Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 22, 2014	2014_312503_0017	T-851-14	Complaint

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26, Midhurst, ON, L0L-1X0

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

SUNSET MANOR HOME FOR SENIOR CITIZENS
49 RAGLAN STREET, COLLINGWOOD, ON, L9Y-4X1

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

LAURA BROWN-HUESKEN (503)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 24, 25, 28, 29, 2014.

During the course of the inspection, the inspector(s) spoke with the director of care, nurse manager (NM), charge nurse, registered practical nurses, and personal support workers.

During the course of the inspection, the inspector(s) reviewed clinical records and policies and procedures related to responsive behaviours, toured South Simcoe home area, and observed the provision of care.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours
Safe and Secure Home

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Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

Review of progress notes for an identified three month period, revealed that resident 2 had multiple incidences of verbal and physical aggression. Interviews with staff indicate that resident 2 was unpredictable and would sometimes display aggression without any warning signs. Resident 2 was reported to have had frequent communication difficulties with staff and co-residents which resulted in increased agitation. Daily during an identified six day period resident 2 had required an as needed dosage of an antipsychotic medication related to the management of the agitation and aggressive behaviours. One day following the six day period, staff responded to residents yelling and found resident 1 upset, holding his/her face with blood dripping on the floor. A co-resident reported that resident 2 had punched resident 1 in the face. Staff report that the altercation was not observed as they were assisting a co-resident into bed at the time of incident, and that the residents were not directly supervised. Prior to the incident resident was seated by the nursing station with an unknown number of co-residents and resident 2 had been calm and was not reported to be displaying signs of agitation. A referral to the Behavioural Support System Mobile Support Team (BSS MST) indicated that on an identified date proceeding this incident, the following interventions were in place for resident 2; redirection, allow to de-escalate on his/her own, and Montessori activities. Interviews with staff revealed that the interventions in place to minimize the risk of altercations between resident 2 and co-residents, were to distract resident 2 and to keep him/her away from co-residents when he/she displayed agitation. The home's NM confirmed that the resident's written plan of care did not include verbal or physical aggression at the time of this incident. Following the incident, staff were directed to begin the staff verification checklist, which required monitoring of resident 2 every 30 minutes. Despite a history of verbal and physical aggression and known unpredictable aggression and agitation which required pharmacological interventions over the six days prior to the incident, resident 2 was left unattended with co-residents and not engaged in activities for distraction. Interventions were not implemented to minimize the risk of altercations between resident 2 and co-residents. [s. 54. (b)]

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

On the evening of an identified date, and identified PSW was bathing a resident on an identified home area. The PSW indicated in an interview that the door into the tub room had been propped open allowing access to the tub room as well as access to an adjoining bathroom and shower room. A curtain was pulled across the entrance way into the tub room to ensure privacy for the resident who was being bathed. Resident 1 had been displaying confusion and was attempting to enter the tub room through the pulled curtain. The PSW redirected the resident into the hallway, and left the door propped open. After the PSW finished assisting with the bath, the tub room was cleaned and the door to the room was closed. The PSW indicated resident 1 was not in the tub room at that time, however the adjoining bathroom and shower room were not visually checked. Approximately 30 minutes later, resident 1 was unable to be located. Staff searched the home area and found the resident wandering in the tub room voicing concern about being unable to find a place to sit down. No injuries were noted. The PSW indicated that the door into the tub room was not supervised during the provision of the bath as it could not be seen though the curtain. A tour of the aforementioned tub room, bathroom and shower room on July 25, 2014, found lifts stored in the bathroom and wet floors in the shower room. Interviews with direct care staff confirmed that the lifts are stored in the bathroom and are a tripping hazard. Interview with the NM confirmed that propping the tub room door open allows residents unsupervised access to the bathroom and shower room and is not a safe environment for the residents. [s. 5.]

2. On the morning of July 25, 2014, the door to the residents' bathroom on the South Simcoe home area was unlocked. Staff acknowledged the door is unlocked which allows residents access to the bathroom. A cabinet within the bathroom was unlocked and contained the following items:
- protective ointments,
- hand and body lotions,
- roll on antiperspirants,
- aerosol deodorant spray cans.

The DOC confirmed that these items could potentially be hazardous to the residents within the secure home area and that the products were not stored in a manner in which they were inaccessible to the residents. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 6. (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 failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Review of progress notes for an identified three month period, revealed that resident 2 had multiple incidences of verbal and physical aggression. A referral to the Behavioural Support System Mobile Support Team (BSS MST) indicated that on an identified date, the following interventions were in place for resident 2; redirection, allow to de-escalate on his/her own, and Montessori activities. High Risk Meeting management notes from and identified date, indicate the BSS MST provided the home with a translation tool to be used for communication with the resident. On an identified date, staff responded to residents yelling and found resident 1 upset, holding his/her face with blood dripping on the floor. A co-resident reported that resident 2 had punched resident 1 in the face. The home's NM confirmed that the resident's written plan of care did not include verbal or physical aggression, and the aforementioned interventions, were not included on the residents care plan on the date of the incident and were further not included in the resident's written plan of care until May 23, 2014. [s. 6. (1) (a)]

Additional Required Actions:

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

WN #4: 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 protect resident 1 from abuse by anyone.

Review of progress notes for an identified three month period, revealed that resident 2 had multiple incidences of verbal and physical aggression. On an identified date, staff responded to residents yelling and found resident 1 upset, holding his/her face with blood dripping on the floor. A co-resident reported that resident 2 had punched resident 1 in the face. Resident 1 was reported to have identified injuries. Staff report that the altercation was not observed as they were assisting a co-resident into bed at the time of incident and that prior to the incident resident 2 had not displayed signs of agitation. Interviews with staff indicate that resident 2 was unpredictable and would sometimes display aggression without any warning signs. Interviews with staff revealed that the interventions in place to minimize the risk of altercations between resident 2 and co-residents, were to distract resident 2 and to keep him away from co-residents when he displayed agitation. An interview with the home's NM confirmed that the resident's written plan of care did not include verbal or physical aggression, and the aforementioned interventions, were not included on the residents care plan on the date of the incident and were further not included in the resident's written plan of care until May 23, 2014. Resident 1 was not protected from abuse by resident 2. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to protect residents from abuse by anyone, to be implemented voluntarily.

Issued on this 1st day of October, 2014

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

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAURA BROWN-HUESKEN (503)
Inspection No. / No de l'inspection :	2014_312503_0017
Log No. / Registre no:	T-851-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 22, 2014
Licensee / Titulaire de permis :	CORPORATION OF THE COUNTY OF SIMCOE 1110 Highway 26, Midhurst, ON, L0L-1X0
LTC Home / Foyer de SLD :	SUNSET MANOR HOME FOR SENIOR CITIZENS 49 RAGLAN STREET, COLLINGWOOD, ON, L9Y-4X1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TOLLEEN PARKIN

To CORPORATION OF THE COUNTY OF SIMCOE, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions. Please submit plan the to Laura.Brown-Huesken@ontario.ca by October 10, 2014.

Grounds / Motifs :

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board

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

and the Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of September, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Laura Brown-Huesken

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