Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

Division des foyers de 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
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 1, 2018	2018_607523_0022	015829-18	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Secord Trails Care Community
263 Wonham Street South INGERSOLL ON N5C 3P6

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

ALI NASSER (523)

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 and 30, 2018.

This Critical Incident inspection was conducted related to an unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care, Clinical Care Partner, Physician, four Registered staff members and two Personal Support Workers.

The inspector(s) also observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home.

Ad-hoc notes were used during this inspection.

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

- **3 WN(s)**
- **2 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Section 2(1) of Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents".

A) The home submitted a Critical Incident System (CIS) report on a certain date related to the unexpected death of a resident. The CIS report showed that the resident had showed a change in status that was not communicated to the Physician.

B) A clinical record review for a specific resident showed a progress note completed on a specific date and time. The note showed that a specific RN was notified at a certain time of the change in resident's status, the RN assessed the resident and administered treatment at a certain time.

In an interview the RN said that they did not inform the physician of the change in the resident's condition.

Clinical record review for the resident showed no further documented assessment of the resident.

ADOC said in an interview that the resident had a change in condition and the nurse did not contact the Physician to inform them of those changes. The ADOC said that it was the home's expectation that the RN would contact and notify the Physician when there was a change in the resident's status.

Clinical Care Partner said that the resident had a change in status that was not communicated to the Physician. The expectation was that the change in resident's status would be communicated to the Physician.

A clinical record review for the resident showed a progress note completed on a specific date and time. The note showed that a specific RN was made aware of the change in the resident's status. The RN went to check the resident and found them not responding..

On a certain date a specific PSW said that on a certain date they were informed during shift report that the resident was not feeling well. The PSW said that during their shift the resident expressed specific signs and symptoms that were reported to the RN.

On a certain date a specific PSW said that on a certain date they were told that the resident was not feeling well. The PSW said that the resident expressed specific signs and symptoms that were reported to the RN.

On a certain date a specific RPN said that on a certain date they were told that the resident was not feeling well. The RPN said the resident expressed specific signs and symptoms that were reported to the RN.

A clinical record review showed no documentation that the RN had notified the Physician of the change in resident's status.

A review of the home's investigation notes showed that the RN said that they did not notify the Physician of the change in resident's status.

On July 31, 2018, the Physician said that they were not informed of the change in resident's status and that it was their expectation to be notified of any change in the resident's status.

C) A clinical record review for a specific resident completed on a specific date. The note showed that a specific RPN was asked by a specific RN to check on the resident's status. RPN and RN called the Physician to inform them of the status, a certain treatment was initiated.

A review of the CIS report showed that the RN did not initiate the treatment as per the care plan.

On a certain date the RN said they were not aware of the specific intervention in the plan of care and they did not initiate the treatment as per the care plan.

On a certain date the RPN said they were under the impression that they did not provide this type of intervention or treatment in the home.

On a certain date the Physician said that the expectation was for the staff to initiate the specific treatment in the home as consented to by resident and/or family.

The Administrator said in an interview that it was the expectation that the staff provide the specific treatment to the resident as per the resident's request and as indicated in their care plan.

Based on these interviews and record review, the resident had express signs and symptoms that represented a change in resident's status. The Registered staff members did not report those changes in the resident's status to the Physician. The Registered staff did not initiate specific treatment at the required time. [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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much details as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide.

The home submitted a call to the Spills Action Centre (SAC) report on a certain date and time related to an unexpected death of a resident. The SAC report showed that the unexpected death occurred the day before the SAC report was initiated.

The home submitted Critical Incident System (CIS) report on a certain date related to the unexpected death of a resident. The CIS report showed that on a specific date and time the nurse found the resident absence of vital signs. The Registered staff member did not call the MOH as per direction.

On a certain date the Administrator said that the registered staff were directed by the On-Call manager to call the ministry action line and report the unexpected death but the staff did not do so. They said that it was the home's expectations to inform the Director immediately of the unexpected death of resident #001. [s. 107. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director was immediately informed, in as much details as is possible in the circumstances, of an unexpected or sudden death, including a death resulting from an accident or suicide, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The home submitted Critical Incident System (CIS) report on a certain date related to unexpected death of a resident. The CIS report showed that the resident had expressed a specific symptom.

A clinical record for the point of care showed that the resident expressed this specific symptom for 5 days.

A review of the Medication Administration Record showed that the resident's specific drugs related to this symptom were not administered as ordered by the prescriber.

On a certain date the Clinical Care Partner said in an interview that the resident did not receive their drugs as ordered by the physician. They said the expectation was for the drugs to be administered as ordered.

On a certain date the Acting Director of Care (ADOC) said in an interview that the drug were not administered to the resident as ordered, and the expectation was for all medications to be administered to residents in accordance with the directions for use specified by the prescriber.

On a certain date the Physician said that the expectation was for the drugs to be administered to the residents as ordered and directed by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 1st day of August, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALI NASSER (523)
Inspection No. / No de l'inspection :	2018_607523_0022
Log No. / No de registre :	015829-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 1, 2018
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Secord Trails Care Community 263 Wonham Street South, INGERSOLL, ON, N5C-3P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JoAnn Zomer

To Vigour Limited Partnership on behalf of Vigour General Partner 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 the following:
1. All Registered staff members have a valid Cardiopulmonary Resuscitation (CPR) certification.
2. All Registered staff members receive training on the home's CPR policy and procedures.
3. Changes in the status of residents is reported to the physician.
4. A process is developed and implemented to identify the resident's resuscitation status and that this status is kept up to date and communicated to staff.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Section 2(1) of Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents".

A) The home submitted a Critical Incident System (CIS) report on a certain date related to the unexpected death of a resident. The CIS report showed that the resident had showed a change in status that was not communicated to the Physician.

B) A clinical record review for a specific resident showed a progress note

completed on a specific date and time. The note showed that a specific RN was notified at a certain time of the change in resident's status, the RN assessed the resident and administered treatment at a certain time.

In an interview the RN said that they did not inform the physician of the change in the resident's condition.

Clinical record review for the resident showed no further documented assessment of the resident.

ADOC said in an interview that the resident had a change in condition and the nurse did not contact the Physician to inform them of those changes. The ADOC said that it was the home's expectation that the RN would contact and notify the Physician when there was a change in the resident's status.

Clinical Care Partner said that the resident had a change in status that was not communicated to the Physician. The expectation was that the change in resident's status would be communicated to the Physician.

A clinical record review for the resident showed a progress note completed on a specific date and time. The note showed that a specific RN was made aware of the change in the resident's status. The RN went to check the resident and found them not responding..

On a certain date a specific PSW said that on a certain date they were informed during shift report that the resident was not feeling well. The PSW said that during their shift the resident expressed specific signs and symptoms that were reported to the RN.

On a certain date a specific PSW said that on a certain date they were told that the resident was not feeling well. The PSW said that the resident expressed specific signs and symptoms that were reported to the RN.

On a certain date a specific RPN said that on a certain date they were told that the resident was not feeling well. The RPN said the resident expressed specific signs and symptoms that were reported to the RN.

A clinical record review showed no documentation that the RN had notified the Physician of the change in resident's status.

A review of the home's investigation notes showed that the RN said that they did not notify the Physician of the change in resident's status.

On July 31, 2018, the Physician said that they were not informed of the change in resident's status and that it was their expectation to be notified of any change in the resident's status.

C) A clinical record review for a specific resident completed on a specific date. The note showed that a specific RPN was asked by a specific RN to check on the resident's status. RPN and RN called the Physician to inform them of the status, a certain treatment was initiated.

A review of the CIS report showed that the RN did not initiate the treatment as per the care plan.

On a certain date the RN said they were not aware of the specific intervention in the plan of care and they did not initiate the treatment as per the care plan.

On a certain date the RPN said they were under the impression that they did not provide this type of intervention or treatment in the home.

On a certain date the Physician said that the expectation was for the staff to initiate the specific treatment in the home as consented to by resident and/or family.

The Administrator said in an interview that it was the expectation that the staff provide the specific treatment to the resident as per the resident's request and as indicated in their care plan.

Based on these interviews and record review, the resident had express signs and symptoms that represented a change in resident's status. The Registered staff members did not report those changes in the resident's status to the Physician. The Registered staff did not initiate specific treatment at the required time. [s. 19. (1)] (523)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 14, 2018

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 1st day of August, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Ali Nasser

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