Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 5, 2013	2013_103193_0002	T-2184-12, T-2189-12	Complaint

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

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

CASTLEVIEW WYCHWOOD TOWERS
351 CHRISTIE STREET, TORONTO, ON, M6G-3C3

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

MONICA NOURI (193)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 19, 21, 26, 27 and April 3/2013

the following complaint logs were inspected: T-2184-12, T-2105-12 and T-2189-12.

During the course of the inspection, the inspector(s) spoke with family members, personal care aides (PCA), registered practical nurses (RPN), nurse managers (NM), maintenance staff, housekeeping staff, buildings and services manager, support assistant, counsellor, behavioral support nurse (BSN), staff support educator (SSE), director of nursing (DON), and the administrator

During the course of the inspection, the inspector(s) reviewed residents health care records, review licensee's policies and procedures, training records, observed provision of care and staff to residents interactions

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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. 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 ensure that resident #1 was protected from verbal, emotional and sexual abuse by the staff in the home on 2 identified occasions.

- On an identified date a staff member of the home witnessed two identified RPNs, A and B, speaking to the resident in a demeaning manner and making inappropriate comments of a sexual nature.
- On another identified date three identified staff members of the home observed the same two RPNs, A and B, appearing to take pictures of the naked resident with a phone camera. Another identified staff member heard RPN A state to the resident that will take a picture to show how the resident looks like naked.
The interview with RPN A and the documented progress notes revealed that this was a strategy to shame the resident and convince the resident to dress.
Another staff interview revealed witnessing on the same day RPN A coming into the nursing station and repeating to the resident inappropriate comments in an attempt to shame the resident, while the resident was in distress waiting for the ambulance for transfer to the hospital.

Staff interview revealed the first incident was shared with other three staff members on the same day, but it was not reported to the administrator until 14 days later due to worries about personal and professional repercussions. The reporting staff name was mentioned when the home's investigation was conducted, fact that had negative impact in the professional relation with other staff members involved in the incident.
Witnessing staff interview for the second incident revealed that a report was made on the same day to the immediate manager despite worries about personal and professional repercussions. Staff was advised on previous occasions to be careful when reporting incidents in the home.

The licensee conducted an investigation of the incident and measures were put in place to prevent
re-occurrence. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 failed to ensure that the care set out in the plan of care for resident #1 was provided to the resident as specified in the plan.

On an identified date RPN A had the appearance of taking pictures of the resident naked. Interview with RPN and review of progress notes revealed that this was used as a strategy to "shame" and convince the resident to dress.
The plan of care for resident #1 does not indicate this strategy to deal with resident's behaviours. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care for resident #1 is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 :

1. Identified staff members of the home failed to report immediately to the Director the suspicion and the information of an alleged verbal, emotional and sexual abuse of resident #1 by staff on two occasions. The resident presented responsive behaviours at that time.

- On an identified date a staff member of the home witnessed two identified RPNs, A and B, speaking to the resident in a demeaning manner and making inappropriate comments of a sexual nature.
Staff interview revealed that incident was shared with other three staff members on the same day, but it was not reported to the administrator until 14 days later due to worries about personal and professional repercussions. This alleged abuse was not reported to the Director.

- On another identified date an identified staff of the home observed the same two RPNs, A and B, appearing to take pictures of the naked resident with a phone camera.
The alleged abuse was reported immediately to the building and services manager and to an identified nurse manager.
The incident was not reported immediately to the Director as required. The report to the Director was made by the licensee 29 days later. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: 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).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff of the home have received the required training under subsection (2) in 2012 in following areas; Residents' Bill of Rights, the duty under section 24 to make mandatory reports, and the protections afforded by section 26.

Through interviews with front line staff and staff support educator (SST) it was determined that not all staff who provide direct care to residents received the training in 2012 as follows;
- 25.6% (117/457) of the staff who provide direct care received the training for Residents' Bill of Rights,
- 33.9% (155/457) of the staff who provide direct care received the training for the duty under section 24 to make mandatory reports, and
- 25.3% (116/457) of the staff who provide direct care received the training for the protections afforded by section 26 [s. 76. (4)]

2. The licensee failed to ensure that all staff receive training in the area of abuse recognition and prevention, as a condition of continuing to have contact with residents.

As per record review and SSE statement not all staff who provide direct care to residents , just 63.8% (292/457) received the training in 2012. [s. 76. (7) 1.]

3. The licensee failed to ensure that all staff receive training in the area of mental health issues, including caring for persons with dementia, as a condition of continuing to have contact with residents.

As per record review and SSE statement not all staff who provide direct care to residents, just 52.9% (242/457) received the training in 2012. [s. 76. (7) 2.]

4. The licensee failed to ensure that all staff receive training in behaviour management, as a condition of continuing to have contact with residents.

As per record review and SSE statement not all staff who provide direct care to residents, just 19.9% (91/457) received the training in 2012. [s. 76. (7) 3.]

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 all staff of the home receive the required training in
** Residents' Bill of Rights,*
** the protections afforded by section 26*
** mental health issues, including caring for persons with dementia, and*
** behaviour management,*
as a condition of continuing to have contact with residents, to be implemented voluntarily.

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:
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).

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the report to the Director under subsection 23(2) of the Act, M510-000073-12 from December 5/2012, include the following actions taken in response to the incident:
* whether an inspector has been contacted, and if so,
* the date of the contact and the name of the inspector. [s. 104. (1) 5.]

2. The licensee failed to ensure that the report was made within 10 days of becoming aware of the alleged abuse.

The report of the alleged abuse was made to the Director 29 days later. [s. 104. (2)]

3. The licensee failed to ensure that the preliminary report was made to the Director within 10 days, and followed by a final report within the time specified by the Director. [s. 104. (3)]

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
**** reports to the Director under subsection 23(2) of the Act, include whether an inspector has been contacted, and if so, the date of the contact and the name of the inspector***
**** reports are made within 10 days of becoming aware of the alleged abuse, and if not everything can be provided in the report within 10 days, the licensee makes a preliminary report to the Director within 10 days and provide the final report within a period of time specified by the Director, to be implemented voluntarily.***

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents contain an explanation of the duty under section 24 of the Act to make mandatory reports as provided in the Act. [s. 20. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the written record related to 2012 evaluation of the home's Responsive behaviours program includes the date when changes made were implemented. [s. 53. (3) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to minimize the risk of altercations and potentially harmful interactions between resident #1 and other male residents when resident #1 will present identified behaviours. [s. 55. (a)]

WN #9: 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 :

1. The licensee failed to ensure that the resident #1's substitute decision maker was immediately notified upon becoming aware of the alleged incident of abuse of the resident that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

On an identified date two RPNs, A and B, were seen by a staff member of the home appearing to take pictures of the naked resident with a phone camera in an attempt to shame the resident and convince the resident to dress. [s. 97. (1) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to notify immediately the appropriate police force of the alleged incident of abuse of resident #1 that the licensee suspected to constitute a criminal offence (as per home's abuse policy definition). [s. 98.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that the written record of the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents from 2012, include the date when the changes and improvements were implemented. [s. 99. (e)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that there was monitoring and documentation of the resident #1's response, and the effectiveness of the drugs administered to the resident on four identified occasions.[s. 134. (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

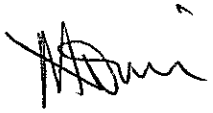
Findings/Faits saillants :

1. The licensee failed to ensure that, before discharging resident #2 under subsection 145(1), a written notice was provided to the resident or the resident's substitute decision maker setting out detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

The home discharged the resident and the written notice was sent to the resident's substitute decision maker 9 days later. [s. 148. (2) (d)]

Issued on this 5th day of April, 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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MONICA NOURI (193)
Inspection No. / No de l'inspection :	2013_103193_0002
Log No. / Registre no:	T-2184-12, T-2189-12
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 5, 2013
Licensee / Titulaire de permis :	TORONTO LONG-TERM CARE HOMES AND SERVICES 55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6
LTC Home / Foyer de SLD :	CASTLEVIEW WYCHWOOD TOWERS 351 CHRISTIE STREET, TORONTO, ON, M6G-3C3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	VIJA MALLIA

To TORONTO LONG-TERM CARE HOMES AND SERVICES, 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) (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, submit and implement a plan to ensure that residents are protected from abuse by anyone. The plan shall include the following;

a) How the licensee will establish an atmosphere that encourages and supports staff in providing information in a manner that would not have the effect of potentially discouraging reporting of abuse and neglect;

b) Update of the licensee's policy to promote zero tolerance of abuse and neglect of residents to include all of the requirements in s. 20(2) of the LTCHA, including 20(2)(d) in that it shall contain an explanation of the duty under section 24 to make mandatory reports, and

c) How the licensee will ensure all staff receive training regarding abuse and neglect including requirements under 76(7) of the LTCHA.

Please submit the plan to Monica.Nouri@ontario.ca by April 19/2013.

Grounds / Motifs :

1. 1) The licensee failed to ensure that resident #1 was protected from verbal, emotional and sexual abuse by the staff in the home on 2 identified occasions.
- On an identified date a staff member of the home witnessed two identified RPNs, A and B, speaking to the resident in a demeaning manner and making inappropriate comments of a sexual nature.
- On another identified date three identified staff members of the home observed the same two RPNs, A and B, appearing to take pictures of the naked resident

with a phone camera. Another identified staff member heard RPN A state to the resident that will take a picture to show how the resident looks like naked. The interview with RPN A and the documented progress notes revealed that this was a strategy to shame the resident and convince the resident to dress. Another staff interview revealed witnessing on the same day RPN A coming into the nursing station and repeating to the resident inappropriate comments in an attempt to shame the resident, while the resident was in distress waiting for transfer to the hospital.

2) Staff interview revealed the first incident was shared with other three staff members on the same day, but it was not reported to the administrator until 14 days later due to worries about personal and professional repercussions. The reporting staff name was mentioned when the home's investigation was conducted, fact that had negative impact in the professional relation with other staff members involved in the incident.
Witnessing staff interview for the second incident revealed that a report was made on the same day to the immediate manager despite worries about personal and professional repercussions. Staff was advised on previous occasions to be careful when reporting incidents in the home.

3) The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents contain an explanation of the duty under section 24 of the Act to make mandatory reports as provided in the Act.

4) The licensee failed to ensure that all staff of the home have received the required training under subsection (2) in 2012 in the duty under section 24 to make mandatory reports and in the area of abuse recognition and prevention, as a condition of continuing to have contact with residents.

Through interviews with front line staff and staff support educator (SST) it was determined that not all staff who provide direct care to residents received training in 2012 as follows;
- 33.9% (155/457) of the staff who provide direct care received the training for the duty under section 24 to make mandatory reports, and
- 63.8% (292/457) of the staff who provide direct care received the training in the area of abuse recognition and prevention. (193)

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 : May 06, 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 and the Director

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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

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

Issued on this 5th day of April, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MONICA NOURI

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