Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Sep 21, 2020	2020_815623_0012	022376-19, 007274-20, 010093-20	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): July 27 - 31, August 10, 2020 - onsite August 11, 12, 2020 - offsite

The following intakes were inspected concurrently:
A log related to the Follow-up to CO#001 from inspection #2019_815623_0016 for s.19 - duty to protect
A log related to a Critical Incident Report - allegation of neglect
A log related to a Critical Incident Report - fall with injury

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), residents and families.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_815623_0016	623

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. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA:
it is a condition of every license that the licensee shall comply with every order made under this Act.

On November 19, 2019, the following compliance order (CO #001) from inspection number 2019_815623_0016 was made under s.19.(1) of the LTCH Act was issued:

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” and the home’s policy “Zero tolerance of abuse and neglect: Investigation and consequences”.

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 identified responsive behaviours, such as monitoring, are being consistently implemented.

A documented record will be kept of this training.

The compliance date was February 28, 2020.

The licensee failed to complete the following:

The licensee failed to ensure that resident #001 was assessed and any strategies and/or interventions were implemented to ensure all residents were protected from abuse.

Also, the required process was not developed and implemented to ensure that interventions that were put in place to manage identified responsive behaviours, such as specific monitoring, were being consistently implemented.

An inspection was initiated to determine compliance with CO #001. A review of the records for specific monitoring for resident #001 identified significant gaps. For an identified period of time, there were numerous shifts that specific monitoring was not provided to resident #001. The care plan identified two specific types of monitoring interventions to ensure all residents were protected from abuse by resident #001.

Interview with RN #103, RPN #104, PSW #105 and #106, and the Administrator confirmed that specific monitoring was to be in place but was not always covered. When there was no specific staff assigned, all staff were expected to assist with monitoring of resident #001 but there was no formal record to support that this took place.

The licensee failed to complete CO #001 to ensure that strategies and/or interventions were implanted to ensure all residents were protected from abuse by resident #001 and to develop and implement a process to ensure that interventions were put into place to manage behaviours, such as specific monitoring, and consistently implemented. [s. 101. (3)]

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 complying with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts, to be implemented voluntarily.

Issued on this 21st day of September, 2020

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

Original report signed by the inspector.