Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 23, 2017	2017_595604_0001	000202-17	Resident Quality Inspection

Licensee/Titulaire de permis

Stayner Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Stayner Care Centre
244 MAIN STREET EAST 7308 HIGHWAY #26, P.O. BOX 350 STAYNER ON L0M 1S0

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

SHIHANA RUMZI (604), ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 9, 10, 11, 12, and 13, 2017.

The following intake was inspected concurrently with the Resident Quality Inspection: Critical Incident Report intake related to a missing resident for over 3 hours, log #035350-15.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, RAI-Coordinator, Continence Care Lead (CCL), Personal Support Workers (PSW), Registered Nurse (RN), Registered Practical Nurse (RPN), Nutrition Manager (NM), and President of the Residents' Council.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of: medication administration, staff and resident interactions, provision of care, conducted reviews of health records, and critical incident log, staff training records, meeting minutes of Resident and Family Council meetings, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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	Legendé 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home was a safe and secure environment for the residents.

The home submitted an identified Critical Incident System (CIS) report on an identified date to the Ministry of Health and Long Term Care (MOHLTC) related to a missing resident for over three hours. The CIS report indicated resident #006 was found to be missing from the home at on an identified date and time. A Code yellow was called, search of the building was conducted and when resident was not found in the home, and the police were called. The resident was found at an identified time, by the police dog not far from the home..

A review of resident #006's electronic Point Click Care (PCC) documentation indicated the resident had been admitted to the home on an identified date. A review of the PCC notes indicated that shortly after admission the resident presented with identified responsive behaviours and had three previous incidences of an identified responsive behaviour prior to the identified in the CIS report. The dates of previous identified responsive behaviours as indicated on the PCC progress notes are as follows:

- On an identified date and time, the resident presented with the identified responsive behaviours and was able to leave the home through and identified area of the home.

- On an identified date and time, the resident was unable to be found in the building after looking for approximately 10 minutes. Administrative staff noticed the resident walking on the side walk and indicated that the resident had walked out with sales staff who were in the home at meal time.

-On an identified date and time, resident #006 presented with the identified responsive behaviour and was able to exit the home.

Admission plan of care dated created on an identified date, indicated a focus as:
-Problematic manner in which resident acts characterized by identified responsive behaviours.

The plan of care identified specific interventions for resident #006.

The plan of care created on an identified date after the incident, did not show evidence of new interventions in place for residents elopement.

A review of four written plans of care on the identified dates for resident #006 in 2014 and 2015, did not show evidence of a reassessment or the plan of care being reviewed and revised when residents' identified responsive behaviour escalated and the plan in

place had not been effective as resident #006 presented with the identified responsive behaviours on three identified dates in 2014 and 2015.

Interviews with PSW #106 and #107 verified they worked on an identified date, when resident #006 presented with the identified responsive behavior on the identified shift. The PSWs stated that the resident presented with the identified responsive behavior in the past on other shifts prior to the incident which occurred on an identified date. The PSWs indicated that resident #006 was able to exit the home on an identified date and time, as a co-resident knew the code to enter and exit the home. The two PSW's indicated resident #006 could not recall information and did not know the exit code to the doors.

An interview with the night RN #108 confirmed he/she worked on an identified date and indicated that resident #006 exited the home with a co-resident who confirmed that he/she let resident #006 out of the home. The RN stated that the home did not ensure that the home was a safe and secure environment for resident #006. The RN further stated that there were no specific interventions used for residents at risk of an identified responsive behaviour and the home did not have other safety measures in place.

An interview with the home's Administrator confirmed resident #006 presented with an identified responsive behaviour on an identified date and shift, when the resident followed a co-resident out of the home. The administrator indicated the home failed to ensure that the home was a safe and secure environment for resident #006.

The severity of the non-compliance and the severity of harm and risk is actual as resident #006 had three previous incidents of the identified responsive behaviour in the home, no interventions where put in place to ensure the resident was safe in the home. The resident has since been transferred to another home with a secure unit.

The scope of the non-compliance is isolated.

A review of the home's compliance history revealed that there has been no previous non-compliances related to the Long-Term Care Homes Act O.Reg. s. 5.

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. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1.The licensee has failed to ensure that the following were documented: 1. The provision of the care set out in the plan of care.

The home submitted an identified CIS report on an identified date to the MOHLTC related to a missing resident for over three hours. The CIS report indicated resident #006 was found to be missing from the home at on an identified date and time. A Code yellow was called, search of the building was conducted and when resident was not found in the home, and the police were called. The resident was found at an identified time, by the police dog not far from the home. The inspector expanded the sample in the home to review written plans of care for residents who were identified as high risk for an identified responsive behaviour.

Interviews with PSW #106 and #107 indicated resident #007 had been identified at high risk for an identified responsive behaviour.

A review of resident #007's written plan of care created on an identified date, indicated under the focus:
-The resident has an identified responsive behaviour. As an intervention staff to monitor the whereabouts of the resident at identified times and to document on the Safety monitoring sheet.

A review of resident #007's "Stayner Care Centre Safety Monitoring Sheet" indicated that the whereabouts of the resident were not carried out as indicated in the written plan of care. A review of the history of the written plan of care indicated the intervention to check the resident had been created on an identified date in 2016. On on four identified shifts and dates in 2016, and three identified shifts and dates in 2017, revealed resident #007 was not checked with in the identified times.

An interview with RN #103 confirmed resident #007 presented with an identified responsive behaviour and staff had been carrying out monitoring on the resident. The RN indicated monitoring is carried out on all three shifts by the RN and is expected to document on the "Stayner Care Centre Safety Monitoring Sheet". The RN confirmed on four identified shifts and dates in 2016, and three identified shifts and dates in 2017, resident #007 was monitored.

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective.

The home submitted an identified CIS report on an identified date to the MOHLTC related to a missing resident for over three hours. The CIS report indicated resident #006 was found to be missing from the home at on an identified date and time. A Code yellow was called, search of the building was conducted and when resident was not found in the home, and the police were called. The resident was found at an identified time, by the police dog not far from the home.

A review of resident #006's electronic Point Click Care (PCC) documentation indicated the resident had been admitted to the home on an identified date. A review of the PCC notes indicated that shortly after admission the resident presented with identified responsive behaviours and had three previous incidences of an identified responsive behaviour prior to the identified in the CIS report. The dates of previous identified responsive behaviours as indicated on the PCC progress notes are as follows:

- On an identified date and time, the resident presented with the identified responsive behaviours and was able to leave the home through and identified area of the home.

- On an identified date and time, the resident was unable to be found in the building after looking for approximately 10 minutes. Administrative staff noticed the resident walking on the side walk and indicated that the resident had walked out with sales staff who were in the home at meal time.

-On an identified date and time, resident #006 presented with the identified responsive behaviour and was able to exit the home.

Admission plan of care dated created on an identified date, indicated a focus as:
-Problematic manner in which resident acts characterized by identified responsive behaviours.

The plan of care identified specific interventions for resident #006.

The plan of care created on an identified date after the incident, did not show evidence of new interventions in place for residents elopement.

A review of four written plans of care on the identified dates for resident #006 in 2014 and 2015, did not show evidence of a reassessment or the plan of care being reviewed and revised when residents' identified responsive behaviour escalated and the plan in place had not been effective as resident #006 presented with the identified responsive behaviours on three identified dates in 2014 and 2015.

An interview with the night RN #108 confirmed he/she worked on an identified date and indicated that resident #006 exited the home with a co-resident who confirmed that he/she let resident #006 out of the home. The RN stated that the plan of care did not consist of specific interventions for resident #006 who was at risk for an identified responsive behaviour.

An interview with the Administrator confirmed that resident #006 had not been reassessed and the plan of care was not reviewed and revised when the care set out in the plan of care had not been effective.

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 ensure that:
-the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act.

During stage one of the Resident Quality Inspection (RQI), it was noted from the census record reviews that seven out of twenty residents from the sample size had missing weights from months A, B, and C in 2016.

Record review of the weights summary on PCC indicated the following residents did not have their weights taken in month A in 2016: Residents #001, #005, #009, #010, #012 and #013.

Record review of the weights summary on PCC indicated that residents #001 and #005 did not have their weights taken in month B in 2016, and resident #004 did not have his/her weight taken in in month C in 2016.

During an interview, RN #103 and the Nutrition Manager (NM) confirmed the above-mentioned residents did not have their weights taken for the months that were identified above.

Record review of the home's policy titled "Resident Rights, Care and Services - Nutrition Care and Hydration Programs - Monthly Weights and Weight Variance Report" revised on November 4, 2014, indicated under policy that: "The weight monitoring system shall: Include measuring and recording of resident's weight monthly after admission".

Interview with the NM confirmed that the home's expectation was for the residents to be weighed monthly as per the home's policy.

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 ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee has failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

1.Resident #001 was triggered in stage two for incontinence through (LR) MDS [MR] assessment. A review of an identified assessment on an identified date indicated resident #001 usually continent for bowel and incontinent for bladder with the use of an identified product.

A review of resident #001's assessments did not show evidence of an "Incontinence Assessment" or an "Assessment of Continence" being carried out on admission or

anytime thereafter.

An interview conducted with PSW #107 verified resident #001 was incontinent of bladder and that staff assisted resident as the resident is able to inform them that he/she needs assistance. The PSW further indicated resident wears an identified product for incontinence.

An interview conducted with RN #103 indicated a "Incontinence Assessment" or an "Assessment of Continence" is to be carried out on admission and thereafter with any change in residents incontinence needs. The RN carried out a review of resident #001's assessments from admission and acknowledged resident #001 never had an "Incontinence Assessment" or an "Assessment of Continence" carried out.

An interview with the CPL #100 indicated an incontinence assessment is to be carried out on admission and thereafter with any change in status. The CPL confirmed a continence assessment was never carried out for resident on admission or anytime thereafter.

2. Resident #002 was triggered in stage two for incontinence (LR) MDS [MR]. A review of the residents identified assessment created on an identified dated, indicated resident #002 indicated continent of bowel and frequently incontinent with bladder, had an identified health issue, was on a scheduled toileting plan with no use of products.

A review of resident #002's assessments did not show evidence of an "Incontinence Assessment" or an "Assessment of Continence" being carried out on admission or anytime thereafter.

An interview conducted with PSW #107 verified resident #002 was incontinent of bladder and that staff assisted the resident at identified times. The PSW further indicated resident used an identified product for continence.

An interview conducted with RN #103 indicated it was the home's expectation is that "Incontinence Assessment" or an "Assessment of Continence" was to be carried out on admission and thereafter with any change in residents incontinence needs. The RN carried out a review of resident #002's assessments from admission and confirmed resident #002 has never had a home identified "Incontinence Assessment" or an "Assessment of Continence" carried out.

An interview with the CPL #100 indicated an incontinence assessment is to be carried out on admission and thereafter with any change in status. The CPL confirmed a continence assessment was never carried out for resident on admission or anytime thereafter.

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 ensure that a resident who is incontinent receives an assessment which includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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

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. 107 (4).

Findings/Faits saillants :

The licensee has failed to ensure that the Director was informed of an incident under subsection (1), (3) or (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, to make a report in writing to the Director setting out the following with respect to the incident: i. the immediate actions that have been taken to prevent recurrence.to make a report in writing to the Director setting out the immediate actions that have been taken to prevent recurrence.

The home submitted an identified CIS report on an identified date to the MOHLTC related to a missing resident for over three hours. The CIS report indicated resident #006 was found to be missing from the home at on an identified date and time. A Code yellow was called, search of the building was conducted and when resident was not found in the home, and the police were called. The resident was found at an identified time, by the police dog not far from the home.

On an identified date, the Director, requested the home to provide an action plan to prevent recurrence of the incident with resident #006. A review of the Long Term Care Home's (LTCH) Net by the inspector did not reveal the home amended the original CIS report which was submitted on an identified date by the home, providing the information required by the Director.

An interview with the Administrator indicated he/she and the Director of Care (DOC) of the home were the two individuals that are able to submit and amend CIS reports. The Administrator when on the LTCH site and verified the information requested by the Director was not provided as of an identified date in 2017.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 23rd day of February, 2017

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

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHIHANA RUMZI (604), ROMELA VILLASPIR (653)
Inspection No. / No de l'inspection :	2017_595604_0001
Log No. / Registre no:	000202-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 23, 2017
Licensee / Titulaire de permis :	Stayner Care Centre Inc. c/o Jarlette Health Services, 5 Beck Boulevard, PENETANGUISHENE, ON, L9M-1C1
LTC Home / Foyer de SLD :	Stayner Care Centre 244 MAIN STREET EAST, 7308 HIGHWAY #26, P.O. BOX 350, STAYNER, ON, L0M-1S0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jackie Schrum

To Stayner 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

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

Within one week of receiving this order, the home shall provide a plan to the inspector on March 3, 2017, the plan shall include:

1) Residents identified with responsive behaviours which include wandering and exit seeking are assessed and the plan of care updated with interventions to ensure strategies are developed and implemented to keep residents safe in the home.

Please submit the plan to the inspector shihana.rumzi@ontario.ca. within one week of receipt of this order.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for the residents.

The home submitted an identified Critical Incident System (CIS) report on an identified date to the Ministry of Health and Long Term Care (MOHLTC) related to a missing resident for over three hours. The CIS report indicated resident #006 was found to be missing from the home at on an identified date and time. A Code yellow was called, search of the building was conducted and when resident was not found in the home, and the police were called. The resident was found at an identified time, by the police dog not far from the home..

A review of resident #006's electronic Point Click Care (PCC) documentation indicated the resident had been admitted to the home on an identified date. A review of the PCC notes indicated that shortly after admission the resident presented with identified responsive behaviours and had three previous

incidences of an identified responsive behaviour prior to the identified in the CIS report. The dates of previous identified responsive behaviours as indicated on the PCC progress notes are as follows:

- On an identified date and time, the resident presented with the identified responsive behaviours and was able to leave the home through and identified area of the home.

- On an identified date and time, the resident was unable to be found in the building after looking for approximately 10 minutes. Administrative staff noticed the resident walking on the side walk and indicated that the resident had walked out with sales staff who were in the home at meal time.

-On an identified date and time, resident #006 presented with the identified responsive behaviour and was able to exit the home.

Admission plan of care dated created on an identified date, indicated a focus as:
-Problematic manner in which resident acts characterized by identified responsive behaviours.

The plan of care identified specific interventions for resident #006.

The plan of care created on an identified date after the incident, did not show evidence of new interventions in place for residents elopement.

A review of four written plans of care on the identified dates for resident #006 in 2014 and 2015, did not show evidence of a reassessment or the plan of care being reviewed and revised when residents' identified responsive behaviour escalated and the plan in place had not been effective as resident #006 presented with the identified responsive behaviours on three identified dates in 2014 and 2015.

Interviews with PSW #106 and #107 verified they worked on an identified date, when resident #006 presented with the identified responsive behavior on the identified shift. The PSWs stated that the resident presented with the identified responsive behavior in the past on other shifts prior to the incident which occurred on an identified date. The PSWs indicated that resident #006 was able to exit the home on an identified date and time, as a co-resident knew the code to enter and exit the home. The two PSW's indicated resident #006 could not

recall information and did not know the exit code to the doors.

An interview with the night RN #108 confirmed he/she worked on an identified date and indicated that resident #006 exited the home with a co-resident who confirmed that he/she let resident #006 out of the home. The RN stated that the home did not ensure that the home was a safe and secure environment for resident #006. The RN further stated that there were no specific interventions used for residents at risk of an identified responsive behaviour and the home did not have other safety measures in place.

An interview with the home's Administrator confirmed resident #006 presented with an identified responsive behaviour on an identified date and shift, when the resident followed a co-resident out of the home. The administrator indicated the home failed to ensure that the home was a safe and secure environment for resident #006.

The severity of the non-compliance and the severity of harm and risk is actual as resident #006 had three previous incidents of the identified responsive behaviour in the home, no interventions where put in place to ensure the resident was safe in the home. The resident has since been transferred to another home with a secure unit.

The scope of the non-compliance is isolated.

A review of the home's compliance history revealed that there has been no previous non-compliances related to the Long-Term Care Homes Act O.Reg. s. 5.
(604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 24, 2017

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 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 23rd day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shihana Rumzi

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