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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Jun 28, 2013	2013_220111_0009	O-000282-13	Complaint

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

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

CARESSANT CARE ON MCLAUGHLIN ROAD
114 McLaughlin Road, LINDSAY, ON, K9V-6L1

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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

This inspection was conducted on the following date(s): May 29 & 30 and telephone interviews on June 6 & 7 , 2013.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), one Registered Nurse (RN), one Registered Practical Nurse(RPN), five Personal Support Workers(PSW), one resident, and a police officer.

During the course of the inspection, the inspector(s) observed one resident, reviewed health records of two residents, reviewed the homes policy on prevention of abuse, staff schedules, staff training records and the homes investigation reports.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

Interviews of staff, review of health care records for Resident #1 & Resident #2, and review of the home's investigation indicated there were witnessed incidents of verbal and emotional abuse that occurred from a staff member towards Resident #1 & Resident #2. The licensee failed to immediately investigate and appropriate action was not taken until 3 days later.

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

A Critical Incident (CI) was submitted by the home for a staff to resident abuse incident.The CI indicated that a staff member was verbally and emotionally abusive towards Resident #1.

Review of the home's investigation and interview of staff indicated staff witnessed another staff member to be verbally abusive towards Resident #1, and verbally and emotionally abusive towards Resident #2.

Review of the progress notes for Resident #1 indicated the DOC notified the Director 3 days after the incidents occurred.

There was no indication the home notified the Director of the staff to resident verbal and emotional abuse towards Resident #2.

The licensee failed to immediately report to the Director witnessed incidents of staff to resident verbal and emotional abuse. [s. 24. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

Review of the progress notes for Resident #1 indicated the Substitute Decision Maker (SDM) was not notified until 3 days after the incidents of staff to resident verbal abuse that occurred.

Review of the progress notes for Resident #2 indicated the SDM was not notified of staff to resident verbal and emotional abuse that occurred.

Interview of the Administrator and the DOC indicated there was no documented evidence that Resident #2's SDM was ever notified of the incident of staff to resident verbal/emotional abuse that occurred.

The licensee failed to ensure the residents' SDM for Resident #1 and #2 were notified immediately upon the licensee becoming aware of witnessed incidents of verbal and emotional abuse by a staff member. The licensee also failed to ensure that Resident #2's SDM was notified following the licensee's investigation. [s. 97. (1) (a)(b)]

Additional Required Actions:

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

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 :

The licensee failed to protect residents from abuse by anyone and ensure that residents are not neglected by the licensee or staff[s.19].

Under O.Reg. 79/10, verbal abuse is defined as:
(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or
(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

Under O.Reg. 79/10, emotional abuse is defined as:
(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or
(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences; [s. 19. (1)]

2.Interviews of staff,review of health care records for Resident #1 & Resident #2, and review of the homes investigation indicated the licensee failed to immediately investigate witnessed incidents of staff to resident verbal and emotional abuse of Resident#1 & #2 by a staff member and appropriate action was not taken until 3 days later.

3. The licensee failed to ensure that all staff receive annual training on the homes policy to promote zero tolerance of abuse and neglect of residents by anyone [s.76 (4)].This issue is reflected under WN#7.

4. The licensee failed to ensure the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident [s.98].This issue is reflected under order #004.

5. The licensee failed to ensure that the resident's substitute decision maker(SDM),

for Resident #1 and Resident #2 were notified immediately upon the licensee becoming aware of a witnessed incident of verbal and emotional abuse by a staff member. The licensee also failed to ensure that Resident #2's SDM was notified following the licensee's investigation [s.97(1)(a)(b)].This issue is reflected under order # 003.

6. The licensee failed to immediately report to the Director witnessed incidents of staff to resident#1 & #2 verbal and emotional abuse [s.24(1)].This issue is reflected under order #002.

7. The licensee failed to immediately investigate witnessed incidents of staff to resident verbal/emotional abuse of Resident#1 & #2 by a staff member and appropriate action was not taken until 3 days later [s.23(1)(a)(b)].This issue is reflected under order # 001.

8. The licensee failed to ensure the Director was provided the names of all residents involved in the incident, the name of the inspector that was contacted, and the report was made within 10 days of becoming aware of the witnessed incidents of staff to resident verbal and emotional abuse [s. 104(1)2,5(2)].This issue was reflected under WN and VPC#6. [s. 19. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

A Critical Incident (CI) was submitted by the home for a staff to resident abuse incident. The CI indicated that a staff member was verbally and emotionally abusive towards Resident #1.

Review of the home's investigation indicated staff member (S#100) was verbally and emotionally abusive towards Resident #1 and #2. Resident #2 was not indicated in the CI report. The licensee failed to ensure the Director was provided the names of any residents involved in the incident. [s. 104. (1) 2.]

2. Review of the CI indicated under actions taken, the "Duty Inspector was contacted". The licensee failed to ensure that the name of the inspector contacted was indicated on the report.
[s. 104. (1) 5.]

3. Review of the CI indicated the report was not made within 10 days of the incident. The licensee failed to ensure that the report was made within 10 days of becoming aware of the witnessed incidents of staff to resident abuse. [s. 104. (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 any incidents of alleged, suspected or witnessed incidents of abuse of a resident by anyone or neglect of a resident by the licensee or staff is reported to the Director and includes names of all residents involved in the incident, the name of the inspector contacted and the report is submitted within 10 days of the incident, to be implemented voluntarily.

WN #6: 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. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

Interview of the DOC and Administrator indicated that there was no documented evidence to indicate that any of the staff who witnessed the staff to resident verbal/emotional abuse towards Resident #1 & Resident #2 received annual training on the homes policy to promote zero tolerance of abuse and neglect until after the incident occurred.

Interview of staff member (S#100) indicated they have worked in the home for greater than 3 years and annual training on the homes abuse prevention policy was not received until after the incident of staff to resident abuse occurred.

Interview of staff member (S#103) indicated the they have worked in the home greater than 9 years and could only recall receiving training on the homes abuse prevention policy recently.

Interview of staff member (S#105) indicated they have worked in the home for less than one year and just received training on the homes abuse prevention policy recently.

The licensee failed to ensure that all staff receive annual training on the home's policy to promote zero tolerance of abuse and neglect of residents.[s. 76. (4)]

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

Issued on this 15th day of July, 2013

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) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2013_220111_0009
Log No. / Registre no:	O-000282-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 28, 2013
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE ON MCLAUGHLIN ROAD 114 McLaughlin Road, LINDSAY, ON, K9V-6L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paul Ludgate

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;

(b) appropriate action is taken in response to every such incident; and

(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee will ensure that all staff, who are aware of any alleged, suspected or witnessed incident of abuse of a resident by anyone, immediately report such knowledge so that the licensee can immediately investigate and take appropriate action in response to every such incident.

Grounds / Motifs :

1. Interviews of staff, review of health care records for Resident #1 & Resident #2, and review of the home's investigation indicated the licensee failed to immediately investigate witnessed incidents of staff to resident verbal and emotional abuse of Resident#1 & #2 by a staff member and appropriate action was not taken until 3 days later. (111)

2.
(111)

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 : Jul 05, 2013

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

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Order / Ordre :

The licensee shall ensure the Director is immediately notified when a person has reasonable grounds to suspect improper care or abuse of a resident by anyone, that results in harm or risk of harm to the resident, regardless of any investigation or actions being taken.

Grounds / Motifs :

1. Review of the home's investigation and interview of staff indicated staff witnessed another staff member to be verbally abusive towards Resident #1, and verbally and emotionally abusive towards Resident #2.

Review of the progress notes for Resident #1 indicated the DOC notified the Director 3 days after the incidents occurred.

There was no indication the home notified the Director of the staff to resident verbal and emotional abuse towards Resident #2.

The licensee failed to immediately report to the Director witnessed incidents of staff to resident verbal and emotional abuse. [s. 24. (1)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 05, 2013

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

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Order / Ordre :

The licensee shall establish a process to ensure the immediate notification of the resident's substitute decision-maker, if any, and any other person specified by the resident actually occurs as per the legislation, upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of the resident that has resulted in a physical injury or pain to the resident, or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

Grounds / Motifs :

1. Review of the progress notes for Resident #1 indicated the Substitute Decision Maker (SDM) was not notified until 3 days after the incidents of staff to resident verbal abuse that occurred.

Review of the progress notes for Resident #2 indicated the SDM was not notified of staff to resident verbal and emotional abuse that occurred.

Interview of the Administrator and the DOC indicated there was no documented evidence that Resident #2's SDM was ever notified of the incident of staff to resident verbal/emotional abuse that occurred.

The licensee failed to ensure the residents' SDM for Resident #1 and #2 were notified immediately upon the licensee becoming aware of witnessed incidents of verbal and emotional abuse by a staff member. The licensee also failed to ensure that Resident #2's SDM was notified following the licensee's investigation. [s. 97. (1) (a)(b)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 05, 2013

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

Order # / Ordre no : 004

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

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 shall prepare, implement and submit a plan to ensure that all residents are protected from verbal and emotional abuse by anyone.
This plan shall ensure that all staff are re-trained on the homes policy of "Prevention of Abuse", specifically-definitions of abuse and all actions to be taken with any alleged, suspected, or witnessed incidents of abuse and neglect, as well as the reporting requirements.

This plan is to be submitted electronically to Lynda.Brown2@ontario.ca by July 8, 2013.

Grounds / Motifs :

1. The licensee failed to protect residents from abuse by anyone and ensure that residents are not neglected by the licensee or staff[s.19].

Under O.Reg. 79/10, verbal abuse is defined as:
(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or
(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

Under O.Reg. 79/10, emotional abuse is defined as:
(a) any threatening, insulting, intimidating or humiliating gestures, actions,

behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or
(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences; (111)

2. 1.The licensee failed to protect residents from abuse by anyone and ensure that residents are not neglected by the licensee or staff[s.19].

Under O.Reg. 79/10, verbal abuse is defined as:
(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or
(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

Under O.Reg. 79/10, emotional abuse is defined as:
(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or
(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences; [s. 19. (1)]

2.Interviews of staff,review of health care records for Resident #1 & Resident #2, and review of the homes investigation indicated the licensee failed to immediately investigate witnessed incidents of staff to resident verbal and emotional abuse of Resident#1 & #2 by a staff member and appropriate action was not taken until 3 days later.

3. The licensee failed to ensure that all staff receive annual training on the

homes policy to promote zero tolerance of abuse and neglect of residents by anyone [s.76(4)].This issue is reflected under WN#7.

4. The licensee failed to ensure the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident [s.98].This issue is reflected under order #004.

5. The licensee failed to ensure that the resident's substitute decision maker (SDM), for Resident #1 and Resident #2 were notified immediately upon the licensee becoming aware of a witnessed incident of verbal and emotional abuse by a staff member. The licensee also failed to ensure that Resident #2's SDM was notified following the licensee's investigation [s.97(1)(a)(b)].This issue is reflected under order # 003.

6. The licensee failed to immediately report to the Director witnessed incidents of staff to resident#1 & #2 verbal and emotional abuse [s.24(1)].This issue is reflected under order #002.

7. The licensee failed to immediately investigate witnessed incidents of staff to resident verbal/emotional abuse of Resident#1 & #2 by a staff member and appropriate action was not taken until 3 days later [s.23(1)(a)(b)].This issue is reflected under order # 001.

8. The licensee failed to ensure the Director was provided the names of all residents involved in the incident, the name of the inspector that was contacted, and the report was made within 10 days of becoming aware of the witnessed incidents of staff to resident verbal and emotional abuse [s. 104(1)2,5(2)].This issue was reflected under WN and VPC#6. [s. 19. (1)] (111)

3. The licensee failed to ensure that all staff receive annual training on the homes policy to promote zero tolerance of abuse and neglect of residents by anyone [s.76(4)].This issue is reflected under WN#7.

The licensee failed to ensure the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident [s.98].This issue is reflected under order #004.

The licensee failed to ensure that the resident's substitute decision maker(SDM),

for Resident #1 and Resident #2 were notified immediately upon the licensee becoming aware of a witnessed incident of verbal and emotional abuse by a staff member. The licensee also failed to ensure that Resident #2's SDM was notified following the licensee's investigation [s.97(1)(a)(b)].This issue is reflected under order # 003.

The licensee failed to immediately report to the Director witnessed incidents of staff to resident#1 & #2 verbal and emotional abuse [s.24(1)].This issue is reflected under order #002.

The licensee failed to immediately investigate witnessed incidents of staff to resident verbal/emotional abuse of Resident#1 & #2 by a staff member and appropriate action was not taken until September 26, 2012 when the staff member was suspended for a period of five days and then relocated to another unit [s.23(1)(a)(b)].This issue is reflected under order # 001.

The licensee failed to ensure the Director was provided the names of all residents involved in the incident, the name of the inspector that was contacted, and the report was made within 10 days of becoming aware of the witnessed incidents of staff to resident verbal and emotional abuse [s. 104(1)2,5(2)].This issue was reflected under WN and VPC#6. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2013

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.

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

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 28th day of June, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LYNDA BROWN

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