Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 03, 2020	2019_563670_0045 (A1)	021178-19, 022614-19	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 Tecumseh
2475 St. Alphonse Street TECUMSEH ON N8N 2X2

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

Amended by DEBRA CHURCHER (670) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

On January 2, 2020, a request for an extension of compliance order due dates for compliance orders #001, #002 and #003 from inspection number 2019_563670_0045 was received by the home's Administrator requesting compliance order #001 to be extended to February 9, 2020, compliance order #002 be extended to March 1, 2020, and compliance order #003 be extended to February 9, 2020, due to the short timeframe given to complete the required tasks. Conversation held with Inspector, Inspection Manager, and in consultation with Acting Service Area Office Manager. The requested extensions were granted.

Issued on this 3 rd day of January, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Amended by DEBRA CHURCHER (670) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 2, 3, 4, 5 and 9, 2019.

The purpose of this inspection was to inspect the following;

Log #022614-19 CIS#2904-000030-19 related to alleged staff to resident sexual abuse.

Log #021178-19 CIS#2904-000026-19 related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Care, two Registered Practical Nurses, one Registered Practical Nurse Resident Assessment Instrument Coordinator, seven Personal Support Workers, one Scheduling Clerk and one contracted agency Caregiver Supervisor.

During the course of this inspection the inspector observed the provision of care, observed staff to resident interactions, reviewed relevant clinical records, reviewed internal investigative documentation and reviewed relevant internal policies and procedures.

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

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

4 WN(s)
1 VPC(s)
3 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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training related to the following:
1. The Residents’ Bill of Rights.
2. The long-term care home’s policy to promote zero tolerance of abuse and neglect of residents.
3. The duty under section 24 to make mandatory reports.
4. The protections afforded by section 26.

The Ministry of Long-Term Care received an after hours call to the info-Line IL-72416-AH on November 26, 2019, and a subsequent Critical Incident System Report (CIS) on a specifc, related to alleged staff to resident sexual abuse.

The Long-Term Care Homes Act, 2007 defines staff as, “Persons who work at the home, pursuant to a contract or agreement with the licensee.”

Farlex Medical Dictionary defines Direct Care as “the provision of services to a patient that require some degree of interaction between the patient and the health care provider”.

During review of the home’s internal investigative notes and the submitted CIS it was determined that the accused staff member, attendant #107 was an employee of Home Instead Senior Care.

During an interview on December 2, 2019, Administrator #101 stated that resident #002 had a specific condition and had one to one staffing in place. If the home was unable to fill the one to one with their own staff members they would utilize agency staff and also utilized Paladin Security company. Administrator #101 stated that the agency staff and security staff did not provide any hands-on care but did interact with the resident and attempted to re-direct verbally.

Review of the Home Instead Senior Care billing information for a specific three month period, showed a total of 358.5 hours billed towards a total of 12 attendants for resident #002.

During an interview on December 3, 2019, Administrator #101 stated that the home does not provide any direct education to contracted staff. Administrator #101 shared that the home had shared their prevention of abuse and neglect policies with Home Instead Seniors Care and was aware that the agency had utilized portions of their policies in the Home Instead Senior Care Behaviour Support Observation Services form. Administrator #101 stated that it was the expectation that the agency would educate their staff on the home’s abuse policy prior to the staff member working in the home. Administrator #101 also shared that they had forwarded the homes abuse policy to Paladin Security with the expectation that the security company would have educated their staff. Administrator #101 acknowledged that the home did not ensure that any contracted staff member had completed any required training as it was assumed that the contracted agency was responsible for this.

The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training related to:
1. The Residents’ Bill of Rights.
2. The long-term care home’s policy to promote zero tolerance of abuse and neglect of residents.
3. The duty under section 24 to make mandatory reports.

4. The protections afforded by section 26. [s. 76. (2) 3.]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The Ministry of Long-Term Care received a Critical Incident System (CIS) report #2904-000026-19 related to a fall with injury for resident #003.

O. Reg. 48 (1) 1. states: "Every licensee of a long-term care home shall ensure

that the following interdisciplinary programs are developed and implemented in the home. A falls prevention and management program to reduce the incidence of falls and the risk of injury."

Review of resident #003's clinical record showed that resident #003 had an unwitnessed fall at a specific time, on a specific date, resulting in an injury.

The home's policy titled Neurological Signs/Head Injury Routine RC-25-01-38, last updated February 2017 stated;
The nurse will implement a head injury routine and obtain neurological signs whenever a resident experiences or is suspected of sustaining a head injury due to a fall or who have been found on the floor (experienced and unwitnessed fall.)

Assess resident's neurological signs:
a) Level of consciousness;
b) Ability to move/handgrips;
c) Pupil response; and
d) Vital signs

Continue with head injury routine, assessing all four (4) neurological indicators as follows until further direction from physician.
a) Every hour X 4 hours, then if stable
b) Every 8 hours X 72 hours.

Review of resident #003's Head Injury Routine (HIR) documentation showed resident #003 a total of five complete assessments and two incomplete assessments on specific dates at specific times.

During an interview with Assistant Director of Care (ADOC) #102 on December 5, 2019, they acknowledged that the HIR should have always included all four neurological signs. ADOC #102 acknowledged that the home's policy regarding HIR assessments had not been followed.

B) Review of resident #004's clinical record showed that resident #004 had an unwitnessed fall at a specific time on a specific date.

Review of resident #004's Head Injury Routine (HIR) documentation showed resident #004 received a total of four complete assessments and two incomplete

assessments on specific dates at specific times.

During an interview with Assistant Director of Care (ADOC) #102 on December 9, 2019, they acknowledged that the HIR should have always included all four neurological signs. ADOC #102 acknowledged that the home's policy regarding HIR assessments had not been followed.

C) Review of resident #005's clinical record showed that resident #005 had an unwitnessed fall at a specific time on a specific date.

Review of resident #005's Head Injury Routine (HIR) documentation showed resident #005 received a total of six complete assessments and three incomplete assessments on specific dates at specific times.

During an interview with Assistant Director of Care (ADOC) #102 on December 9, 2019, they acknowledged that the HIR should have always included all four neurological signs. ADOC #102 acknowledged that the home's policy regarding HIR assessments had not been followed.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system institute or otherwise put in place was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 234. Staff records

Specifically failed to comply with the following:

s. 234. (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience.
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession.
3. Where applicable, the results of the staff member's police record check under subsection 75 (2) of the Act.
4. Where applicable, the staff member's declarations under subsection 215 (4).
O. Reg. 79/10, s. 234 (1); O. Reg. 451/18, s. 4.

Findings/Faits saillants :

1. The licensee has failed to ensure that a record was kept for each staff member of the home that included at least the following with respect to the staff member: Where applicable, the results of the staff member’s police record check under subsection 75 (2) of the Act.

The Ministry of Long-Term Care received an after-hours call to the info-Line IL-72416-AH on a specific date, and a subsequent Critical Incident System Report (CIS) on a specific date, related to alleged staff to resident sexual abuse.

The Long-Term Care Homes Act, 2007 defines staff as, “Persons who work at the home, pursuant to a contract or agreement with the licensee.”

Farlex Medical Dictionary defines Direct Care as “the provision of services to a patient that require some degree of interaction between the patient and the health care provider”.

During review of the home’s internal investigative notes and the submitted CIS it was determined that the accused staff member, attendant #107 was an employee

of Home Instead Senior Care.

During an interview with Scheduler #108 on December 3, 2019, they stated that when Home Instead Seniors Care or Paladin Security were used the home was not informed of what staff member that would be attending the home they were only informed that a staff member is coming.

During an interview on December 4, 2019, with Home Instead Caregiver Supervisor they stated that the agency required basic police checks of all employees prior to hire with the agency but did not require vulnerable sector checks.

During an interview on December 2, 2019, Administrator #101 stated that resident #002 had a specific condition and had one to one staffing in place. If the home was unable to fill the one to one with their own staff they would utilize agency staff and also utilized Paladin Security. Administrator #101 stated that the agency staff and security staff did not provide any hands-on care but did interact with the resident and attempted to re-direct verbally. Administrator #101 acknowledged that neither Home Instead Seniors Care or Paladin Security routinely provided the results of their staff members police checks with the Long-Term Care home but it was the assumption of the home that the required police checks had been completed.

The licensee has failed to ensure that a record was kept for each staff member of the home that included at least the following with respect to the staff member: Where applicable, the results of the staff member's police record check under subsection 75 (2) of the Act. [s. 234. (1) 3.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #003 and resident #004 set out clear directions to staff and others who provided direct care to the resident.

A) The Ministry of Long-Term Care received a Critical Incident System (CIS) report #2904-000026-19 related to a fall with injury for resident #003.

Review of resident #003's clinical record showed that resident #003 had an unwitnessed fall at a specific time on a specific date, resulting in an injury.

During an observation of resident #003's room on a specific date, specific equipment was noted.

Review of resident #003's plan of care did not show any reference to the use of the specific equipment.

During an interview on December 9, 2019, with Assistant Director of Care (ADOC) #102 they stated that resident #003 used the specific equipment as a fall

prevention intervention. ADOC #102 acknowledged that the specific equipment was not included in the plan of care and should have been.

B) Review of resident #004's clinical record showed that resident #004 had an unwitnessed fall at a specific time on a specific date.

During an observation of resident #004's room on a specific date, specific equipment was noted.

Review of resident #004's plan of care did not show any reference to the use of the specific equipment.

During an interview on December 9, 2019, with Assistant Director of Care (ADOC) #102 they stated that resident #004 used the specific equipment as fall prevention intervention. ADOC #102 acknowledged that the specific equipment was not included in the plan of care and should have been.

The licensee has failed to ensure that the plan of care for resident #003 and resident #004 set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 3 rd day of January, 2020 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DEBRA CHURCHER (670) - (A1)
Inspection No. / No de l'inspection :	2019_563670_0045 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	021178-19, 022614-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 03, 2020(A1)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Tecumseh 2475 St. Alphonse Street, TECUMSEH, ON, N8N-2X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tom Wilson

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

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

The licensee must be compliant with The Long-Term Care Homes Act 2007 s. 76. (2).

Specifically;
A) The licensee will ensure that all staff members, including any contracted staff that meet The Long-Term Care Homes Act, 2007 definition of staff, will not perform any duties until they have received training related to the following;
1. The Residents' Bill of Rights.
2. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
3. The duty under section 24 to make mandatory reports.
4. The protections afforded by section 26.

B) The licensee will ensure that records are kept on site indicating the staff members that received the training and the date the training was completed .

Grounds / Motifs :

1. 1. The licensee has failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training related to the following:
1. The Residents' Bill of Rights.
2. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
3. The duty under section 24 to make mandatory reports.
4. The protections afforded by section 26.

The Ministry of Long-Term Care received an after hours call to the info-Line IL-72416-AH on November 26, 2019, and a subsequent Critical Incident System Report (CIS) on a specifc, related to alleged staff to resident sexual abuse.

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During review of the home's internal investigative notes and the submitted CIS it was determined that the accused staff member, attendant #107 was an employee of Home Instead Senior Care.

During an interview on December 2, 2019, Administrator #101 stated that resident #002 had a specific condition and had one to one staffing in place. If the home was unable to fill the one to one with their own staff members they would utilize agency staff and also utilized Paladin Security company. Administrator #101 stated that the agency staff and security staff did not provide any hands-on care but did interact with the resident and attempted to re-direct verbally.

Review of the Home Instead Senior Care billing information for a specific three month period, showed a total of 358.5 hours billed towards a total of 12 attendants for resident #002.

During an interview on December 3, 2019, Administrator #101 stated that the home does not provide any direct education to contracted staff. Administrator #101 shared that the home had shared their prevention of abuse and neglect policies with Home Instead Seniors Care and was aware that the agency had utilized portions of their policies in the Home Instead Senior Care Behaviour Support Observation Services form. Administrator #101 stated that it was the expectation that the agency would educate their staff on the home's abuse policy prior to the staff member working in the home. Administrator #101 also shared that they had forwarded the homes abuse policy to Paladin Security with the expectation that the security company would have educated their staff. Administrator #101 acknowledged that the home did not ensure that any contracted staff member had completed any required training as it was assumed that the contracted agency was responsible for this.

The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training related to:
1. The Residents' Bill of Rights.
2. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
3. The duty under section 24 to make mandatory reports.
4. The protections afforded by section 26.

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

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on September 13, 2018, as a Voluntary Plan of Correction (VPC) in a Complaint Inspection #2018_563670_0019.
(670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 09, 2020(A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 r. 8.(1). (a). (b). Specifically;
A) The licensee must ensure that the home's policy RC-25-01-38 Neurological Signs/Head Injury Routine is implemented and complied with.
B) The licensee must ensure that all Registered Nurses and Practical Nurses receive re-training related to the home's policy RC-25-01-38 Neurological Signs/Head Injury Routine.
C) The licensee must keep a record related to the training that indicates the staff members that received the training and the date the training was completed.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The Ministry of Long-Term Care received a Critical Incident System (CIS) report #2904-000026-19 related to a fall with injury for resident #003.

O. Reg. 48 (1) 1. states: "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home. A falls prevention and management program to reduce the incidence of falls and the

risk of injury."

Review of resident #003's clinical record showed that resident #003 had an unwitnessed fall at a specific time, on a specific date, resulting in an injury.

The home's policy titled Neurological Signs/Head Injury Routine RC-25-01-38, last updated February 2017 stated;
The nurse will implement a head injury routine and obtain neurological signs whenever a resident experiences or is suspected of sustaining a head injury due to a fall or who have been found on the floor (experienced and unwitnessed fall.)

Assess resident's neurological signs:
a) Level of consciousness;
b) Ability to move/handgrips;
c) Pupil response; and
d) Vital signs

Continue with head injury routine, assessing all four (4) neurological indicators as follows until further direction from physician.
a) Every hour X 4 hours, then if stable
b) Every 8 hours X 72 hours.

Review of resident #003's Head Injury Routine (HIR) documentation showed resident #003 a total of five complete assessments and two incomplete assessments on specific dates at specific times.

During an interview with Assistant Director of Care (ADOC) #102 on December 5, 2019, they acknowledged that the HIR should have always included all four neurological signs. ADOC #102 acknowledged that the home's policy regarding HIR assessments had not been followed.

B) Review of resident #004's clinical record showed that resident #004 had an unwitnessed fall at a specific time on a specific date.

Review of resident #004's Head Injury Routine (HIR) documentation showed resident #004 received a total of four complete assessments and two incomplete

assessments on specific dates at specific times.

During an interview with Assistant Director of Care (ADOC) #102 on December 9, 2019, they acknowledged that the HIR should have always included all four neurological signs. ADOC #102 acknowledged that the home's policy regarding HIR assessments had not been followed.

C) Review of resident #005's clinical record showed that resident #005 had an unwitnessed fall at a specific time on a specific date.

Review of resident #005's Head Injury Routine (HIR) documentation showed resident #005 received a total of six complete assessments and three incomplete assessments on specific dates at specific times.

During an interview with Assistant Director of Care (ADOC) #102 on December 9, 2019, they acknowledged that the HIR should have always included all four neurological signs. ADOC #102 acknowledged that the home's policy regarding HIR assessments had not been followed.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system institute or otherwise put in place was complied with

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on October 25, 2017, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2017_566669_0023.

(670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2020(A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 234. (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience.
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession.
3. Where applicable, the results of the staff member's police record check under subsection 75 (2) of the Act.
4. Where applicable, the staff member's declarations under subsection 215 (4). O. Reg. 79/10, s. 234 (1); O. Reg. 451/18, s. 4.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 r. 234. (1) 3.

Specifically;
A) The home will ensure a record is kept of the results of police checks of all staff members, including any contracted staff that meet The Long-Term Care Homes Act, 2007 definition of staff.
B) The home will ensure that no staff member interacts with any resident or performs any of their duties in the home prior to the home obtaining record of the staff member's police check.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that a record was kept for each staff member of the home that included at least the following with respect to the staff member: Where applicable, the results of the staff member's police record check under subsection 75 (2) of the Act.

The Ministry of Long-Term Care received an after-hours call to the info-Line IL-72416-AH on a specific date, and a subsequent Critical Incident System Report (CIS) on a specific date, related to alleged staff to resident sexual abuse.

The Long-Term Care Homes Act, 2007 defines staff as, "Persons who work at the home, pursuant to a contract or agreement with the licensee."

Farlex Medical Dictionary defines Direct Care as "the provision of services to a patient that require some degree of interaction between the patient and the health care provider".

During review of the home's internal investigative notes and the submitted CIS it was determined that the accused staff member, attendant #107 was an employee of Home Instead Senior Care.

During an interview with Scheduler #108 on December 3, 2019, they stated that when Home Instead Seniors Care or Paladin Security were used the home was not informed of what staff member that would be attending the home they were only informed that a staff member is coming.

During an interview on December 4, 2019, with Home Instead Caregiver Supervisor they stated that the agency required basic police checks of all employees prior to hire with the agency but did not require vulnerable sector checks.

During an interview on December 2, 2019, Administrator #101 stated that resident #002 had a specific condition and had one to one staffing in place. If the home was unable to fill the one to one with their own staff they would utilize agency staff and also utilized Paladin Security. Administrator #101 stated that the agency staff and security staff did not provide any hands-on care but did interact with the resident and attempted to re-direct verbally. Administrator #101 acknowledged that neither Home Instead Seniors Care or Paladin Security routinely provided the results of their staff members police checks with the Long-Term Care home but it was the assumption of the home that the required police checks had been completed.

The licensee has failed to ensure that a record was kept for each staff member of the home that included at least the following with respect to the staff member: Where

applicable, the results of the staff member's police record check under subsection 75 (2) of the Act.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on September 13, 2018, as a Voluntary Plan of Correction (VPC) in a Complaint Inspection #2018_563670_0019.
(670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 09, 2020(A1)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 3 rd day of January, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by DEBRA CHURCHER (670) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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