Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 20, 2019	2019_739694_0007	029566-17, 015085-18, 017994-18, 023920-18, 000025-19, 005491-19	Critical Incident System

Licensee/Titulaire de permis

Southampton Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Southampton Care Centre
140 Grey Street Southampton ON N0H 2L0

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

AMANDA COULTER (694), NATALIE MORONEY (610)

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): May 2, 3, 6, 7, 8, 9, 10, 14, and 15, 2019.

The following intakes were completed during this inspection:
Log #029566-17, #023920-18, #000025-19, #015085-18, and #005491-19, related to Responsive Behaviour and Prevention of Abuse and Neglect, and #017994-18, related to infection control.

This inspection was completed concurrently with Complaint inspection #2019_739694_0008.

During the course of the inspection the inspectors toured the home and observed resident care, services and activities. Clinical records and plans of care for identified residents were reviewed. Also, relevant documents were reviewed including but not limited to the home's documentation and procedures as related to the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Co-Director of Care (Co-DOC), Behavioural Support Ontario (BSO) Registered Nurse (RN), BSO Personal Support Worker (PSW), Environmental Service Manager, Activation Manager, dietary aides, RNs, Registered Practical Nurses (RPN), Personal Support Workers (PSW)/ Health Care Aides (HCA), family members and residents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure there were procedures and interventions developed and implemented, to assist residents and staff who are at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

A) The home submitted a number of Critical Incident (CI) reports to the Ministry of Health and Long Term Care (MOHLTC) related to allegations of inappropriate behaviours by an identified resident towards co-residents.

The homes policy "Resident Rights, Care and Services- Responsive Behaviours- Program" stated in part that:
All direct care staff are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a potential risk to the residents and/or staff, that those residents have a communication logo indicating high risk for responsive behaviours posted at the bedside.
That all residents are approached for care according to their plan of care.

A review of the plan of care found that the identified resident had exhibited inappropriate behaviours toward other residents in the home.

The plan of care at the time of the most recent incidents, identified a number of

interventions that would be implemented to address the inappropriate behaviours exhibited by the identified resident toward other residents in the home.

The physician documented in the progress notes "problematic behaviour" and "more supervision" would be required.

The resident was observed on more than one occasion and it was noted that interventions to address the inappropriate behaviours had not been implemented. In addition, the process to identify the resident as having behaviours was not in place.

B) A CI report stated that a resident exhibited responsive behaviours towards another resident. The resident had a specified intervention in place at the time of the incident.

The CI report stated that the responsive behaviours exhibited by the identified resident were witnessed by a staff member and they did not intervene. The report also indicated that the home was aware of previous altercations between the identified resident and co-residents.

The plan of care for the resident did not provide direction for staff in relation to preventing further altercations. No triggers were identified for the behaviours. The resident's plan of care did not identify that increased monitoring was in place.

Despite what the home had put in place to address the resident's responsive behaviours there continued to be altercations with co-residents.

In an interview with the DOC they acknowledged "staff just know", and none of the directions/strategies to manage the identified resident's responsive behavhiours were part of the resident's plan of care.

The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of behaviours including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 55. (a)]

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. 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.

For the purposes of the definition of 'abuse' in subsection 2 (1) of the Act, physical abuse is the use of physical force by a resident that causes physical injury to another resident.

A Critical Incident Systems (CIS) report was submitted to the Director in relation to an altercation between two residents which resulted in injury to a resident.

In separate interviews with staff, each stated that the identified resident had exhibited responsive behaviours toward co-residents.

The records stated that the injured resident was assessed and provided with treatment after the incident.

The licensee failed to protect a resident from physical abuse. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents are protected from abuse, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, immediately reported the suspicion and the information upon which it was based to the
Director.

The homes policy "Abuse –Zero –Tolerance Policy for Resident Abuse and Neglect", stated in part that 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 Ministry of Health and Long Term Care (MOHLTC) abuse of a resident by anyone. Suspected and or confirmed allegations of abuse shall be immediately reported.

During an interview with the DOC they said that they were aware of an alleged incident of inappropriate responsive behaviours by a resident toward another resident which resulted in injury to one of the residents. The DOC conducted an investigation to look into the incident, but did not immediately report the alleged abuse to the Director.

The licensee had reasonable grounds to suspect that abuse of a resident had occurred, but they did not immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A resident's documentation, showed that two staff members observed the resident exhibit inappropriate behaviours toward another resident but they had not contacted the SDM.

The homes policy "Abuse –Zero –Tolerance Policy for Resident Abuse and Neglect", stated the resident's Substitute Decision Maker (SDM) or any other person specified by the resident will be promptly advised of the alleged, suspected or witnessed incident of abuse.

Record review of documentation showed there was no evidence that the resident's SDM was notified of the incident.

During an interview with the DOC they said that they were aware of the incident of inappropriate behaviour by the identified resident toward another resident.

The licensee failed to ensure that a resident's SDM and any other person specified by the resident, were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident. [s. 97. (1) (b)]

Issued on this 8th day of July, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA COULTER (694), NATALIE MORONEY (610)
Inspection No. / No de l'inspection :	2019_739694_0007
Log No. / No de registre :	029566-17, 015085-18, 017994-18, 023920-18, 000025-19, 005491-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 20, 2019
Licensee / Titulaire de permis :	Southampton Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	Southampton Care Centre 140 Grey Street, Southampton, ON, N0H-2L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brenda Ohm

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee must be compliant with s. 55(a) of O. Reg. 79/10.

Specifically the licensee must:
a) Ensure that procedures and interventions are developed and implemented for residents with responsive behaviours to minimize the risk of altercations.
b) Ensure a written procedure for determining when one to one staffing would be utilized and when it would be discontinued, including the parameters used to make those decisions.
c) Ensure that all direct care staff receive training related to the procedures for managing resident's with responsive behaviours including:
-how resident's at risk of behaviours are identified,
-where staff receive direction for interventions to manage resident' responsive behaviours,
-the procedure used when staff are assigned to provide one to one monitoring for resident's with responsive behaviours,
d) Ensure that a written record is kept of the training including staff names, dates and training content.

Grounds / Motifs :

1. The licensee failed to ensure there were procedures and interventions

developed and implemented, to assist residents and staff who are at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

A) The home submitted a number of Critical Incident (CI) reports to the Ministry of Health and Long Term Care (MOHLTC) related to allegations of inappropriate behaviours by an identified resident towards co-residents.

The homes policy "Resident Rights, Care and Services- Responsive Behaviours-Program" stated in part that:
All direct care staff are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a potential risk to the residents and/or staff, that those residents have a communication logo indicating high risk for responsive behaviours posted at the bedside.
That all residents are approached for care according to their plan of care.

A review of the plan of care found that the identified resident had exhibited inappropriate behaviours toward other residents in the home.

The plan of care at the time of the most recent incidents, identified a number of interventions that would be implemented to address the inappropriate behaviours exhibited by the identified resident toward other residents in the home.

The physician documented in the progress notes "problematic behaviour" and "more supervision" would be required.

The resident was observed on more than one occasion and it was noted that interventions to address the inappropriate behaviours had not been implemented. In addition, the process to identify the resident as having behaviours was not in place.

B) A CI report stated that a resident exhibited responsive behaviours towards another resident. The resident had a specified intervention in place at the time of the incident.

The CI report stated that the responsive behaviours exhibited by the identified resident were witnessed by a staff member and they did not intervene. The report also indicated that the home was aware of previous altercations between the identified resident and co-residents.

The plan of care for the resident did not provide direction for staff in relation to preventing further altercations. No triggers were identified for the behaviours. The resident's plan of care did not identify that increased monitoring was in place.

Despite what the home had put in place to address the resident's responsive behaviours there continued to be altercations with co-residents.

In an interview with the DOC they acknowledged "staff just know", and none of the directions/strategies to manage the identified resident's responsive behavhiours were part of the resident's plan of care.

The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of behaviours including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 55. (a)]

The scope of the non-compliance was level 2, pattern. The severity of the non-compliance was level 2, minimal harm or minimal risk. The home has a level 2 compliance history of one or more non-compliance in the last three full years. (610)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 11, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 20th day of June, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amanda Coulter

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