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

Amended Public Copy/Copie modifiée 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
Sep 17, 2019	2019_755728_0016 (A1)	014864-19, 015044-19, 015204-19	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Bruce
30 Park Street WALKERTON ON N0G 2V0

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

Brucelea Haven Long Term Care Home - Corporation of the County of Bruce
41 McGivern Street West P.O. Box 1600 WALKERTON ON N0G 2V0

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

Amended by MARIA MCGILL (728) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

change compliance due date

Issued on this 17th day of September, 2019 (A1)

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

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*

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Brucelea Haven Long Term Care Home - Corporation of the County of Bruce
41 McGivern Street West P.O. Box 1600 WALKERTON ON N0G 2V0

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

Amended by MARIA MCGILL (728) - (A1)

Amended 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): August 6-8, 2019.

The following intakes were completed in this Critical Incident System Inspection:

Log #014864-19 related to fall resulting in a significant change,

Log #015044-19 and Log# 015204-19 related to unexpected deaths.

During the course of the inspection, the inspector(s) spoke with the Director of Health Services, the Administration, the Director of Care - Quality (DOC-Q), the Director of Care - Clinical (DOC-C), the Administrative Supervisor, Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

The inspector(s) reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, and the home's documentation related to relevant investigations.

Observations were made of residents, resident care provision, and staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition

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

1 WN(s)
0 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 :

The licensee failed to ensure that resident #002 was protected from neglect.

Ontario Regulation 79/10 defined neglect as the failure to provide a resident with the treatment, care, services, or assistance required for health, safety, or well-being, and included inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents.

i) A Critical Incident (CI) was submitted to the Ministry of Long-term Care (MLTC), related to the unexpected death of resident #002. The CI documented that the resident had been experiencing identified symptoms.

The resident's plan of care identified risks related to their symptoms and specified interventions, if resident #002 presented with the symptoms, that included calling a physician.

Documentation stated the resident was exhibiting specific symptoms for four days until a physician was notified.

Resident #002's plan of care documented that RPN #114 faxed a physician requesting that they review the resident's progress notes for an identified period of time and provide a recommendation for care. The physician prescribed a treatment for the resident based on a review of the progress notes. The resident passed away soon after.

RPN #114 said that it was possible that inconsistencies in staffing contributed to the delay in contacting the physician. RPN #108 said that they did not contact the physician following an identified event or when the resident was displaying symptoms because they planned to monitor resident #002 over a two day period.

DOC-Q #102 said that there was a four day period of time where the resident displayed symptoms prior to the physician being notified. DOC-Q said that

registered staff should have contacted the physician when the resident initially presented with the specified symptoms.

ii) There was no documentation in the resident's plan of care to support that resident #002's substitute decision maker (SDM) was notified when resident #002's condition changed.

DOC-Q #102 said that resident #002's SDM should have been contacted by the home when they initially presented with the specified symptoms. Because they were not notified they were not provided the opportunity to be included in the resident's plan of care during the days prior to the resident's death.

The licensee failed to ensure that resident #002 was protected from neglect when they were not provided the opportunity for treatment or assessment by a physician or including the SDM in their plan of care. [s. 19. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

Issued on this 17th day of September, 2019 (A1)

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

Ordre(s) de l'inspecteur

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MARIA MCGILL (728) - (A1)
Inspection No. / No de l'inspection :	2019_755728_0016 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	014864-19, 015044-19, 015204-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 17, 2019(A1)
Licensee / Titulaire de permis :	Corporation of the County of Bruce 30 Park Street, WALKERTON, ON, N0G-2V0
LTC Home / Foyer de SLD :	Brucelea Haven Long Term Care Home - Corporation of the County of Bruce 41 McGivern Street West, P.O. Box 1600, WALKERTON, ON, N0G-2V0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Willie VanKlooster

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 Corporation of the County of Bruce, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 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 :

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically, the licensee must:
a) ensure that all residents are protected from neglect;
b) ensure that any residents substitute decision maker is given the opportunity to participate fully in the development and implementation of the residents plan of care; and,
c) provide and maintain documentation of education to all registered staff related to the home's process when a resident experiences a change in status including but not limited to:
i) when a physician is required to be notified;
ii) what the level of care means; and,
iii) the process for involving substitute decision makers in care decisions.

Grounds / Motifs :

1. The licensee failed to ensure that resident #002 was protected from neglect.

Ontario Regulation 79/10 defined neglect as the failure to provide a resident with the treatment, care, services, or assistance required for health, safety, or well-being, and included inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents.

i) A Critical Incident (CI) was submitted to the Ministry of Long-term Care (MLTC), related to the unexpected death of resident #002. The CI documented that the resident had been experiencing identified symptoms.

The resident's plan of care identified risks related to their symptoms and specified interventions, if resident #002 presented with the symptoms, that included calling a physician.

Documentation stated the resident was exhibiting specific symptoms for four days until a physician was notified.

Resident #002's plan of care documented that RPN #114 faxed a physician requesting that they review the resident's progress notes for an identified period of time and provide a recommendation for care. The physician prescribed a treatment for the resident based on a review of the progress notes. The resident passed away soon after.

RPN #114 said that it was possible that inconsistencies in staffing contributed to the delay in contacting the physician. RPN #108 said that they did not contact the physician following an identified event or when the resident was displaying symptoms because they planned to monitor resident #002 over a two day period.

DOC-Q #102 said that there was a four day period of time where the resident displayed symptoms prior to the physician being notified. DOC-Q said that registered staff should have contacted the physician when the resident initially presented with the specified symptoms.

ii) There was no documentation in the resident's plan of care to support that resident #002's substitute decision maker (SDM) was notified when resident #002's condition changed.

DOC-Q #102 said that resident #002's SDM should have been contacted by the home when they initially presented with the specified symptoms. Because they were not notified they were not provided the opportunity to be included in the resident's plan of care during the days prior to the resident's death.

The licensee failed to ensure that resident #002 was protected from neglect when they were not provided the opportunity for treatment or assessment by a physician or including the SDM in their plan of care.

The severity of this issue was determined to be a level 4 as there was serious harm to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 3 history as they had previous non-compliance to the same subsection that included:
- compliance order (CO) issued June 11, 2019 (2019_610633_0005)
- CO issued October 26, 2018 (2018_580568_0014)
- CO issued January 18, 2018 (2017_610633_0023) (728)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Sep 20, 2019(A1)

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 17th day of September, 2019 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by MARIA MCGILL (728) - (A1)

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