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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 19, 2019	2019_815623_0016	018114-19	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

SARAH GILLIS (623)

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): September 20, 24 and 25, 2019

The following intake was inspected:
Log #018114-19 for Critical Incident Report (CIR) related to resident to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapy Assistant (PTA), Personal Support Workers (PSW), Director of Care Clerk, Activation Aid (AA), residents and families.

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.
- **5 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 :

1. The licensee failed to ensure that resident #002 was protected from abuse by anyone.

A Critical Incident Report (CIR) was submitted to the Director on a specified date for an incident of alleged resident to resident abuse that occurred on the same day. The CIR indicated that resident #001 approached resident #002 who was sitting in an identified resident common area. Resident #001 exhibited an identified responsive behaviour towardsresident #002. Resident #001 was removed from the area and placed on enhanced monitoring. The physician, police and SDM for both residents were immediately notified of the incident.

Review of the security camera video footage was completed by Inspector #623. The Administrator and RPN #105 provided inspector #623 with video footage of the incident and confirmed the identity of staff and residents involved. Inspector #623 reviewed the video footage on a specified date for a specified period of time.

Resident #001's written plan of care that was current at the time of the incident and indicated specific identified responsive behaviours. Resident #001 had a prior incident of a similar nature. Goals and interventions were identified for resident #001 including frequent checks.

During an interview with Inspector #623, Physiotherapy Assistant #103 indicated that on a specified date they were in an identified area of the home when out of the corner of their eye they saw resident #001 and resident #002 together. PTA #103 indicated that they were aware that resident #001 and #002 were not supposed to be alone together because of a previous incident that had occurred involving resident #001 exhibiting an identified responsive behavior towards resident #002. The PTA indicated they did not actually see resident #001 exhibited an identified responsive behavior towards resident #002, just saw the residents sitting together and felt it was unusual because they knew that resident #001 was not supposed to be near resident #002. PTA #103 indicated that they approached resident #001 and suggested that they go to another area of the home and assisted the resident to move to a different area. PTA #103 indicated that Activity Aid (AA) #104 was also in the same area at the time of the incident and indicated that they did not see resident #001 approach resident #002. PTA #103 notified the Resident Program Manager #106 about what happened. Together they immediately informed RPN #105 and watched the security video of what had taken place. The PTA indicated that after viewing the security video they realized resident #001 had exhibited and identified responsive behavior towards resident #002, RPN #105 and the Resident Program Manager #106 notified the Administrator of the incident.

During an interview with Inspector #623, Behavioural Support Ontario (BSO) RPN #102 indicated that resident #001 had a previous history of a similar incident involving resident #002. Following that incident resident #001 was seen by an external support service and recommendations were made for changes to the resident's medications as well as frequent safety checks put in place. There was an improvement in responsive behaviours for resident #001 and there were no further incidents. A decision was made that the safety checks were no longer required, and it was discontinued on an identified date. The BSO RPN indicated that the physician was also attempting to reduce the amount of specific medications that were required. Following the incident that took place on a specified date, which involved resident #001 and #002, the frequent safety checks were reinstated for resident #001 and new medication order was received. A referral was also made to an external support service for consultation. BSO RPN #102 indicated that during a specified period of time resident #001 was placed on frequent safety checks and this was to be documented by the PSW staff. On a specified date, it was decided by the Administrator that resident #001 was to have a specified nursing intervention. BSO RPN indicated that they were not certain if the specified nursing intervention was consistently being done for resident #001 once it was initiated.

During an interview with Inspector #623, the Acting DOC indicated that there were gaps in the specified nursing intervention for resident #001 on specific identified dates. The staff scheduled to provide the intervention was used to fill other vacancies and there was no staff available to monitor resident #001. The Acting DOC indicated that during that time, resident #001 was supposed to receive frequent safety checks in place of the specified nursing intervention. The Acting DOC indicated that at the time, they were not made aware that there was no one providing resident #001 with monitoring, but confirmed that after reviewing the records monitoring was not provided.

During an interview with Inspector #623 the Administrator provided one piece of paper to Inspector #623 and indicated that was the internal investigation for the reported incident of resident to resident abuse involving resident #001 and resident #002. The Administrator indicated that there was no formal interview with staff who observed the incident or of the resident's involved. The document provided was a timeline of events as they occurred which identified that the incident was immediately reported to the Director, SDM and police. The Administrator indicated that they did not review the video camera footage until the following day and they did not interview the staff who were present at the time of the incident during the investigation. The Administrator indicated that there was no written record of any investigation for the incident of abuse other than the CIR.

Review of the clinical records for resident #002 including assessments and progress notes from a specified period of time was completed by Inspector #623. On an identified date there is a progress note by RN #111 that indicated resident #002's SDM was notified of the incident of the incident involving resident #001. The SDM indicated they were upset, and they would be calling the Administrator to discuss the incident. There was no documentation in resident #002's clinical record to indicate that the incident had occurred besides notification of the SDM. There were no assessments documented and no documentation to indicate that staff ensured the safety of resident #002 and provided emotional support to the resident. There is no documented record of an accurate detailed description the incident including any injuries or the resident's condition at the time of the incident.

The licensee failed to ensure that resident #002 was protected from abuse by resident #001, pursuant to s.19 of the LTCHA 2007 as identified by the following:

When resident #001 exhibited an identified responsive behavior towards resident #002 without consent, appropriate actions were not taken in response to the incident. On a specified date resident #001 exhibited an identified responsive behavior towards resident #002, resident #001 did not receive frequent safety checks, DOS monitoring and specified nursing interventions as required by the plan of care and under LTCHA, 2007, s. 6. (7) under WN #2.

When resident #001 exhibited responsive behaviours towards resident #002 on a specified date, appropriate actions including immediate investigation were not taken in response to resident #001's exhibited an identified responsive behavior towards resident #002, as indicated under LTCHA, 2007, s.23(1)(a) under WN #4.

When resident #001 demonstrated and identified responsive behavior towards resident #002 on an identified date, the home did not follow their policy Zero Tolerance of Resident Abuse and Neglect: Response and reporting #RC-02-01-02 and Investigation and Consequences #RC-02-01-03 by failing to ensure resident #002 was fully assessed following the incident including accurate detailed description of the resident's condition and the assessments documented in the resident's clinical records, as well as conduct an immediate investigation and keep detailed records, as indicated under LTCHA, 2007, s.20 under WN #3.

When the home failed to ensure that all staff receive annual retraining related to the homes policy to promote zero tolerance of abuse and neglect of residents as well as the

duty to make mandatory reports under section 24 of the Act as indicated under LTCHA, 2007, s. 76. (4) under WN #5. [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. 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 the care set out in the plan of care provided to the resident as specified in the plan.

A Critical Incident Report (CIR) was submitted to the Director on a specified date for an incident of abuse of a resident by another resident that occurred on the same day.

The CIR indicated that on a specified date resident #001 was observed sitting beside resident #002 in a specific resident common area of the home. Resident #001 exhibited an identified responsive behavior towards resident #002. Resident #001 was immediately removed from the area and placed on frequent checks. The physician, police and SDM for both residents were notified of the incident.

On a specified date during an interview with Inspector #623, the Administrator indicated that resident #001 was currently on frequent safety checks but the resident would be placed on specified nursing intervention to ensure the safety of all residents. The Administrator indicated that a staff person would be assigned to provide the specified nursing intervention.

A review of the current written plan of care for resident #001 was completed by Inspector #623. Specific responsive behaviours were identified which included interventions.

A review of the DOS (Dementia Observation System) frequent safety check records that were initiated on a specified date and time, for resident #001 was completed by Inspector #623. There were several dates and times noted to have no documentation of observations.

A review of the specified nursing intervention schedule for resident #001 was completed by Inspector #623. The specified nursing intervention was initiated on a specified date and time, the schedule that was provided indicated that the specified nursing intervention was not consistently provided. It was identified that on two specific dates that there was no staff available to provide the specified nursing intervention for the resident for an identified period of time on both days.

Review of the progress notes for resident #001 for a specific identified period of time was completed by Inspector #623. The documentation indicated that specified nursing interventions were initiated on a specified date and time. The progress notes also identified the dates and time that the specified nursing intervention was not provided for resident #001.

During an interview with Inspector #623, BSO RPN #102 indicated that resident #001 had a previous history of a similar incident involving resident #002. Following that incident resident #001 was seen by an external support service and recommendations were made for changes to the resident's medications as well as enhanced safety checks that where to be completed. There was an improvement in responsive behaviours so the safety checks were discontinued on a specified date. Following the incident of resident to resident abuse involving resident #001 exhibited an identified responsive behavior towards resident #002, frequent safety checks were reinstated. BSO RPN #102 indicated that for an identified period of time resident #001 was to receive frequent safety check with DOS monitoring and it was to be documented on paper by the PSW staff. On an identified date it was decided that resident #001 was to receive specified nursing interventions. BSO RPN indicated that they were not certain, if the specified nursing intervention was always in place for resident #001 after it was initiated.

During an interview with Inspector #623, the Acting DOC indicated that there were gaps in the specified nursing intervention for resident #001 on two identified dates due to the staff that were scheduled being pulled to cover vacant shifts in the home. The Acting DOC indicated that during that time, resident #001 was supposed to receive frequent monitoring. The Acting DOC indicated that they were not made aware that there was no one providing resident #001 with specified nursing interventions during that time. The

Acting DOC provided the frequent safety check documentation sheets to Inspector #623. It was identified that there is no documentation on specific identified dates. It was also noted that there were no frequent checks documented on an identified date and time when the specified nursing intervention staff began their shift. The Acting DOC indicated that the expectation is that the PSW staff will document at specified intervals on a paper record when a resident is being monitored and there should be no gaps in the monitoring.

The licensee failed to ensure that the care set out in the plan of care for resident #001 safety checks was provided to the resident as specified in the plan. [s. 6. (7)]

WN #3: 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 failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Review of the licensee's policy Extendicare - Zero Tolerance of Resident Abuse and Neglect: Response and reporting #RC-02-01-02 (last updated April 2017) indicated the following:

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Policy:
Anyone who witnesses or suspects abuse or neglect of a resident by another resident, staff or other person must report the incident. The report may be made to the home and or external authorities. At minimum, any individual who witnesses or suspect abuse or neglect of a resident must notify management immediately.

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All Staff:
2. Immediately respond to any form of alleged, potential, suspected or witnessed abuse;
4. Ensure the safety of and provide support to the abuse victim(s) through completion of full assessments, a determination of resident needs and a documented plan to meet those needs;
9. In case of physical and/or sexual abuse, it is imperative to preserve potential evidence as the incident may result in criminal charges and ensure that: accurate detailed descriptions of injuries/condition are documented in the resident chart.

Review of the licensee's policy Extendicare - Zero tolerance of abuse and neglect: Investigation and Consequences #RC-02-01-03 (last updated April 2017) indicated the following:

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Policy:
All reported incidents of abuse and/or neglect will be objectively, thoroughly and promptly investigated.

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Procedure: Administrator of designate
1. The Administrator of designate will oversee the completion of all steps required by the policy and procedures, in order to manage the case to resolution. This includes:
a. promptly initiating an investigation (immediately if there is harm or risk of harm to a resident).
h. Ensuring that a copy of the documentation and all other evidence collected is stored within a secured area of the home.

Review of the clinical records including assessments and progress notes for resident #002 for a specified period of time was completed by Inspector #623. On an identified date a progress note by RN #111 indicated that resident #002's SDM was notified of an incident of abuse by resident #001. The SDM indicated they were upset, as this had happened before, and they would be calling the Administrator to discuss the incident. There was no documentation in resident #002's clinical record to indicate that the incident had occurred besides notification of the SDM. There were no assessments documented including a head to toe skin assessment to assess for physical injury. There is no documentation to indicate that staff ensured the safety of resident #002 and provided support to the resident. There is no documented record of an accurate detailed

description the incident including any injuries or the resident's condition at the time of the incident.

RN #111 was unavailable for interview during this inspection.

During an interview with Inspector #623, the Administrator indicated that there was no written record of an investigation for the alleged resident to resident abuse of resident #002 by resident #001. The Administrator indicated that they did not immediately investigate the incident. The incident was immediately reported to the Director, SDM and police.

During an interview with Inspector #623, the Acting Director of Care indicated that there is no documented record for resident #002 to indicate that at the time of the incident of abuse, an assessment was completed to determine the physical and emotional well being of the resident. The Acting DOC indicated there is also no record of an immediate investigation as the incident was reported to the Administrator. The Acting DOC indicated that the expectation of the licensee is that the abuse policy will be followed including an immediate investigation conducted and detailed records kept. Resident #002 should have been fully assessed following the incident including an accurate detailed description of the resident's condition and the assessment should have been documented in the resident's clinical records.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

WN #4: 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: i) abuse of a resident by anyone.

A Critical Incident Report (CIR) was submitted to the Director on a specified date for an incident of abuse of a resident by another resident that occurred on the same day.

The CIR indicated that on an identified date resident #001 was observed sitting beside resident #002 in a resident common area of the home. Resident #001 exhibited an identified responsive behavior towards resident #002. Resident #001 was immediately removed from the area and placed on frequent checks.

On a specified date Inspector #623 requested that the Administrator provide the licensee's internal investigation for the incident of resident to resident abuse. A copy of the CIR was provided to the inspector along with one page that was a point form timeline of events that had occurred following the report of the abuse incident to the Administrator.

On a specified date during an interview with Inspector #623 the Administrator provided one piece of paper to Inspector #623 and indicated that was the internal investigation for the allegation of resident to resident abuse involving resident #001 and resident #002. The Administrator indicated that there was no formal interview with staff who observed

the incident or of the resident's involved. The document provided was a timeline of events as they occurred. The Administrator indicated that they did not review the video camera footage until the following day and they did not interview the staff who were present at the time of the incident during the investigation. The Administrator indicated that there was no written record of any investigation for the alleged incident of abuse other than the CIR and the timeline that was provided. The Administrator indicated that the licensee's expectation is that an investigation would be conducted immediately once becoming aware of the allegation of abuse.

During an interview with Inspector #623, the Acting DOC indicated that they became aware of the alleged incident on a specified date, one week after the incident and conducted their own investigation the following day, which included interviewing all staff who were present at the time of the alleged resident to resident abuse. The Acting DOC provided the inspector with copies of the investigation interviews.

The licensee failed to ensure that the abuse of resident #002 by resident #001 that was reported on a specified date, was immediately investigated. [s. 23. (1) (a)]

WN #5: 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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

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 staff receive training on the home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities as well as training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident.

A Critical Incident Report (CIR) was submitted to the Director on a specified date for an alleged incident of abuse of a resident by another resident that occurred on the same day. During the inspection it was discovered that Physiotherapy Assistant (PTA)#103 was the staff person who initially discovered resident #001 and #002 together.

During an interview with Inspector #623, PTA #103 indicated that on a specified date they observed resident #001 and resident #002 sitting together in a common area. The PTA indicated not actually seeing resident #001 displayed the identified responsive behavior towards resident #002. The PTA only saw them sitting together and felt it was unusual because they knew that resident #001 was not supposed to be near resident #002. PTA #103 indicated that they approached resident #001 and suggested that they move to a different area and assisted the resident to relocate. PTA #103 indicated that Activity Aide (AA) #104 was also present at the time of the incident and indicated that they did not see resident #001 approach resident #002. PTA #103 notified Resident Program Manager #106 about what had occurred, and together they told RPN #105. They then watched the security video of resident #001 and resident #002 thereby realizing the incident had occurred. The PTA indicated at that point they felt they had reported the incident and they were not a part of any further reporting or investigation. The PTA indicated that they have never received any training related to zero tolerance of abuse and neglect by Extendicare. The PTA indicated that upon hire at Achieva Health, they did complete training through Achieva but did not receive training by Extendicare specific to their policies related to the zero tolerance of abuse and neglect program prior to working in the home. The PTA indicated that they are not aware of the reporting process for any alleged, witnessed or suspected abuse or a duty to protect. PTA #103 indicated that they have worked in the home for an identified period of time as a contracted PTA with Achieva Health. Date of hire in the home was confirmed by the Acting DOC.

During an interview with Inspector #623, the DOC Clerk provided a list of staff education for Zero Tolerance of Abuse completed in 2018. The DOC clerk indicated that PTA #103 had worked in the home for approximately two years and there is no record of the PTA attending education in the home, including Zero Tolerance of Abuse and Neglect as well as s. 24 of the Act - Duty to Report. The DOC Clerk indicated that the PTA appears to have been missed in the education sessions.

During an interview with Inspector #623, the Acting DOC indicated that prior to beginning work in the home, PTA #103 completed education that was provided by Achieva Health. The education was not specific to Extendicare's policy to promote zero tolerance of abuse and neglect of residents or mandatory reporting under s. 24 of the Act.

The licensee failed to ensure that staff receive training on the home policy to promote zero tolerance of abuse and neglect of residents and mandatory reporting under section 24 of the Act prior to performing their responsibilities. [s. 76. (2) 3.]

2. The licensee has failed to ensure that all staff receive retraining annually related to the home's policy to promote zero tolerance of abuse and neglect of residents and the duty to make mandatory reports under section 24 of the Act.

Review of the licensee's annual education records for 2018 in Surge Learning identified that the Extendicare Zero Tolerance of Abuse and Neglect (A module – which includes mandatory reports under section 24 of the Act) training was only completed by 60.3% (44 of 73) of the staff.

During an interview with Inspector #623, the DOC Clerk provided a list of staff who completed the education for Zero Tolerance of Abuse from Surge learning for 2018. The DOC clerk indicated that this was a complete list of all staff who completed the online mandatory education in the home, for Zero Tolerance of Abuse and s. 24 Duty to Report. The DOC Clerk indicated that there was not 100% participation by all staff.

During an interview with Inspector #623, the Acting Director of Care indicated that they were new to their position in the home and were unfamiliar with the 2018 education that was provided. The Acting DOC indicated that education was provided to staff in January 2019 related to s. 24 immediate reporting but not all staff have completed yet for 2019. The Acting DOC also confirmed the education module in Surge learning for Zero Tolerance of Abuse and Neglect includes mandatory reports under section 24 of the Act.

The Administrator was not available for interview at the time of the inspection.

The licensee failed to ensure that all staff receive retraining annually related to the homes policy to promote zero tolerance of abuse and neglect of residents, and the duty to make mandatory reports under section 24 of the Act. [s. 76. (4)]

Issued on this 22nd day of November, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

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Name of Inspector (ID #) / Nom de l’inspecteur (No) :	SARAH GILLIS (623)
Inspection No. / No de l’inspection :	2019_815623_0016
Log No. / No de registre :	018114-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 19, 2019
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
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 :	Nik Chandrabalan

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Extendicare (Canada) 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) (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 shall ensure that resident #001 is assessed and any strategies and/or interventions are implemented to ensure all residents are protected from abuse.

Upon receipt of this order the licensee shall ensure training is provided to all staff on the home's policy "Zero Tolerance of Resident Abuse and Neglect: Response and reporting" #RC-02-01-02 and the home's policy "Zero tolerance of abuse and neglect: Investigation and Consequences" #RC-02-01-03

Specifically the home will train the staff to:
-Ensure that all staff are aware of what constitutes abuse.
-Ensure all staff are aware of the duty to report under s. 24 of the Act,
-Ensure that all staff are aware of risks in the home and any situations which may lead to abuse.
-Develop and implement a process to ensure that interventions put in place to manage specific identified responsive behaviours, such as specified nursing intervention, are being consistently implemented.

A documented record will be kept of this training.

Grounds / Motifs :

1. 1. The licensee failed to ensure that resident #002 was protected from abuse by anyone.

A Critical Incident Report (CIR) was submitted to the Director on a specified date

for an incident of alleged resident to resident abuse that occurred on the same day. The CIR indicated that resident #001 approached resident #002 who was sitting in an identified resident common area. Resident #001 exhibited an identified responsive behaviour towardsresident #002. Resident #001 was removed from the area and placed on enhanced monitoring. The physician, police and SDM for both residents were immediately notified of the incident.

Review of the security camera video footage was completed by Inspector #623. The Administrator and RPN #105 provided inspector #623 with video footage of the incident and confirmed the identity of staff and residents involved. Inspector #623 reviewed the video footage on a specified date for a specified period of time.

Resident #001's written plan of care that was current at the time of the incident and indicated specific identified responsive behaviours. Resident #001 had a prior incident of a similar nature. Goals and interventions were identified for resident #001 including frequent checks.

During an interview with Inspector #623, Physiotherapy Assistant #103 indicated that on a specified date they were in an identified area of the home when out of the corner of their eye they saw resident #001 and resident #002 together. PTA #103 indicated that they were aware that resident #001 and #002 were not supposed to be alone together because of a previous incident that had occurred involving resident #001 exhibiting an identified responsive behavior towards resident #002. The PTA indicated they did not actually see resident #001 exhibited an identified responsive behavior towards resident #002, just saw the residents sitting together and felt it was unusual because they knew that resident #001 was not supposed to be near resident #002. PTA #103 indicated that they approached resident #001 and suggested that they go to another area of the home and assisted the resident to move to a different area. PTA #103 indicated that Activity Aid (AA) #104 was also in the same area at the time of the incident and indicated that they did not see resident #001 approach resident #002. PTA #103 notified the Resident Program Manager #106 about what happened. Together they immediately informed RPN #105 and watched the security video of what had taken place. The PTA indicated that after viewing the security video they realized resident #001 had exhibited and identified responsive behavior towards resident #002, RPN #105 and the Resident Program Manager #106

notified the Administrator of the incident.

During an interview with Inspector #623, Behavioural Support Ontario (BSO) RPN #102 indicated that resident #001 had a previous history of a similar incident involving resident #002. Following that incident resident #001 was seen by an external support service and recommendations were made for changes to the resident's medications as well as frequent safety checks put in place. There was an improvement in responsive behaviours for resident #001 and there were no further incidents. A decision was made that the safety checks were no longer required, and it was discontinued on an identified date. The BSO RPN indicated that the physician was also attempting to reduce the amount of specific medications that were required. Following the incident that took place on a specified date, which involved resident #001 and #002, the frequent safety checks were reinstated for resident #001 and new medication order was received. A referral was also made to an external support service for consultation. BSO RPN #102 indicated that during a specified period of time resident #001 was placed on frequent safety checks and this was to be documented by the PSW staff. On a specified date, it was decided by the Administrator that resident #001 was to have a specified nursing intervention. BSO RPN indicated that they were not certain if the specified nursing intervention was consistently being done for resident #001 once it was initiated.

During an interview with Inspector #623, the Acting DOC indicated that there were gaps in the specified nursing intervention for resident #001 on specific identified dates. The staff scheduled to provide the intervention was used to fill other vacancies and there was no staff available to monitor resident #001. The Acting DOC indicated that during that time, resident #001 was supposed to receive frequent safety checks in place of the specified nursing intervention. The Acting DOC indicated that at the time, they were not made aware that there was no one providing resident #001 with monitoring, but confirmed that after reviewing the records monitoring was not provided.

During an interview with Inspector #623 the Administrator provided one piece of paper to Inspector #623 and indicated that was the internal investigation for the reported incident of resident to resident abuse involving resident #001 and resident #002. The Administrator indicated that there was no formal interview with staff who observed the incident or of the resident's involved. The document

provided was a timeline of events as they occurred which identified that the incident was immediately reported to the Director, SDM and police. The Administrator indicated that they did not review the video camera footage until the following day and they did not interview the staff who were present at the time of the incident during the investigation. The Administrator indicated that there was no written record of any investigation for the incident of abuse other than the CIR.

Review of the clinical records for resident #002 including assessments and progress notes from a specified period of time was completed by Inspector #623. On an identified date there is a progress note by RN #111 that indicated resident #002's SDM was notified of the incident of the incident involving resident #001. The SDM indicated they were upset, and they would be calling the Administrator to discuss the incident. There was no documentation in resident #002's clinical record to indicate that the incident had occurred besides notification of the SDM. There were no assessments documented and no documentation to indicate that staff ensured the safety of resident #002 and provided emotional support to the resident. There is no documented record of an accurate detailed description the incident including any injuries or the resident's condition at the time of the incident.

The licensee failed to ensure that resident #002 was protected from abuse by resident #001, pursuant to s.19 of the LTCHA 2007 as identified by the following:

When resident #001 exhibited an identified responsive behavior towards resident #002 without consent, appropriate actions were not taken in response to the incident. On a specified date resident #001 exhibited an identified responsive behavior towards resident #002, resident #001 did not receive frequent safety checks, DOS monitoring and specified nursing interventions as required by the plan of care and under LTCHA, 2007, s. 6. (7) under WN #2.

When resident #001 exhibited responsive behaviours towards resident #002 on a specified date, appropriate actions including immediate investigation were not taken in response to resident #001's exhibited an identified responsive behavior towards resident #002, as indicated under LTCHA, 2007, s.23(1)(a) under WN #4.

When resident #001 demonstrated and identified responsive behavior towards resident #002 on an identified date, the home did not follow their policy Zero Tolerance of Resident Abuse and Neglect: Response and reporting #RC-02-01-02 and Investigation and Consequences #RC-02-01-03 by failing to ensure resident #002 was fully assessed following the incident including accurate detailed description of the resident's condition and the assessments documented in the resident's clinical records, as well as conduct an immediate investigation and keep detailed records, as indicated under LTCHA, 2007, s.20 under WN #3.

When the home failed to ensure that all staff receive annual retraining related to the homes policy to promote zero tolerance of abuse and neglect of residents as well as the duty to make mandatory reports under section 24 of the Act as indicated under LTCHA, 2007, s. 76. (4) under WN #5. [s. 19. (1)]

The severity of this issue was determined to be a level three as there was actual harm to resident #002. The scope of the issue was a level one as it related to one resident reviewed. The history was level two as the home had previous non-compliance to a different subsection of the Act.
(623)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 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 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 19th day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sarah Gillis

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