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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 19, 2015	2015_365194_0002	001550-15, 001551-15, 001576-15	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE CENTRAL ONTARIO INC
82 Park Road North OSHAWA ON L1J 4L1

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

EXTENDICARE HALIBURTON
167 PARK STREET P.O. BOX 780 HALIBURTON ON K0M 1S0

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

CHANTAL LAFRENIERE (194)

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 28, 29, 30 and February 9, 2015

Inspected during the course of this inspection were Critical Incident logs #O-001550-15, #O-001551-15 and a complaint log #O-001576-15.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care,(Admin/DOC),Identified Residents, Family, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and Housekeeping staff.

Also completed during the inspection was observation of identified residents, provision of staff/resident care, review of licensee policy related to abuse, complaints and responsive behaviours, internal investigation into abuse incidents, complaint logs, nursing schedules, clinical health records of identified residents and staff educational records.

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

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **8 VPC(s)**
- **2 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. 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 are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purpose of the definition of "abuse" in subsection 2(1) of the Act,
"Physical Abuse" means to subsection (2)
-the use of physical force by anyone other than a resident that causes physical injury or pain

"Sexual Abuse" means,
-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

Between the period of an identified month, two Critical Incidents Reports (CIR) of sexual abuse, between residents and one Critical Incident Report (CIR) of physical abuse, staff to resident, was reported.

Log #O-001550-15 and #O-001551-15

On an identified date, PSW #103 witnessed Resident #1, being sexually abusive towards Resident #2. Later the same day, PSW #103 witnessed Resident #1, being sexually abusive towards Resident #3's.

Log # O-001576-15

Seven days later, Resident #4 reported to PSW during morning care, of being physically abused by staff. The resident complained of pain. The PSW reported the incident to the RN #126.

During the inspection of these three allegations of abuse the following areas of concern were noted:

-Immediate reporting of the three allegations of abuse as directed by the legislation was not completed. WN#6(s.24)
-Registered staff identified that no education related to immediate notification related to abuse was completed. WN#7(s.76)
-Immediate investigation into the three allegations of abuse was not completed. WN#5(s.23)
-Actions to protect the residents in the three allegations of abuse were not taken WN#5(s.23)

-Failure to comply with the licensee's Abuse policy "OPER-02-02-04" WN#4(s.20)
-Failure to notify the appropriate police force immediately notified WN#9(s.98)
-Failure to notify resident's substitute decision maker(SDM), if any, and any other person specified by the resident immediately upon the licensee becoming aware of an alleged abuse WN#8(s.97)
-Care set out related to responsive behaviours was not provided as specified in the plan WN#3(s.6(7)) [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is an employee of the licensee and member of the regular nursing staff is on duty and present at all times unless there is an allowable exception to this requirement.

s.45(1) related to exceptions directs;
for homes with a licensed bed capacity of 64 bed or fewer,

-in case of an emergency where the back-up plan referred to in clause 31(3)(d) of this regulation fails to ensure that the requirements under subsection 8(3) of this Act is met,

A registered practical nurse who is a member of the regular nursing staff may be used if the Director of Nursing or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by phone.

An "emergency" as defined in the Act , means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

During the period of December 8, 2014 to February 1, 2015 there were 11 shifts identified where an RN was not on duty and present in the home.

During an interview with the DOC/Administrator related the identified shifts, the inspector was informed that the RN shifts filled by an RPN were RN vacation shifts and RN sick calls. The DOC/Administrator informed the inspector that the back up plan in place at the home when RN shifts can not be filled, was to call in the RPN's. [s. 8. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care related to a resident with responsive behaviours was provided to the resident as specified in the plan

The crisis plan of care initiated during an identified period for Resident #1 directs one to one (1:1) supervision to be provided for the resident for safety of self and others.

RN#110 described an incident that occurred on an identified date when the PSW staff, who was providing 1:1 supervision for Resident #1, went to break and co-workers were asked to "watch the resident". Resident #1 was seen by co-worker crossing the hall into a co-resident room, Resident #1 was redirected to his room by staff.

PSW#109 informed inspector that on the identified date the 1:1 staff member had asked staff #114 to watch Resident#1, when PSW #109 came to the lounge, it was noted that Resident#1 was not being supervised and was "circling" residents in the lounge.
RN #113 indicated being aware of this incident and is unable to explain why staff #114 was not watching the resident.
Staff #114 indicated being asked to watch resident #1 by the PSW responsible for the 1:1 care of the resident. Staff # 114 stated "I thought RPN was watching and I was only to listen, I wasn't sure what was expected" staff #114 indicated that Resident #1 was sitting in the TV lounge watching TV in front of the nursing station and staff #114 was in the front hall by the main door, staff #114 indicated not hearing anything so did not feel there was anything to watch or look at.

Both incidents described above placed residents in the home at potential risk from Resident #1 who was to be monitored 1:1 for inappropriate responsive behaviours. [s. 6. (7)]

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 by ensuring that care set out related to abusive residents, in the plan of care is provided as specified in the plan., to be implemented voluntarily.

WN #4: 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 the policy that promotes zero tolerance of abuse and neglect of resident was complied with.

The licensee's Policy of Abuse "OPER-02-02-04" involving residents directs:
Responding/Reporting - suspected or witnessed abuse;
-immediately report (verbally) any suspected or witnessed abuse to the Administrator, Director of Care or their designate must report the incident as required by provincial legislation.
-anyone who suspects or witnesses abuse and/or neglect that causes or may cause harm to a resident is required to contact the Ministry of Health and Long Term Care (MOHLTC).

Actions to be taken if another resident,
-if possible, relocate the resident to a safe location
-assign an employee to stay with the alleged perpetrator
-if the alleged perpetrator is to remain in the home, request that the medical practitioner/designate assess the resident as soon as possible

-contact the SDM if any
-consider the appropriateness of implementing 1:1 staffing
-contact regulatory bodies that provide for additional resources to assist in managing the behaviours.

Upon Notification of abuse:
-contact police, if a criminal offence has taken place (eg physical assault). Otherwise,confer with Regional Director as to whether or not to contact police.
-Immediately notify the following, if the resident experiences abuse that resulted in physical injury or pain or distress that can be detrimental to the health and well being of the resident.
  -the resident's Substitute Decision Maker.
-Initiate an internal investigation and complete a preliminary report before going off duty.

Log # O-001550-15 and #O-001551-15

On an identified date two incidents of sexual abuse were witnessed by PSW at the home. PSW reported the incidents to the RN #104.

RN #104 did not immediately notify the Administrator, the MOHLTC, police or Substitute Decision Maker(SDM),initiate an investigation into the allegations or take action to ensure the residents safety as directed by the policy.

Log #O-001576-15

On an identified date, RN#126 on duty was notified by the PSW providing care to Resident #4, that an allegation of abuse by staff was brought forward by the resident.

RN #126 left a message for the Administrator, did not notify the MOHLTC, Police, Power of Attorney (POA),initiate an investigation into the allegations or take action to ensure the resident's safety as directed by the policy. [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 by ensuring the licensee's policies on abuse are complied with by all staff., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:

Logs #O-001550-15, #O-001551-15

On an identified date, PSW #103 witnessed Resident #1, being sexual abusive towards Resident #2. Later the same day , PSW #103 witnessed Resident #1 being sexually abusive towards Resident #3.

PSW #103 indicated she reported both incidents to RN #104.

RN #104 indicated during interview that she did not feel the information related to her by PSW "warranted calling police or notifying the Administrator/DOC."

RN #101 indicated investigation into the abuse was initiated on the following day.

Log #O-001576-15
Seven days later, Resident #4 reported to PSW during morning care, of being physically abused by staff.. The resident complained of pain. The PSW reported the incident to the RN #126, who did not initiate an immediate investigation.

RN #101 indicated that the investigation into the allegation of abuse for this incident was initiated later that day. . [s. 23. (1) (a)]

2. The licensee has failed to ensure that appropriate action was taken in response to the incident.

Log #O-001550-15, #O-001551-15

PSW #103 reported 2 separate incidents of sexual abuse involving Resident # 1 to RN #104 on an identified date. An investigation was not initiated, Administrator/DOC was not immediately notified, Police were not called, no interventions were put into place to ensure the safety of other residents in the home.
-1:1 supervision for Resident#1 was not initiated for 26 hours.

Log#O-001576-15
Seven days later, Resident #4 reported to PSW during morning care, of being physically abused by staff. The resident complained of pain. The PSW reported the incident to the RN #126.

The two PSW staff were taken off work rotation two days after the allegations of abuse, pending outcome of investigation. [s. 23. (1) (b)]

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 by ensuring that will all allegations of abuse an immediate investigation is initiated and action taken to protect residents safety., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that an incidents of sexual and physical abuse were immediately reported to the Director

Log #O-001550-15 and #O-001551-15

On an identified date, PSW #103 witnessed Resident #1, being sexual abusive towards Resident #2. Later the same day , PSW #103 witnessed Resident #1 being sexually abusive towards Resident #3.

RN #101 indicated that the incidents involving Resident # 1, #2 and #3 above were not reported to the Director until 30 hours later. [s. 24. (1)]

2. Log # O-001576-15

Seven days later, Resident #4 reported to PSW during morning care, of being physically abused by staff. The resident complained of pain. The PSW reported the incident to the RN #126. RN #126 called the DOC/Administrator at home and on the cell phone and left messages. The Director was notified of allegation of abuse 36 hours later. [s. 24. (1)]

3. The POA of Resident #4 informed the inspector that during the past year, 3 verbal concerns had been brought forward to the DOC/Administrator at the home.

DOC/Administrator has informed the inspector when asked about the verbal allegations involving Resident # 4, that she remembers the incidents and that an investigation was completed with no evidence to support the allegations in all cases. DOC/Administrator has informed inspector that the 3 reported incidents were not reported to the Director [s. 24. (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 by ensuring that all allegation of abuse by anyone is immediately reported to the Director., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retaining annually relating to the following:
The duty to make mandatory reports under section 24.

Interview with Registered staff # 126, 112, 113, 110 and 104 indicated that they were not aware of their responsibilities as required in the licensee's Policy "OPER-02-02-04 or LTCHA, 2007, s. 24 for immediate notification/mandatory reports. All staff interviewed indicated that incidents were reported to the Administrator/Director of Care who would manage or direct.

Administrator/Director of Care indicated, during interview with inspection, that staff were responsible for immediate notification/mandatory reports in her absence. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensure that all staff have received retaining annually relating to the following:
The duty to make mandatory reports under section 24., to be implemented voluntarily.

WN #8: 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 SDM's were immediately notified upon becoming aware of abuse resulting in pain or distress to the residents.

Log#O-001550-15 and #O-001551-15

On an identified date, PSW #103 witnessed Resident #1, being sexual abusive towards Resident #2. Later the same day , PSW #103 witnessed Resident #1 being sexually abusive towards Resident #3.

SDM's were not notified of the incidents until the next day.

Log#O-001576-15
Seven days later, Resident #4 reported to PSW during morning care, of being physically abused by staff. The resident complained of pain. The PSW reported the incident to the RN #126. RN #126 did not contact SDM to inform of the allegations.

The SDM came to the home to visit and the Resident informed the SDM of the allegations of abuse. [s. 97. (1) (a)]

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 by ensuring that the resident's substitute decision maker (SDM), if any, and any other person specified by the resident are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse 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., to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate police force was immediately notified of abuse.

Log #O-001550-15 and #O-001551-15

On an identified date two episodes of sexual abuse were reported at the home. Police were notified the next day.

Log# O-001576-15
Seven days later, Resident #4 reported to PSW during morning care, of being physically abused by staff. The resident complained of pain. The PSW reported the incident to the RN #126. The police was not notified, family called the police later that day. [s. 98.]

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 by ensuring that appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence., to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant?

The POA of Resident #4 informed the inspector that during the past year, 3 verbal concerns had been brought forward to the DOC/Administrator at the home.

DOC/Administrator has informed the inspector when asked about the verbal allegations involving Resident # 4, that she remembers the incidents and that an investigation was completed with no evidence to support the allegations in all cases. DOC/Administrator has informed inspector that the 3 reported incidents were not reported to the Director.

The licensee's complaint log indicated 21 recorded incidents for 2014. The complaint log does not identify the 3 incidents involving Resident #4 related to "rough handling" by staff.

The licensee's was issued a Written Notification for this area of non-compliance in October 2014 under inspection # 2014_293554_0035. [s. 101. (2)]

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 by ensuring that all verbal complaints are documented and records kept in the homes complaint log., to be implemented voluntarily.

Issued on this 2nd day of March, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2015_365194_0002
Log No. / Registre no:	001550-15, 001551-15, 001576-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 19, 2015
Licensee / Titulaire de permis :	EXTENDICARE CENTRAL ONTARIO INC 82 Park Road North, OSHAWA, ON, L1J-4L1
LTC Home / Foyer de SLD :	EXTENDICARE HALIBURTON 167 PARK STREET, P.O. BOX 780, HALIBURTON, ON, K0M-1S0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JANE ROSENBERG

To EXTENDICARE CENTRAL ONTARIO INC, 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) (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, implement and submit a corrective action plan to ensure that the following measures are in place so that residents are protected from abuse by anyone.

- ensuring all allegations of abuse involving residents are to be reported immediately to the Director. LTCHA, 2007 s. 24(1)
- re-education and ensuring compliance of all staff related to the licensee's Policy on Abuse "OPER-02-02-04". Specifically focusing on staff responsibility as it relates to, immediate notification of the Director. LTCHA, 2007 s. 24(1)
- ensuring that all allegations of abuse are immediately investigated and that actions are take to ensure resident safety. LTCHA, 2007 s. 23(1)(a)(b)
- ensuring that the resident's substitute decision -maker, if any, and any other person specified by the resident, are notified of incidents of abuse. O.Reg 79/10 s. 97(1)(a)(b)
- ensuring that appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse that the licensee constitutes a criminal offence. O.Reg.79/10 s. 98
- ensuring that the care set out related to responsive behaviours is provided as specified in the plan WN#3(s.6(7))

The licensee will provide a written plan by March 01, 2015.
This plan must be submitted in writing to the MOHLTC, Attention: Chantal Lafreniere, Fax (613)569-9670.

Grounds / Motifs :

1. For the purpose of the definition of "abuse" in subsection 2(1) of the Act, "Physical Abuse" means to subsection (2)

-the use of physical force by anyone other than a resident that causes physical injury or pain

"Sexual Abuse" means,
-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

Between the period of an identified month, two Critical Incidents Reports (CIR) of sexual abuse, between residents and one Critical Incident Report (CIR) of physical abuse, staff to resident, was reported.

Log #O-001550-15 and #O-001551-15

On an identified date, PSW #103 witnessed Resident 1#, being sexually abusive towards Resident #2. Later the same day, PSW #103 witnessed Resident #1, being sexually abusive towards Resident #3's.

Log # O-001576-15

Seven days later, Resident #4 reported to PSW during morning care, of being physically abused by staff. The resident complained of pain. The PSW reported the incident to the RN #126.

During the inspection of these three allegations of abuse the following areas of concern were noted:

-Immediate reporting of the three allegations of abuse as directed by the legislation was not completed. WN#6(s.24)
-Registered staff identified that no education related to immediate notification related to abuse was completed. WN#7(s.76)
-Immediate investigation into the three allegations of abuse was not completed. WN#5(s.23)
-Actions to protect the residents in the three allegations of abuse were not taken WN#5(s.23)
-Failure to comply with the licensee's Abuse policy "OPER-02-02-04" WN#4(s.20)
-Failure to notify the appropriate police force immediately notified WN#9(s.98)
-Failure to notify resident's substitute decision maker(SDM), if any, and any

other person specified by the resident immediately upon the licensee becoming aware of an alleged abuse WN#8(s.97)
-Care set out related to responsive behaviours was not provided as specified in the plan WN#3(s.6(7)) [s. 19. (1)] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure measures are in place for at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

The licensee will provide a written plan by March 01, 2015.
This plan must be submitted in writing to the MOHLTC, Attention: Chantal Lafreniere, Fax (613)569-9670.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who is an employee of the licensee and member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement.

s.45(1) related to exceptions directs;
for homes with a licensed bed capacity of 64 bed or fewer,

in case of an emergency where the back-up plan referred to in clause 31(3)(d) of this regulation fails to ensure that the requirments under subsection 8(3) of this Act is met,

A registered practical nurse who is a member of the regular nursing staff may be used if the Director of Nursing or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by phone.

An "emergency" as defined in the Act , means an unforseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

During the period of December 8, 2014 to February 1, 2015 there were 11 shifts identified were an RN was not on duty and present in the home.

During an interview with the DOC/Administrator related the identified shifts, the inspector was informed that the RN shifts filled by an RPN were RN vacation shifts and RN sick calls. The DOC/Administrator informed the inspector that the back up plan in place at the home when RN shifts can not be filled, was to call in the RPN's. (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2015

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 19th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

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