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

London Service Area Office
130 Dufferin Avenue 4th floor
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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
Feb 6, 2020	2020_729615_0003	023795-19	Critical Incident System

Licensee/Titulaire de permis

S & R Nursing Homes Ltd.
265 North Front Street Suite 200 SARNIA ON N7T 7X1

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

Twin Lakes Terrace Long Term Care Community
1310 Murphy Road SARNIA ON N7S 6K5

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

HELENE DESABRAIS (615)

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): January 30 and 31, 2020.

The following Critical Incident (CI) was inspected during this inspection:

CI #2889-000010-19/Log #023795-19 related to prevention of abuse, neglect, and retaliation.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Registered Practical Nurse - Behavioural Support Ontario and one Personal Support Worker.

The inspector(s) also toured the home, observed resident to resident interactions, reviewed clinical records, incident report, investigation notes and reviewed specific policies and procedures of the home.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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 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.

On a specific date, the home submitted Critical Incident report #2889-000010-19/Log #023795-19 to the Ministry of Long Term Care indicating resident to resident physical abuse resulting in injuries.

Review of resident's progress notes in Point Click Care (PCC) as follow:

On five separate dates, it was documented that the two same residents had verbal and/or physical altercations. On a specific date, a last physical altercation occurred resulting in physical injuries to the identified resident.

A review of the resident's plan of care, identified that there was no documented evidence to support that identifying factors that would trigger such altercations between the two residents and interventions in place.

During interviews, a Registered Practical Nurse - Behavioural Support Ontario and a Personal Support Worker, both stated not knowing what the resident's triggers were, that the resident's behaviours were unpredictable and that no training was provided to them on behaviours related to these specific residents.

During an interview, the Director of Care agreed that one of the resident had behaviours towards the other resident over time and that there were no identifying factors and no plan of care around their occurring incidents documented. The DOC added that staff in the home were not provided training regarding to these two residents and that maybe it could help.

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

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where a written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

O. Regs, 79/10, s.2 (1) For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “sexual abuse” means, (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; (“mauvais traitement d’ordre sexuel”).

On a specific date, the home submitted Critical Incident (CI) #2889-000010-19/Log #023795-19 related to resident to resident physical abuse.

During a review of a resident's progress notes in Point Click Care (PCC) the following was discovered:

On two specific dates, the resident was found with residents with inappropriate behaviours towards them. On a different date, the resident was found sexually abusing a resident.

Review of the home's policy #ADMIN 08-05 titled "Resident Abuse and Neglect" last revised November 7, 2019, stated in part "Any employee or volunteer who witness an incident of resident abuse, or has knowledge of an incident that constitutes resident abuse or neglect, will immediately inform the Administrator, Manager Resident Care (MRC), or in their absence, the Charge Nurse/delegate in the home, of any incident of suspected or witnessed abuse".

A review of the resident's plan of care, there were no documented evidence to support that there were identifying factors based on an assessment that would trigger such behaviours.

During an interview, a Registered Practical Nurse - Behavioural Support Ontario and a Personal Support Worker both stated that the incident on that specific date, was abuse of sexual nature and should of been reported to the management team.

During an interview, the Director of Care stated that the incident between the residents on that specific date was abuse of sexual nature and should of been reported to the management team so that it could be reported to the Director.

The licensee has failed to ensure that where a written policy that promotes zero tolerance of abuse and neglect of residents was complied with. [s. 20. (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 that where a written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 138. Absences

Specifically failed to comply with the following:

s. 138. (2) The requirements referred to in subsection (1) are,
(a) in the case of a medical absence, that the length of the medical absence does not exceed 30 days; O. Reg. 79/10, s. 138 (2).
(b) in the case of a psychiatric absence, that the length of the psychiatric absence does not exceed 60 days; O. Reg. 79/10, s. 138 (2).
(c) in the case of a casual absence during the period between midnight on a Saturday and midnight on the following Saturday, that the total length of the resident's casual absences during the period does not exceed 48 hours; O. Reg. 79/10, s. 138 (2).
(d) in the case of a vacation absence, that the total length of the resident's vacation absences during the calendar year does not exceed 21 days. O. Reg. 79/10, s. 138 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a long-stay resident of the home returns from a medical absence, psychiatric absence, casual absence, or vacation absence, the resident receives the same class of accommodation, the same room, and the same bed in the room, that the resident had before the absence. O. Reg. 79/10, s. 138 (1).

O. Reg. 79/10, s.138 (2) The requirements referred to in subsection (1) are, (b) in the case of a psychiatric absence, that the length of the psychiatric absence does not exceed 60 days.

On a specific date, the home reported to the Ministry of Long Term Care, via the after hour pager, an incident related to resident to resident physical abuse.

During an interview, the Administrator stated that one resident was sent to the hospital for a psychiatric assessment after the incident.

Review of the home's documentation, a letter was sent to the resident's family to inform them that the resident was being discharged from the home, 30 days after the resident was admitted to the hospital on a psychiatric leave.

During a telephone interview, a Local Health Integration Network (LHIN) Manager stated they had been involved later in the process of discharging the resident and that their understanding was that the family had come to the home, gave up the bed and cleaned the room.

During a telephone interview with the resident's family, they stated that they did not give up the bed but was told that the resident was not coming back to the home as they were being discharged from the home.

During an interview, the DOC stated that the identified resident should not of have been discharged from the home prior to the 60 days psychiatric leave.

During an interview, the Administrator and DOC stated that it was the first time they had discharged a resident, that they weren't too sure of the process and that the legislation was confusing to them.

The licensee failed to ensure that when a long-stay resident of the home returns from a

medical absence, psychiatric absence, casual absence, or vacation absence, the resident receives the same class of accommodation, the same room, and the same bed in the room, that the resident had before the absence. O. Reg. 79/10, s. 138 (1). O. Reg. 79/10, s. 138 (2) The requirements referred to in subsection (1) are, (b) in the case of a psychiatric absence, that the length of the psychiatric absence does not exceed 60 days. [s. 138. (2)]

Issued on this 10th day of February, 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) :	HELENE DESABRAIS (615)
Inspection No. / No de l'inspection :	2020_729615_0003
Log No. / No de registre :	023795-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 6, 2020
Licensee / Titulaire de permis :	S & R Nursing Homes Ltd. 265 North Front Street, Suite 200, SARNIA, ON, N7T-7X1
LTC Home / Foyer de SLD :	Twin Lakes Terrace Long Term Care Community 1310 Murphy Road, SARNIA, ON, N7S-6K5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cathy McIntosh

To S & R Nursing Homes Ltd., 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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee shall prepare and submit a plan for achieving compliance with LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)(a).

The plan must include:

1. What immediate and long term actions will be implemented for any resident exhibiting responsive behaviours that pose a risk to other residents and/or staff.

2.Training and education for all staff members providing care to residents in the home who exhibit responsive behaviours, who will be responsible for providing the training, a list of all staff; including the dates of who attended the training. Training shall be provided to all staff members no later than the compliance due date.

3. Identify triggering factors related to any residents in the home that exhibit responsive behaviours and what interventions will be implemented into their plan of care.

Please submit the plan, in writing quoting log number 023795-19 to Helene Desabrais, Long Term Care Homes Inspector, Ministry of Long-Term Care, Inspection Branch at helene.desabrais@ontario.ca no later than February 11, 2020.

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.

On a specific date, the home submitted Critical Incident report #2889-000010-19/Log #023795-19 to the Ministry of Long Term Care indicating resident to resident physical abuse resulting in injuries.

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

During this inspection, this non-compliance was found to have a severity of actual harm to the resident. The scope was isolated. The home had no previous history of non-compliance in this area.

(615)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 03, 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:

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 6th day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Helene Desabrais

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