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 prévue le Loi de 2007 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

Sudbury Service Area Office
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Nov 27, 2015;	2015_391603_0031 (A2)	023862-15, 021234-15	Follow up

Licensee/Titulaire de permis

CORPORATION OF THE TOWN OF KIRKLAND LAKE
3 KIRKLAND STREET WEST POSTAL BAG 1757 KIRKLAND LAKE ON P2N 3P4

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

TECK PIONEER RESIDENCE
145A GOVERNMENT ROAD EAST POSTAL BAG SERVICE 3800 KIRKLAND LAKE ON P2N 3P4

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

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 prévue le Loi de 2007 les foyers de soins de longue durée

SYLVIE LAVICTOIRE (603) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The long term care home has requested an extension to compliance from December 4 to December 11, 2015.

Issued on this 27 day of November 2015 (A2)

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

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

Ministère de la Santé et des Soins de longue durée

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

SYLVIE LAVICTOIRE (603) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 27-29, 2015

During the course of the inspection, the Inspector reviewed residents' health care records, reviewed various policies, procedures, and programs, conducted a daily walk-through of the home, observed the delivery of resident care and staff to resident interactions. The following logs related to the Ministry of Health and Long-Term Care were also completed during the inspection: #023862-15 and #021234-15.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Ward Clerk, and Residents.

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining

Responsive Behaviours

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

2 WN(s)
1 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 53. (4)	CO #002	2015_380593_0013	603

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. 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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #001.

On October 28, 2015, Inspector #603 interviewed S#100 who explained that resident #001 received a specific injection every week to try and responsive behaviors.

Inspector #603 reviewed resident #001's health care record and on October 16, 2015, there was a physician's order for the same specific medication every week.

Inspector reviewed the resident's care plan, which indicated that the resident received the same injections every two weeks, which was not in line with the care actually provided and the current physician order. [s. 6. (1)]

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

On October 29, 2015, Inspector #603 observed resident #004 sitting in a tilted wheelchair, with a seat belt on. Inspector interviewed S#106 who confirmed the resident was sitting in a tilted wheelchair with a seat belt on. Staff #106 explained that resident #004 also requires 2 bed rails while in bed.

Inspector reviewed resident #004's health care records and noted on the Safety - Restraint record form that resident #004 required a tilted chair and a seat belt for safety. There was no indication for bed rails. Inspector reviewed the resident's care plan which indicated the need for 2 half bed rails to be raised when resident in bed and a seat belt while in wheelchair. There was no mention of a tilted chair requirement as a form of restraint. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #008.

On October 29, 2015, Inspector #603 observed resident #008 to be tilted in their wheelchair with no seat belt on. Inspector interviewed S#106 who explained that the resident did not have a seat belt on while in the tilted wheelchair because the home was doing a two week trial without the seat belt and utilizing a specific device for safety.

Inspector reviewed resident's health care record and noted that on the Safety-

Restraint record form, the form still indicated a tilted chair and seatbelt to be applied for safety. Inspector reviewed the resident's care plan and under restraint, the resident required a tilted chair and there was no mention of a seat belt. The care plan included a 2 week trial of a specific device while in wheelchair for safety.

Inspector interviewed S#100 who explained that because the resident was on the trial period, the resident did not require a seat belt and yet the Safety - Restraint record form still had a tilted chair and seat belt as a form of restraint. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #009 as specified in the plan.

On October 29, 2015, Inspector #603 observed resident #009 to be sitting in a wheelchair, with a seat belt on. The wheelchair was not tilted. Inspector interviewed S#106 who explained that the resident was not tilted as ordered by the physician because the resident uses their feet to mobilize self.

Inspector reviewed resident #009's health care record and on the Safety - Restraint record form, it indicated the need for a tilted chair and a seat belt for safety. Inspector reviewed the resident's care plan which indicated the need for a tilted wheelchair and a seat belt while in the wheelchair. The care plan also indicated that the restraint needed to be undone and reapplied at least hourly, repositioned as needed and document on restraint record. Inspector reviewed the Safety - Restraint record form and there was no documentation of the staff undoing and reapplying the seat belt at least hourly. [s. 6. (7)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

a) On October 28, 2015, Inspector #603 reviewed resident #001's health care record. The progress notes indicated that a PSW witnessed resident #001 kissing resident #002. Inspector reviewed resident #001's care plan which indicated that with any incident of inappropriate sexual behavior, the staff are to increase monitoring: 10 minute checks for 1 hour, then 30 minute checks while awake for 24hrs. The staff are to document on ABC charting, DOS, POC and PCC. On review of the resident's health care record, Inspector found no documentation for the increased monitoring on the ABC charting, DOS, and POC, for a specific incident. Staff #100 confirmed that there was no increased monitoring and thus no documentation for this incident; in fact, S#100 noted that on POC, there was no area to document inappropriate sexual

behavior.

b) On October 28, 2015, Inspector reviewed resident #001's care plan which indicated that the resident was to have a yellow banner placed across their door frame, to deter wandering residents, from entering resident #001's room. On October 28, 2015, Inspector observed resident #001 sleeping in their room with their door open. The yellow banner was not placed across their doorway; in fact, all yellow bands were seen dangling from the different room doorways on that unit. Inspector noted resident #002 wandering the unit, including in front of resident #001's room. Staff #100, who was in attendance with Inspector, noted resident #002 wandering around resident #001's room and instructed S#101 who was passing by, to apply the yellow banner across resident #001's doorway as required. [s. 6. (7)]

6. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #006 as specified in the plan.

On October 27, 2015, Inspector #603 reviewed a Critical Incident Report (CI) which was reported to the Director. According to the CI, a staff member reported that resident #005 was walking in their unit and asked where their room was, and to make sure that "the resident right there" (pointed at resident #006) doesn't see where their room was. According to the CI, resident #005 explained that they had just asked resident #006 where their room was and resident #006 reacted with sexual touching. Resident #005 did not cry but seemed concerned that resident #006 would know where they lived. At a later time, other staff members re interviewed resident #005 who repeated the same incident to the staff. At that time, resident #005 was visibly upset with tears in their eyes. The police was called and discussed the incident with resident #006 who admitted to some parts of the story, as told by resident #005.

On October 28, 2015, Inspector attempted to interview resident #006 who was not in their room or on their unit. Inspector interviewed S#103 and S#102 who did not know the resident's whereabouts. Staff #103 and #102 looked for the resident and consulted with another staff member who again, did not know the resident's whereabouts. Staff #103 explained that the resident often went to the auditorium or on a different unit. Staff #102 and #103 explained that the resident's badge was programmed to alert staff if they went into other resident's rooms. Staff #102 also explained that staff on the other unit know to monitor resident #006's activities as they are red flagged for sexually responsive behaviors. Inspector went to the auditorium and to the other unit and could not find resident #006. The staff on the other unit explained that they were familiar with resident #006 but had not seen them. Inspector

went back to resident #006's unit where again, they were nowhere to be found. Approximately 1/2 hour later, resident #006 returned and went to their room. Staff #102 and #103 did not ask the resident where they were for the past 30 minutes.

Inspector reviewed the resident's care plan which had a focus of Locomotion On/Off the unit. The interventions included a badge programmed to alert staff when resident entered other resident's room and staff were to respond immediately to the pager call. Staff were to monitor resident #006's whereabouts hourly, related to sexually responsive behavior exhibited toward other residents. If resident was seen on a different unit, staff were to question who they were visiting and ensure they only visited certain residents and then return to their unit. In this case, the staff on the resident's unit were not aware of the resident's whereabouts as required in their plan. [s. 6. (7)]

7. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

On a certain date, Inspector #603 observed resident #002 wandering unsupervised on their unit, including in front of resident #001's room. On the unit, all yellow bands were dangling and not set up across the doorways, including resident #001's doorway. Staff #100 who was in attendance with Inspector, noted resident #002 wandering around resident #001's room and instructed S#101 who was passing by, to apply the yellow banner across resident #001's doorway.

Inspector reviewed resident #002's care plan, which indicated that the resident was allowed to wander on the unit with supervision. The care plan also indicated to apply yellow banners to targeted door-ways as needed to deter resident #002 from entering. In this case, resident #002 was wandering the unit without supervision and yellow banners were not set up across the doorways as required in the plan. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 001,002

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class.

On a certain date, Inspector #603 observed resident #004 sitting in a tilted wheelchair with a seat belt on. Inspector interviewed S#106 who explained that for safety reasons, resident #004 required to sit in a tilted wheelchair with a seat belt on and while in bed, the resident required 2 upper bed rails to be engaged.

Inspector reviewed resident #004's health care records and noted on the Safety - Restraint Record form that resident #004 required a tilted chair and a seat belt on for safety. There was no indication for bed rails. Inspector reviewed the resident's care plan which indicated the need for 2 half bed rails to be raised when resident in bed and a seat belt while in wheelchair. There was no indication of a tilted chair required as a form of restraint. In the health care record, Inspector reviewed an order for 1/2 side rails to be engaged and and order for a seat belt while sitting in a wheelchair. There was no order for a tilted wheelchair. [s. 31. (2) 4.]

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 ensuring that the restraint plan of care include an order by the physician or the registered nurse in the extended class, to be implemented voluntarily.

Issued on this 27 day of November 2015 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : SYLVIE LAVICTOIRE (603) - (A2)

Inspection No. / No de l'inspection : 2015_391603_0031 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 023862-15, 021234-15 (A2)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Nov 27, 2015;(A2)

Licensee / Titulaire de permis : CORPORATION OF THE TOWN OF KIRKLAND LAKE
3 KIRKLAND STREET WEST, POSTAL BAG 1757, KIRKLAND LAKE, ON, P2N-3P4

LTC Home / Foyer de SLD : TECK PIONEER RESIDENCE
145A GOVERNMENT ROAD EAST, POSTAL BAG SERVICE 3800, KIRKLAND LAKE, ON, P2N-3P4

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Nancy Theriault

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To CORPORATION OF THE TOWN OF KIRKLAND LAKE, 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. 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

(A2)
The licensee shall:
1. Review all written plans of care for residents who use tilted chairs and other
restraints, to ensure that all plans set out clear directions to staff and others who
provide direct care to the residents.
2. Review resident #001 s plan of care regarding medication administration, to ensure that the plan set out clear directions to staff and others who provide direct care to the resident.
3. Develop and implement an audit process that will identify those plans of care
that do not provide clear direction so that they can be updated immediately.
4. Develop a system of communication for both registered and non registered
nursing staff and others who provide direct care to residents, to ensure that residents current care needs are clearly identified on plans of care.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #001.

On October 28, 2015, Inspector #603 interviewed S#100 who explained that resident #001 received a specific injection every week to try and responsive behaviors.

Inspector #603 reviewed resident #001's health care record and on October 16, 2015, there was a physician's order for the same specific medication every week.

Inspector reviewed the resident's care plan, which indicated that the resident received the same injections every two weeks, which was not in line with the care actually provided and the current physician order. (603)

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #008.

On October 29, 2015, Inspector #603 observed resident #008 to be tilted in their wheelchair with no seat belt on. Inspector interviewed S#106 who explained that the resident did not have a seat belt on while in the tilted wheelchair because the home was doing a two week trial without the seat belt and utilizing a specific device for safety.

Inspector reviewed resident's health care record and noted that on the Safety-Restraint record form, the form still indicated a tilted chair and seatbelt to be applied for safety. Inspector reviewed the resident's care plan and under restraint, the resident required a tilted chair and there was no mention of a seat belt. The care plan included a 2 week trial of a specific device while in wheelchair for safety.

Inspector interviewed S#100 who explained that because the resident was on the trial period, the resident did not require a seat belt and yet the Safety - Restraint record form still had a tilted chair and seat belt as a form of restraint. (603)

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

On October 29, 2015, Inspector #603 observed resident #004 sitting in a tilted wheelchair, with a seat belt on. Inspector interviewed S#106 who confirmed the resident was sitting in a tilted wheelchair with a seat belt on. Staff #106 explained that resident #004 also requires 2 bed rails while in bed.

Inspector reviewed resident #004's health care records and noted on the Safety - Restraint record form that resident #004 required a tilted chair and a seat belt for safety. There was no indication for bed rails. Inspector reviewed the resident's care plan which indicated the need for 2 half bed rails to be raised when resident in bed and a seat belt while in wheelchair. There was no mention of a tilted chair requirement as a form of restraint.

LTCHA, 2007 S.O. 2007, s. 6. (1) (c) was issued previously as WN and VPC during Inspection #2014_332575_0021, a WN and VPC during Inspection #2014_283544_0026, and a WN during Inspection #2013_138151_0021.

The decision to issue this compliance order was based on the scope which involved three out of seven residents inspected during the Follow Up, the severity which indicated a potential for actual harm and the compliance history which despite previous non-compliance (NC), NC continues with this area of the legislation. (603)

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

Dec 11, 2015(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_391603_0022, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall:

1. Immediately re educate all staff and others who provide direct care to the residents on the Use of Restraints Policy. The re education must also include the safe use of restraints, monitoring of residents who are restrained, and restraint documentation. The licensee shall keep a written record of all staff and others who have been re educated on the Use of Restraints Policy.
2. Immediately re educate all staff and others who provide direct care to resident #001, #002 and #006 regarding interventions in their plans of care to manage responsive behaviors.
3. Develop and implement an audit process that will identify when care is not provided to resident #001, #002 and #006, as specified in their plans so that corrective actions can be implemented in a timely manner.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

On a certain date, Inspector #603 observed resident #002 wandering unsupervised on their unit, including in front of resident #001's room. On the unit, all yellow bands were dangling and not set up across the doorways, including resident #001's doorway. Staff #100 who was in attendance with Inspector, noted resident #002 wandering around resident #001's room and instructed S#101 who was passing by, to apply the yellow banner across resident #001's doorway.

Inspector reviewed resident #002's care plan, which indicated that the resident was allowed to wander on the unit with supervision. The care plan also indicated to apply yellow banners to targeted door-ways as needed to deter resident #002 from entering. In this case, resident #002 was wandering the unit without supervision and yellow banners were not set up across the doorways as required in the plan. (603)

(A1)
2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #006 as specified in the plan.

On October 27, 2015, Inspector #603 reviewed a Critical Incident Report (CI) which was reported to the Director on September 9, 2015. The CI happened on September 9, 2015, when a PSW reported to the RN in charge that resident #005 was walking in the Wright Hargreaves hallway and asked where their room was, and to make sure that "the man right there" (pointed at resident #006) doesn t see where their room was. According to the CI, resident #005 explained that they had just asked resident #006 where their room was and resident #006 took resident #005 s hand and put it in resident #006 s pants and pressed it against their penis. Resident #005 did not cry but seemed concerned that resident #006 would know where they lived. Resident #005 also explained that resident #006 s pant zipper was down and that it was how they put resident #005 s hand on their penis. The RN in charge and another staff member interviewed resident #005 who repeated the same incident to the staff. At that time, resident #005 was visibly upset with tears in their eyes. The police was called and visited resident #006 who admitted to some parts of the story, as told by resident #005.

On October 28, 2015, Inspector attempted to interview resident #006 who was not in their room or on their unit. Inspector interviewed S#103 and S#102 who did not know the resident s whereabouts. Staff #103 and #102 looked for the resident and consulted with another staff member who again, did not know the resident s whereabouts. Staff #103 explained that the resident often went to the auditorium or on the Teck unit, which was downstairs. Staff #102 and #103 explained that the resident s badge was programmed to alert staff if they went into female rooms. Staff #103 also explained that the staff on the Teck unit know to monitor resident #006 s activities as they are "red flagged for inappropriate sexual behaviors". Inspector went to the auditorium and to the Teck Unit and could not find resident #006. The staff on the Teck unit explained that they were familiar with resident #006 but had not seen him. Inspector went back to resident #006 s unit where again, he was nowhere to be found. Approximately 1 2 hour later, resident #006 returned, walking slowly with their walker and went to their room. Staff #102 and #103 did not ask the resident where their whereabouts were.

Inspector reviewed the resident s care plan which had a focus on Locomotion On Off the unit. The interventions included a badge programmed to alert staff when resident entered other resident s room and staff were to respond immediately to pager call. Staff were to monitor whereabouts hourly, related to inappropriate sexual behavior exhibited toward female residents. If resident was seen on the Teck unit, staff were to question who he was visiting and ensure he only visited male residents and then return upstairs to his unit. In this case, the staff on the resident s unit were not aware of the resident s whereabouts as required in his plan.

Since the incident of September 9, 2015, resident #006 has continued to wander the hallways, lingering near female residents rooms, stopping and looking into female residents rooms, and displaying inappropriate sexual behaviors on October 21, 2015, where he was masturbating in a bathroom with door open, and on October 29, 2015, resident #006 was observed in the auditorium with his belt undone and pants unzipped, while children from daycare were visiting. (603)

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

a) On October 28, 2015, Inspector #603 reviewed resident #001's health care record. The progress notes indicated that a PSW witnessed resident #001 kissing resident #002. Inspector reviewed resident #001's care plan which indicated that with any incident of inappropriate sexual behavior, the staff are to increase monitoring: 10 minute checks for 1 hour, then 30 minute checks while awake for 24hrs. The staff are to document on ABC charting, DOS, POC and PCC. On review of the resident's health care record, Inspector found no documentation for the increased monitoring on the ABC charting, DOS, and POC, for a specific incident. Staff #100 confirmed that there was no increased monitoring and thus no documentation for this incident; in fact, S#100 noted that on POC, there was no area to document inappropriate sexual behavior.

b) On October 28, 2015, Inspector reviewed resident #001's care plan which indicated that the resident was to have a yellow banner placed across their door frame, to deter wandering residents, from entering resident #001's room. On October 28, 2015, Inspector observed resident #001 sleeping in their room with their door open. The yellow banner was not placed across their doorway; in fact, all yellow bands were seen dangling from the different room doorways on that unit. Inspector noted resident #002 wandering the unit, including in front of resident #001's room. Staff #100, who was in attendance with Inspector, noted resident #002 wandering around resident #001's room and instructed S#101 who was passing by, to apply the yellow banner across resident #001's doorway as required. (603)

4. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #008.

On October 29, 2015, Inspector #603 observed resident #008 to be tilted in their wheelchair with no seat belt on. Inspector interviewed S#106 who explained that the resident did not have a seat belt on while in the tilted wheelchair because the home was doing a two week trial without the seat belt and utilizing a specific device for safety.

Inspector reviewed resident's health care record and noted that on the Safety-Restraint record form, the form still indicated a tilted chair and seatbelt to be applied for safety. Inspector reviewed the resident's care plan and under restraint, the resident required a tilted chair and there was no mention of a seat belt. The care plan included a 2 week trial of a specific device while in wheelchair for safety.

Inspector interviewed S#100 who explained that because the resident was on the trial period, the resident did not require a seat belt and yet the Safety - Restraint record form still had a tilted chair and seat belt as a form of restraint. (603)

5. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #009 as specified in the plan.

On October 29, 2015, Inspector #603 observed resident #009 to be sitting in a wheelchair, with a seat belt on. The wheelchair was not tilted. Inspector interviewed S#106 who explained that the resident was not tilted as ordered by the physician because the resident uses their feet to mobilize self.

Inspector reviewed resident #009's health care record and on the Safety - Restraint record form, it indicated the need for a tilted chair and a seat belt for safety. Inspector reviewed the resident's care plan which indicated the need for a tilted wheelchair and a seat belt while in the wheelchair. The care plan also indicated that the restraint needed to be undone and reapplied at least hourly, repositioned as needed and document on restraint record. Inspector reviewed the Safety - Restraint record form and there was no documentation of the staff undoing and reapplying the seat belt at least hourly.

LTCHA, 2007 S.O. 2007, s. 6. (7) was issued previously as CO during Inspection #2015_391603_0022, WN and VPC during Inspection #2014_332575_0021, WN during Inspection #2014_283544_0025, and WN and VPC during Inspection #2013_138151_0020.

The decision to re-issue this compliance order was based on the scope which involved five out of the seven residents inspected during the Follow Up, the severity which indicated a potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including a compliance order, NC continues with this area of the legislation. (603)

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

Dec 11, 2015(A2)

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

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 and the Director

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

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

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
Toronto ON M5S 2B1
Télécopieur : 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
Toronto ON M5S 2B1
Télécopieur : 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 27 day of November 2015 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : SYLVIE LAVICTOIRE - (A2)

Service Area Office /
Bureau régional de services : Sudbury