Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection/ Genre d'inspection
Jan 24, 2017	2016_229213_0038	022711-16, 033528-16	Follow up

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 WOODSTOCK NURSING HOME
81 FYFE AVENUE WOODSTOCK ON N4S 8Y2

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

RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

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

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

This inspection was conducted on the following date(s): October 28, 31, November 1, 2, 3, 4, 8, 9, 10, 14, 15, 16, 17, 18, 29, 30, December 1, 2, 5, 6, 7, 8, 12, 13, 15, 16, 19, 2016, January 3, 4, 5, 6, 9, 10, 12, 13, 16, 17, 18, 19, 2017

This follow up inspection was completed related to two previously issued orders:
- Orders issued as a result of a critical incident inspection log #018577-16, inspection #2016_258519_0007 related to care plan being based on assessment of safety risks associated with the use of a specific mobility device.
- Orders issued as a result of the Resident Quality Inspection log #002290-16, inspection #2016_326569_0021 related to reporting abuse and neglect to the Director.

Findings of non-compliance related to LTCHA,2007,S.O.2007, c.8 s.24(1) found in inspection #2016_303563_0042, log # 033550-16 have been issued as a compliance order in this inspection.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Director of Nursing, an Occupational Therapist, two Registered Nurses, a family member and two residents.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of safety risks with respect to the resident.

A compliance order was issued on June 29, 2016 with a compliance date of August 4, 2016 after a resident sustained an injury outside the home while using a specific mobility device. The compliance order stated the licensee will do an interdisciplinary assessment of the safety risks associated with the use of a specific mobility device for the resident and develop a plan of care based on the results

of the assessment.

An Occupational Therapist (OT) completed an assessment of the resident. The hand written assessment found in the resident's paper chart noted the several directions related to safety, comfort and positioning.

The most current plan of care for the resident did not include any of the above directions related to the use of the specific mobility device.

In an interview with a Registered Nurse, she said that the resident did use the specific mobility device following an injury. The RN said that the resident left the home and went out in the community using a specific mobility device with a specific intervention in place.

In reviewing the Leave of Absence (LOA) Sign Out Book on the unit where the resident resided, the resident signed out as leaving the home on eight occasions.

In an interview with Resident Assessment Instrument (RAI) Coordinator, the RAI Coordinator reviewed the assessment and the care plan and said that none of the directions identified in the OT assessment were identified in the plan of care. The RAI Coordinator also said that the instructions in the LOA book were not identified in the Kardex, they were only in the care plan. She said that Personal Support Workers only have access to the Kardex and not the care plan, so they would not have been aware of these instructions. The RAI Coordinator also said that the resident left the home and went out in the community using a specific mobility device with a specific intervention in place.

In an interview with the Director of Nursing (DON), the DON reviewed the OT assessment and the resident's care plan and agreed that none of the directions identified in the OT assessment were identified in the plan of care. The DON later that day said that the OT assessment was in the registered staff communication book, found in the locked medication room. She agreed that Personal Support Workers do not have access to the locked medication room.

The health records were reviewed for five other residents who used a specific mobility device in the home at the time of the inspection and there were no assessments found on admission or quarterly related to the use of a specific mobility device prior to December 2016.

In an interview with a resident, they recalled having had a test using a specific mobility device. The resident said that they had never had any type of assessment or test prior to December 2016 and that they had been using a specific mobility device for several years.

In an interview with a full time Registered Nurse (RN), the RN said that she was not aware that assessments were completed related to the use of a specific mobility device in the home and had never seen one.

In a phone interview with the home's Occupational Therapist (OT), the OT said she was not aware of the home's policy indicating that an assessment would be completed on admission and quarterly related to the use of a specific mobility device or the agreement. She said that she was asked by the Director of Nursing to complete assessments on all residents who used a specific mobility device in the home as a new initiative in the home. The OT said that the assessments completed in December

2016 were the first and only assessments completed by her in the two years she has worked in the home. The OT said that it was the responsibility of the registered nursing staff to incorporate the results and recommendations of her assessments into the resident's care plans.

Inspectors were in the home as of October 28, 2016 to the time of the report. In December 2016, Inspectors began requesting documentation and interviewing staff regarding the follow up order regarding interdisciplinary assessments being completed related to safety risks with the use of a specific mobility device. Assessments related to the use of specific mobility devices were not completed for any residents using a specific mobility device until December 2016.

The home failed to ensure that the plans of care were based on, at a minimum, interdisciplinary assessment of safety risks with respect to six residents regarding the use of a specific mobility device.

The severity of this non compliance is minimal harm/risk or potential for actual harm/risk and the scope is widespread with six out of six residents affected. The home has a history of non-compliance in this subsection of the legislation, it was issued as compliance order #001 June 29, 2016 with a compliance date of August 4, 2016. [s. 26. (3) 19.]

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, s. 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, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 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, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that 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 had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Compliance order #001 was issued on October 20, 2016 with a compliance date of October 31, 2016 following the home's Resident Quality Inspection (RQI) (log #018577-16, inspection #2016_258519_0007). The order stated "the licensee must ensure that any allegations or suspicions of abuse of a resident by anyone is reported immediately to the Director".

In an interview with the Director of Nursing (DON), when asked by Inspector #213, what was done regarding compliance order #001, the DON said that the Acting Administrator had been working on an action plan. When asked what the DON had done to achieve compliance related to order #001, she said "nothing to date".

The Acting Administrator provided Inspector #213 with the Plan of Corrective Action related to the compliance order #001 issued following the RQI and said that she had emailed the plan to the Director of Nursing in September 2016. The plan indicated "the Director of Nursing (DON) and Resident Care Coordinator (RCC) will review mandatory reporting requirements with the registered staff. A reference binder will be available at each nursing station for the registered staff. The DON and RCC will review the Abuse policy with all staff with an emphasis on physical and verbal abuse. Staff will review their roles and responsibilities when witnessing or suspecting abuse of a resident. Staff will be strongly reminded of their reporting responsibilities to their immediate supervisor". The plan also indicated "all nurse managers are to be trained on Critical Incident (CI) reporting/submissions. All nurse managers are to have Ministry of Health (MOH) access. CI reports are to be reviewed at the weekly management meeting".

In interviews with two Registered Nurses, both nurses were unaware of a reference binder and were unable to locate any reminders or reviews regarding mandatory reporting or reporting

requirements.

In an interview with the DON and the Acting Administrator, the Inspector requested documentation of the review of mandatory reporting requirements reviewed with registered staff and all staff, the reference binder, and the strong reminder of reporting responsibilities. The home was unable to produce any documentation of the action items identified in the Plan of Corrective Action related to compliance order #001 issued following the Resident Quality Inspection (RQI). The DON also said that one of the Resident Care Coordinators had access to the critical incident reporting system, the other did not at that time.

The home submitted a Critical Incident (CI) related to an alleged incident of staff to resident abuse that occurred. The resident reported to the Registered Nurse (RN) that a staff member was rough during care and that the RN observed an injury to the resident.

In an interview with the resident, the resident recalled being treated roughly and caused pain and injury to the resident. During the interview, the resident was observed to be injured.

In an interview with the Director of Nursing (DON), the DON said that she was on vacation at the time of the incident and that the Resident Care Coordinator (RCC) submitted the CI and that RCC spoke to the resident regarding the incident.

In an interview with the RCC, the RCC said that the RN reported the allegation to her and she and the RN spoke to the resident about the suspicion right away, she was aware of the incident and the injuries, but that she did not have access to the Ministry of Health and Long Term Care Critical Incident System and had not used it yet. The RCC than provided the information to the other RCC to submit the report. The RCC said that she had no documentation of the incident or the conversation with the resident. The RCC could not recall the date of the incident or the date that she provided the information to the other RCC to submit the Critical Incident report to the Director.

Progress notes were reviewed in Point Click Care by Inspector #213 and the RCC. No documentation was found related to the resident's allegation or injuries.

In an interview with the RN, the RN said that she did not recall the date of the incident or if she had made a progress note regarding the incident. She recalled noting an injury and it appeared that someone pulled the resident to assist to transfer.

In an interview with both Resident Care Coordinators, they both agreed that according to the critical incident report, the Director was notified of the suspicion of physical abuse 28 hours after the incident was reported to the home.

In an interview with the Acting Administrator, she said that she was aware of the reported suspicion of abuse involving the resident that was reported and agreed that the Critical Incident was not immediately reported to the Director.

The licensee failed to immediately report a suspicion of staff to resident physical abuse to the Director.

The severity of this non-compliance is minimal risk, the scope is wide spread with one out of one resident affected. The home has a history of non-compliance in this subsection of the legislation; a compliance order was issued on November 25, 2015 and reissued on October 20, 2016 with a compliance date of October 31, 2016. [s. 24. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 24th day of January, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RHONDA KUKOLY (213)
Inspection No. / No de l'inspection :	2016_229213_0038
Log No. / Registre no:	022711-16, 033528-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 24, 2017
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 WOODSTOCK NURSING HOME 81 FYFE AVENUE, WOODSTOCK, ON, N4S-8Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gay Goetz

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:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_258519_0007, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee will ensure that all residents who use a specific mobility device have an interdisciplinary assessment of the safety risks associated with the use of a specific mobility device at a minimum, on admission, on acquisition of a new specific mobility device, at least every six months, or more often as the home's policy stipulates, and at any other time when a resident's care needs change affecting the use of a specific mobility device; and the plan of care will be based on the results of the assessment.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of safety risks with respect to the resident.

A compliance order was issued on June 29, 2016 with a compliance date of August 4, 2016 after a resident sustained an injury outside the home while using a specific mobility device. The compliance order stated the licensee will do an interdisciplinary assessment of the safety risks associated with the use of a specific mobility device for the resident and develop a plan of care based on the results of the assessment.

An Occupational Therapist (OT) completed an assessment of the resident. The hand written assessment found in the resident's paper chart noted the several directions related to safety, comfort and positioning.

The most current plan of care for the resident did not include any of the above directions related to the use of the specific mobility device.

In an interview with a Registered Nurse, she said that the resident did use the specific mobility device following an injury. The RN said that the resident left the home and went out in the community using a specific mobility device with a specific intervention in place.

In reviewing the Leave of Absence (LOA) Sign Out Book on the unit where the resident resided, the resident signed out as leaving the home on eight occasions.

In an interview with Resident Assessment Instrument (RAI) Coordinator, the RAI Coordinator reviewed the assessment and the care plan and said that none of the directions identified in the OT assessment were identified in the plan of care. The

RAI Coordinator also said that the instructions in the LOA book were not identified in the Kardex, they were only in the care plan. She said that Personal Support Workers only have access to the Kardex and not the care plan, so they would not have been aware of these instructions. The RAI Coordinator also said that the resident left the home and went out in the community using a specific mobility device with a specific intervention in place.

In an interview with the Director of Nursing (DON), the DON reviewed the OT assessment and the resident's care plan and agreed that none of the directions identified in the OT assessment were identified in the plan of care. The DON later that day said that the OT assessment was in the registered staff communication book, found in the locked medication room. She agreed that Personal Support Workers do not have access to the locked medication room.

The health records were reviewed for five other residents who used a specific mobility device in the home at the time of the inspection and there were no assessments found on admission or quarterly related to the use of a specific mobility device prior to December 2016.

In an interview with a resident, they recalled having had a test using a specific mobility device. The resident said that they had never had any type of assessment or test prior to December 2016 and that they had been using a specific mobility device for several years.

In an interview with a full time Registered Nurse (RN), the RN said that she was not aware that assessments were completed related to the use of a specific mobility device in the home and had never seen one.

In a phone interview with the home's Occupational Therapist (OT), the OT said she was not aware of the home's policy indicating that an assessment would be completed on admission and quarterly related to the use of a specific mobility device or the agreement. She said that she was asked by the Director of Nursing to complete assessments on all residents who used a specific mobility device in the home as a new initiative in the home. The OT said that the assessments completed in December 2016 were the first and only assessments completed by her in the two years she has worked in the home. The OT said that it was the responsibility of the registered nursing staff to incorporate the results and recommendations of her assessments into the resident's care plans.

Inspectors were in the home as of October 28, 2016 to the time of the report. In December 2016, Inspectors began requesting documentation and interviewing staff regarding the follow up order regarding interdisciplinary assessments being completed related to safety risks with the use of a specific mobility device. Assessments related to the use of specific mobility devices were not completed for any residents using a specific mobility device until December 2016.

The home failed to ensure that the plans of care were based on, at a minimum, interdisciplinary assessment of safety risks with respect to six residents regarding the use of a specific mobility device.

The severity of this non compliance is minimal harm/risk or potential for actual harm/risk and the scope is widespread with six out of six residents affected. The home has a history of non-compliance in this subsection of the legislation, it was issued as compliance order #001 June 29, 2016 with a compliance date of August 4, 2016. [s. 26. (3) 19.]

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 28, 2017

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 : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_326569_0021, CO #001;

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, s. 24 (1), 195 (2).

Order / Ordre :

The licensee will ensure that any person who has reasonable grounds to suspect that 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, occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that 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 had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Compliance order #001 was issued on October 20, 2016 with a compliance date of October 31, 2016 following the home's Resident Quality Inspection (RQI) (log #018577-16, inspection #2016_258519_0007). The order stated "the licensee must ensure that any allegations or suspicions of abuse of a resident by anyone is reported immediately to the Director".

In an interview with the Director of Nursing (DON), when asked by Inspector #213, about what was done regarding compliance order #001, the DON said that the Acting Administrator had been working on an action plan. When asked what the DON had done to achieve compliance related to order #001, she said "nothing to date".

The Acting Administrator provided Inspector #213 with the Plan of Corrective Action related to the compliance order #001 issued following the RQI and said that she had emailed the plan to the Director of Nursing in September 2016. The plan indicated "the Director of Nursing (DON) and Resident Care Coordinator (RCC) will review mandatory reporting requirements with the registered staff. A reference binder will be available at each nursing station for the registered staff. The DON and RCC will review the Abuse policy with all staff with an emphasis on physical and verbal abuse. Staff will review their roles and responsibilities when witnessing or suspecting abuse of a resident. Staff will be strongly reminded of their reporting responsibilities to their immediate supervisor". The plan also indicated "all nurse managers are to be trained on Critical Incident (CI) reporting/submissions. All nurse managers are to have Ministry of Health (MOH) access. CI reports are to be reviewed at the weekly management meeting".

In interviews with two Registered Nurses, both nurses were unaware of a reference binder and were unable to locate any reminders or reviews regarding mandatory reporting or reporting requirements.

In an interview with the DON and the Acting Administrator, the Inspector requested documentation of the review of mandatory reporting requirements reviewed with registered staff and all staff, the reference binder, and the strong reminder of reporting responsibilities. The home was unable to produce any documentation of the action items identified in the Plan of Corrective Action related to compliance order #001 issued following the Resident Quality Inspection (RQI). The DON also said that one of the Resident Care Coordinators had access to the critical incident reporting system, the other did not at that time.

The home submitted a Critical Incident (CI) related to an alleged incident of staff to resident abuse that occurred. The resident reported to the Registered Nurse (RN) that a staff member was rough during care and that the RN observed an injury to the resident.

In an interview with the resident, the resident recalled being treated roughly and caused pain and injury to the resident. During the interview, the resident was observed to be injured.

In an interview with the Director of Nursing (DON), the DON said that she was on vacation at the time of the incident and that the Resident Care Coordinator (RCC) submitted the CI and that RCC spoke to the resident regarding the incident.

In an interview with the RCC, the RCC said that the RN reported the allegation to her and she and the RN spoke to the resident about the suspicion right away, she was aware of the incident and the injuries, but that she did not have access to the Ministry of Health and Long Term Care Critical Incident System and had not used it yet. The RCC than provided the information to the other RCC to submit the report. The RCC said that she had no documentation of the incident or the conversation with the resident. The RCC could not recall the date of the incident or the date that she provided the information to the other RCC to submit the Critical Incident report to the Director.

Progress notes were reviewed in Point Click Care by Inspector #213 and the RCC. No documentation was found related to the resident's allegation or injuries.

In an interview with the RN, the RN said that she did not recall the date of the incident or if she had made a progress note regarding the incident. She recalled noting an injury and it appeared that the resident was pulled to assist to transfer.

In an interview with both Resident Care Coordinators, they both agreed that according to the critical incident report, the Director was notified of the suspicion of physical abuse 28 hours after the incident was reported to the home.

In an interview with the Acting Administrator, she said that she was aware of the reported suspicion of abuse involving the resident that was reported and agreed that the Critical Incident was not immediately reported to the Director.

The licensee failed to immediately report a suspicion of staff to resident physical abuse to the Director.

The severity of this non-compliance is minimal risk, the scope is wide spread with one out of one resident affected. The home has a history of non-compliance in this subsection of the legislation; a compliance order was issued on November 25,

2015 and reissued on October 20, 2016 with a compliance date of October 31, 2016. [s. 24. (1)]

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 27, 2017

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 24th day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RHONDA KUKOLY

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