investigation, that the results substantiated the allegations of abuse, and that immediate actions were taken.

During the same interview with the DOC, a review of the CIS report was conducted. The DOC verified that the actions taken to prevent recurrence were known to them when the CIS report was submitted but did not include the information to the Director. The DOC verified that the CIS report also did not include any long-term actions planned to correct the situation or prevent recurrence, but should have. [s. 104. (1) 4.]

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 report to the Director under subsection 23 (2) of the Act includes the following description of the individuals involved in the incident:
(i) names of all residents involved in the incident,
(ii) names of any staff members or other persons who were present at or discovered the incident,
(iii) names of staff members who responded or were responding to the incident,
(iv) the immediate actions that have been taken to prevent recurrence, and
(v) the long-term actions planned to correct the situation and prevent recurrence., to be implemented voluntarily.

Issued on this 2nd day of September, 2020

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) :	CHAD CAMPS (609)
Inspection No. / No de l'inspection :	2020_771609_0015
Log No. / No de registre :	010039-20, 010253-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 1, 2020
Licensee / Titulaire de permis :	Anson General Hospital 58 Anson Drive, IROQUOIS FALLS, ON, P0K-1E0
LTC Home / Foyer de SLD :	South Centennial Manor 240 Fyfe Street, IROQUOIS FALLS, ON, P0K-1E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paul Chatelain

To Anson General Hospital, you are hereby required to comply with the following order (s) by the date(s) set out below:

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 : 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 :

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

The licensee must be compliant with s. 19 (1) of the Long-Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee must:

a) Provide retraining and maintain records of the retraining to all staff on the definitions of abuse and neglect as defined by the Regulation;

b) Provide retraining and maintain records of the retraining to all staff on the responsibility of all staff related to the prevention, recognition, response, and reporting of abuse and neglect;

c) Ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident is immediately notified upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being;

d) Ensure that if staff members fail to adhere to the home's Zero Tolerance of Abuse and Neglect and/or Duty to Report policies, the home promptly acts to provide retraining, discipline and/or coaching, and that a record is maintained of the actions taken;

e) Develop a process by which staff who are known to have abused and/or neglected residents and continues to work with residents in the home are monitored and their on-going performance evaluated for three months or longer if continued concerns arise from their performance;

f) Ensure every alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee knows of, or that is reported to the licensee, is immediately investigated and that a record of the investigation is maintained.

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.

Physical abuse, as defined in Ontario Regulation (O. Reg.) 79/10, means the use of physical force by anyone other than a resident that causes physical injury or pain.

Verbal abuse, as defined in O. Reg. 79/10, means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Neglect, as defined in O. Reg. 79/10, means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #609 reviewed the home's Zero Tolerance of Abuse and Neglect policy (February 2018), which defined physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain and described rough handling of residents as an example of physical abuse. The policy defined verbal abuse as any form of verbal communication of a belittling or degrading nature which may diminish a resident's sense of well-being and described inappropriate manner of speaking which was upsetting to the resident as an example. The policy further defined neglect as the failure to provide a resident with the care or assistance they required for health, safety or well-being and described failing to provide care as set out in their plan of care as an example.

The policy indicated that all residents in the home had the right to be free from abuse and neglect and that employees who were reporting witnessed or suspected incidents of abuse or neglect of a resident would immediately report the allegations to the DOC/delegate or Chief Executive Officer.

The home's Zero Tolerance of Abuse and Neglect policy required the home to immediately notify the Substitute Decision-Maker (SDM) of incidents where residents were harmed and within 12 hours for all other situations of alleged or witnessed abuse or neglect.

The policy further required the DOC/delegate to determine the appropriate management action(s) to be taken as a result of the findings of the investigation into allegations of abuse or neglect of residents.

a) A Critical Incident System (CIS) report was submitted by the home to the Director, which outlined how Personal Support Worker (PSW) #100 responded to a resident's call for assistance and verbally and physically abused them.

A review of the resident's health care records found in a progress note that the resident was injured by the PSW.

During an interview with the resident, they described being injured by the PSW when they assisted them. The resident stated that the PSW would verbally abuse them as well.

b) A review the home's internal investigation notes found that while the DOC was conducting their investigation, multiple additional allegations of abuse of other residents were reported to them by staff and residents.

The internal investigation outlined how another resident reported to the DOC, that PSW #100 had injured them while providing care. The resident had previously reported the incident to PSW #111.

During an interview with the PSW #111, they verified that the resident had told them about the incident and injury prior to the DOC conducting their internal investigation. The PSW denied reporting the allegations of abuse to the home.

A review of the resident's health care records found no mention of the incident nor the resident's injury.

During an interview with the DOC, they verified that they had become aware of the allegations of abuse by the PSW during their internal investigation.

c) A review the home's internal investigation notes found that PSW #100 had an incident with another resident where they verbally and physically abused them which caused injury.

A review of the resident's health care records found in a progress note that the PSW had verbally and physically abused them.

During an interview with the resident, they recalled the incident and stated they had been verbally abused and physically injured by the PSW while they provided care.

During an interview with PSW #111, they verified that they observed the resident being verbally and physically abused by the PSW.

PSW #111 further verified that they did not report the witnessed abuse of the resident to the home.

d) A review of the home's internal investigation notes found that the DOC observed via video footage that PSW #100 provided abusive and improper care to another resident.

During an interview with the DOC, they described observing through the video footage, that the PSW provided abusive and improper care to the resident.

A review of the resident's health care records found no mention of the abusive and improper care provided to the resident by the PSW.

During the same interview with the DOC, they denied notifying the resident's SDM of the allegations of abusive and improper care that they observed.

e) A review of the home's internal investigation notes found that PSW #100 had completed all care for their assigned residents in an improper manner.

During an interview with PSW #111, they verified that they were aware that the PSW had completed the care for their assigned residents in the improper manner.

PSW #111 acknowledged that it would be considered neglect to provide the care in the improper manner. The PSW also acknowledged that they did not report the allegations of neglect to the home until the DOC was conducting their investigation.

During an interview with the DOC, a review of the care needs for PSW #100's assigned residents was conducted. The DOC indicated that some of the residents were neglected when the PSW provided their care in the improper manner.

The DOC denied reporting the allegations of neglect to the SDMs of the residents after becoming aware of the allegations of neglect.

f) During an interview with PSW #111, they verified that they considered it neglect to provide care in an improper manner, yet did just that after they found out that PSW #100 had done the same.

During an interview with the DOC, a review of the care needs of the PSW's assigned residents was conducted. The DOC indicated that some of the residents were neglected when the PSW provided their care in the improper manner.

The DOC indicated that they were unaware that the PSW had neglected residents until the Inspector notified them of the allegations.

g) During an interview with the DOC, allegations of potential verbal abuse of another resident by PSW #100, that was not reported to the home by an RPN was reviewed. The allegations of physical abuse and neglect of residents by PSW #100, that were not reported to the home by a PSW were also reviewed.

Despite the multiple allegations of abuse and neglect not reported to the home by the RPN or the PSW, the DOC denied taking any management actions to correct their lack of reporting, such as education or discipline as outlined in the home's Zero Tolerance of Abuse and Neglect policy.

h) A review of PSW #100's Human Resources (HR) file found:

-A document which substantiated how the PSW had neglected a resident;
-A document which outlined that they would be verbally abusive and neglectful of residents; and
-A written letter of complaint by a family member of a resident who described

verbal abuse and neglect by the PSW.

During an interview with the DOC, they verified that they were provided a letter of complaint by a resident's family member, which they acknowledged was not forwarded to the Director. After receiving the letter of complaint, they denied taking any other actions to protect residents from the PSW.

i) The DOC described that staff had concerns about working with PSW #100. The DOC described how residents had ongoing concerns with the care the PSW provided. The DOC denied any heightened awareness or monitoring of the PSW's performance to ensure the residents safety despite the multiple and ongoing concerns they identified with the PSW's performance.

A review of a document outlined how the home's investigation had found that PSW #100 had physically abused multiple residents.

The decision to issue a Compliance Order (CO) was based on the severity of the issue, which was a level three, indicating that there was actual harm to residents. The scope of the issue was a level one, indicating that the issue was isolated. The home's compliance history for the issue was a level three, indicating previous non-compliance to the same subsection:

- CO #002 issued July 11, 2019, in inspection report #2019_782736_0015. (609)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2020

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. 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee must be compliant with s. 24 (1) LTCHA, 2007.

Specifically, the licensee must:

a) Ensure 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006;

b) Provide retraining and maintain records of the retraining to the home's Management/Leadership Team on their requirement under s. 24 (1) of the LTCHA, 2007 to immediately report all suspicions of abuse or neglect of residents;

c) Provide retraining and maintain records of the retraining to the home's Management/Leadership Team on their requirement to submit Critical Incident reports with all the required information within the time frames set out under s. 107 of O. Reg. 79/10; and

d) Ensure that when the home receives a written complaint concerning the care of a resident or the operation of the long-term care home immediately forwards it to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was 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; and
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.

Inspector #609 reviewed the home's Duty to Report policy (August 2017), which indicated the duty to report, and that the licensee or person managing the home was guilty of an offense if they failed to make a report as required.

The policy outlined that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident and 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 were to be immediately reported to the [Director].

a) A CIS report was submitted by the home to the Director, which outlined allegations of physical and verbal abuse of a resident by PSW #100, that occurred a number of days previously.

During an interview with the DOC, they described being informed by the resident of the allegations of verbal and physical abuse the day after the incident occurred.

During the same interview with the DOC, a review of critical incident was conducted. The DOC verified that they submitted the report a number of days after they became aware of the allegations of abuse of the resident. They further verified that they should have immediately reported the allegations of abuse to the Director.

b) A review the home's internal investigation for the CIS, found that the DOC had reviewed video footage, which showed PSW #100 providing abusive and improper care to another resident.

During an interview with the DOC, they outlined seeing the PSW providing abusive and improper care to the resident, while conducting the home's internal investigation.

The DOC verified that the potential abuse of the resident by the PSW that they saw on video was not reported to the Director.

c) A review of the home's internal investigation notes for the CIS found that the

DOC was informed by other residents of allegations that PSW #100 had physically abused them.

During an interview with the DOC, they outlined how while conducting the home's internal investigation, they were informed by other residents of allegations that the PSW physically abused them while providing care.

The DOC verified that the potential abuse of the other residents that they became aware was not reported to the Director.

d) A review of the home's internal investigation for the CIS found a letter which described how a family member of a resident observed PSW #100 neglect residents.

During an interview with the DOC, they described receiving the written letter from a resident's family member. The DOC verified that the letter, which contained allegations of neglect by the PSW was not reported to the Director.

The decision to issue a CO was based on the severity of the issue, which was a level two, indicating that there was minimal harm or minimal risk to residents. The scope of the issue was a level three, indicating that the issue was widespread. The home's compliance history for the issue was a level three, indicating previous non-compliance to the same subsection:

- Voluntary Plan of Correction (VPC) issued July 11, 2019, in inspection report #2019_782736_0015; and
- Written Notification (WN) issued February 22, 2018, in inspection report #2018_624196_0001. (609)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2020

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 :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

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

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

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.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

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

The licensee must be compliant with r. 9. (1) 2 of O. Reg. 79/10.

Specifically, the licensee must:

a) Ensure all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff;

b) Ensure that keypad door codes to non-residential areas in the home are never posted where residents can access them;

c) Provide retraining and maintain records of the retraining to all staff on their responsibility to recognize and report broken or malfunctioning doors to the maintenance staff for prompt repair;

d) Develop an ongoing facility wide auditing process to ensure all doors to non-residential areas are in proper working condition. Maintain a record of the ongoing process and the actions taken as a result of the process; and

e) Ensure that no supplies or equipment in the home obstruct or prevent doors to non-residential areas from closing.

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

a) During a tour of the home, Inspector #609 observed that the door leading to the home's staff entrance in the D-wing had the access code posted beside the keypad. Using the posted code, the Inspector was able open the door and enter:

-The home's unlocked and unattended storage room (labeled conference room) which housed numerous chemicals, that included bleach and concentrated broad-spectrum sanitizer;
-The home's unlocked and unattended receiving area and exit outside of the home via the receiving door;
-The home's unlocked and unattended laundry room where chemicals were

noted; and
-The home's unlocked and unattended maintenance room which was filled with tools and chemicals and exit outside of the home via the maintenance door.

During an interview with a Food Services Worker (FSW), they indicated that the access code to the D-wing had been posted above the keypad for over two weeks because it was a new code.

During an interview with a Laundry Services staff member, they verified that residents would have been able to pass through the staff entrance door into D-wing via the posted access code.

During an interview with the DOC, they verified the Inspector's observations and indicated that the access code to D-wing had been posted above the keypad for a minimum for two weeks and that it should not have been.

When asked for the policy on doors in the home, the DOC indicated that they were unable to locate one.

b) During a tour of the home, the Inspector observed:

-Linen Room #221 unlocked and unattended. The door had a sign which indicated that the door was to remain locked;
-Utility Room #90A unlocked and unattended;
-Tub Room #90 unlocked and unattended;
-Lift Room #93 was closed using a barrel-bolt latch accessible to anyone on the outside of the door;
-Storage Room #180 unlocked and unattended, which housed medical equipment and supplies which included oxygen concentrators;
-The Nursing Office open and unattended, with a sign on the door which indicated that it was to be kept shut; and
-Dining Room #117 open, unattended with a lab cart noted just inside the door. The lab cart was unlocked with the key left in the lock. The Inspector was able to open the cart and observed numerous needles and vials for blood specimen collection inside.

During an interview with an RPN, they verified that Storage Room #180 should

have been locked and that the automatic door closer was not working properly. The RPN further verified that the lab cart should not have been left unlocked in the dining room and proceeded to take the lab cart to the medical storage area.

c) During a tour of the home, the Inspector observed the door to the home's Kitchen (Room 54) was unlocked and the Kitchen was unattended. A sign on the door stated, "Please don't lock door".

During an interview with a FSW, they indicated that the keypad to the Kitchen door had been broken since June 29, 2020, and that they did not lock the door, even when the Kitchen was unattended by staff.

During an interview with a Maintenance Staff member, they indicated that they were unaware of the sign stating to not lock the Kitchen door and thought that the FSWs were using the secondary key lock on the door.

During an interview with a FSW, they indicated that until a new keypad was installed, they were keeping the Kitchen door unlocked, even when unattended and throughout the night.

During a tour of the home, the Inspector observed an ambulatory resident sitting directly outside the unlocked door leading into an unattended Kitchen.

d) During a tour of the home, the Inspector observed for the second time that Linen Room #221 was unlocked and unattended.

During an interview with a PSW, they verified the Inspector's observations and verified that the door should have been locked when not attended by staff.

e) During a tour of the home, the Inspector observed the home's Nursing Station unattended and that the two doors to either side of the Nursing Station had been removed. The Inspector was able to pass through the Nursing Station and enter:

-An open Storage Room, which was so full of equipment and supplies (which included chemicals) that the door could not close;
-A second open Storage Room, which housed supplies and equipment which included scissors; and

-A Staff Kitchen/Locker Room, which had a full, hot pot of coffee percolating in the coffee machine.

During an interview with a Maintenance Staff member, they verified that the Nursing Station doors had been removed at the request of the home's Joint Health and Safety Committee on June 9, 2020. They acknowledged that at the time they removed the Nursing Station doors they were concerned that residents would be able to enter the Nursing Station, Storage Rooms as well as the Staff Kitchen/Locker Room but had removed them anyway.

During an interview with the DOC, they indicated that the two Storage Rooms and the Staff Kitchen/Locker Room had "old locks" and that staff were unable to lock them. The DOC indicated that they would have to either replace the doors or the locks and would have a Locksmith assess them.

During another interview with the DOC, they stated that "there was no excuse for the doors to be open".

The decision to issue a CO was based on the severity of the issue, which was a level three, indicating that there was actual harm or actual risk to residents. The scope of the issue was a level two, indicating that the issue was a pattern. The home's compliance history for the issue was a level two, indicating previous non-compliance to a different subsection. (609)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2020

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. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee must be compliant with r. 17. (1) (e) and r. 17. (1) (f) of O. Reg. 79/10.

Specifically, the licensee must:

a) Ensure that the resident-staff communication and response system is available in every area accessible by residents and clearly indicates when activated where the signal is coming from;

b) Ensure that the home has an operable resident-staff communication and response system that complies with r. 17 of O. Reg. 79/10; and

c) Develop a temporary process by which staff are able to identify where signals are coming from until an operable resident-staff communication and response system is installed or repaired.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident-staff communication and

response system was available in every area accessible by residents.

Inspector #609 reviewed email correspondence between the DOC and the Buildings Maintenance Manager which identified that there were missing call bells in resident accessible areas.

A review of the home's Call Bell Response Time policy (September 2017), required the home to have a resident-staff communication and response system as specified under section 17 of the Regulation.

During a tour of the home the Inspector found no call bells located in the following five resident accessible areas:

-Family Room;
-Chapel;
-Craft Room;
-TV Room; and
-Physiotherapy Room.

During an interview with the Building Maintenance Manager, they verified that the identified resident accessible areas were without call bells and that the replacement resident-staff communication and response system would have them installed. (609)

2. The licensee has failed to ensure that the resident-staff communication and response system clearly indicated when activated where the signal was coming from.

During a tour of the home, a staff member described to Inspector #609 how the resident-staff communication and response system had a "ghost" bell that had been going off for weeks.

During an interview with a resident, they indicated that call bell system had been constantly ringing for two months which was affecting their sleep.

A review of the home's maintenance work orders, found that on June 28, 2020, the resident-staff communication and response system began ringing when no

bells were being pulled.

During an interview with the a Maintenance Staff member, they verified that the system continued to alarm non-stop, about one week after they attempted to fix the system on June 29, 2020.

During an interview with the Buildings Maintenance Manager, they described assessing the resident-staff communication and response system, together, with an outside technician and determined on July 6, 2020, that the system required replacement.

A review of correspondence from the staff to the home dated July 22, 2020, indicated that the resident-staff communication and response system continued to malfunction, that the "ghost bell is driving the staff and residents close to insanity" and that the ringing was non-stop 24 hours a day.

The Inspector observed that the resident-staff communication and response system did not stop ringing for the entire duration of the on-site inspection from August 10-14, 2020.

During an interview with an RN, they described how the call bell system had been ringing without someone activating the system for weeks. They gave the example of providing care to residents in their rooms and not knowing if the call bell system had been activated by another resident over the continuously ringing false alarm. They further described how they would have to leave the room and check the central panel at the nursing station to know if a resident had called or not.

During an interview with the Administrator on August 12, 2020, they denied being made aware that the resident-staff communication and response system had been malfunctioning for over eight weeks. They indicated that there was a proposal for a new $60000 system, that the home did not have the money for, but would purchase it.

A review of the home's purchase order found that the replacement resident-staff communication and response system was approved on August 12, 2020, or 37 days after the home determined that the system required replacing.

During an interview with the DOC, they indicated that the malfunctioning resident-staff communication and response system was a "major" concern. They described that if staff were providing care in another room, they would not be able to distinguish the ghost bell from a bell being pulled and would have to check the central panel at the nursing station to see if there was an actual call.

The DOC nor Buildings Maintenance Manager were able to provide the Inspector with an estimated time for the resident-staff communication and response system to be replaced.

The decision to issue a CO was based on the severity of the issue, which was a level three, indicating that there was actual harm or actual risk to residents. The scope of the issue was a level three, indicating that the issue was widespread. The home's compliance history for the issue was a level two, indicating previous non-compliance to a different subsection. (609)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2020

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

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 1st day of September, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chad Camps

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