Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée**

**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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## Amended Public Copy/Copie modifiée du public de permis

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 26, 2017; | 2016_191107_0012 (A1) (Appeal\Dir#: DR# 065) | 028163-16 | Resident Quality Inspection |

### Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF DUFFERIN
151 Centre St SHELBURNE ON L0N 1S4

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

DUFFERIN OAKS
151 CENTRE STREET SHELBURNE ON L0N 1S4

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

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d’inspection prévue le Loi de 2007 les foyers de soins de longue durée**

Mary Nestor (Director) - (A1)(Appeal\Dir#: DR# 065)

## Amended Inspection Summary/Résumé de l’inspection modifié

**Director Review DR# 065 of Inspector's Order(s) has been rescinded.**

**Issued on this 26 day of January 2017 (A1)(Appeal\Dir#: DR# 065)**

**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**

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

Mary Nestor (Director) - (A1)(Appeal/Dir# DR# 065)

## Amended Inspection Summary/Résumé de l'inspection modifié

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): September 26, 27, 28, 29, 30, October 5, 6, 7, 2016**

**Inspector Kathy Millar #527 completed Inspection Protocols during this Resident Quality Inspection; however, due to technical difficulties, their name does not appear on the computer generated version of this report.**

**Additional inspections were completed concurrently with this Resident Quality Inspection:**

**004929-14 - CIS Notification - improper/incompetent care - pain medication. No non-compliance identified.**

**008937-15 - Complaint/Response - toileting, pain medication. No non-compliance identified.**

**002868-15 - CIS Notification - fall with fracture. Non-compliance r. 107(3)4 identified in this report.**

**006640-16 - CIS Notification - alleged staff to resident abuse. Non-compliance s. 20(1) identified in this report.**

**028990-15 - CIS Notification - fall with fracture. Non-compliance r. 107(3)4 identified in this report.**

**030496-15 - CIS Notification - alleged resident to resident abuse. Non-**

**compliance s. 19(1), s. 20(1), s. 6(1)(a), s. 6(7), s. 6(10)(b), r. 53(4)(c) identified in this report.**

**017392-16 - CIS Notification - alleged staff to resident abuse. Non-compliance s. 19(1), s. 20(1), s. 23(1)(a) were identified in this report.**

**017148-15 - CIS Notification - fall with fracture. No non-compliance identified.**

**During the course of the inspection, the inspector(s) spoke with residents, family members, the Administrator, Director of Care, Assistant Director of Care, Registered Nurses (RN), Registered Practical Nurses, Health Care Aides (HCA), Personal Support Workers (PSW), Resident Assessment Instrument/Minimum Data Set (RAI-MDS) Co-ordinators, Building Manager, Office Receptionist, Dietary Manager, Registered Dietitian, Family Council, Residents' Council,**

**The following Inspection Protocols were used during this inspection:**

**Continence Care and Bowel Management**

**Falls Prevention**

**Family Council**

**Infection Prevention and Control**

**Medication**

**Minimizing of Restraining**

**Nutrition and Hydration**

**Pain**

**Prevention of Abuse, Neglect and Retaliation**

**Residents' Council**

**Responsive Behaviours**

**Skin and Wound Care**

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

**12 WN(s)**
**10 VPC(s)**
**1 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) Resident #046 reported abuse and care concerns to RPN #107. Two PSWs, #115 and #133, also reported a witnessed incident of staff to resident abuse where PSW #134 was abusive to the resident. The incident was reported to RPN #107 and RN #138 at the time of the incident (morning); however, registered staff did not follow the home's policy, "Abuse Policy GN 3-020, and GN 3-030" and the staff member continued working with resident #046 and other residents for the rest of the day. The RPN identified that PSW #134 was having a difficult day both prior to the incident and after the incident; however, the staff member continued working with residents during that time.

Residents were not protected from abuse by staff in the home by removing the staff member pending an investigation as per the home's prevention of abuse policy. (107)

B) The home's "Abuse Policy GN 3-020", revised February 2015 and "Abuse Investigation GN 3-030", revised January 2015, identified that the following steps would be taken when abuse occurred: all individuals who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident must immediately report the suspicion to the Ministry of Health and Long Term Care (MOHLTC) through the Critical Incident system; staff were to notify the resident's substitute decision maker and any other person specified by the resident, immediately report to the police any alleged, suspected or witnessed incident of abuse that may constitute a criminal offense, immediately protect all residents from further harm, conduct an investigation according to procedure GN 3-030, submit a final report to the MOHTLC outlining the findings of the investigation and the corrective action taken, and notify the resident and resident's SDM of the results of the abuse investigation immediately upon the completion of the

investigation. The policy also directed staff to arrange a care conference to assess the situation and determine appropriate interventions if the abuser was an incompetent resident.

Resident #124 had an incident of abuse towards another resident on a specified date. The Director was informed of two other incidents of abuse related to resident #124 that occurred on two days at the end of the same month. All of the identified residents that resident #124 had abused had cognitive impairment. The Director was not immediately informed of the later two incidents and was notified one and two days after the incidents. No other critical incidents related to abuse by resident #124 were reported to the Director.

Review of resident #124's progress notes over a one month period, reflected at least 26 incidents of abusive behaviour against other residents and another 19 incidents of inappropriate behaviour towards other residents. None of the incidents of abuse were reported to the Director at the Ministry of Health and Long Term Care. The Director of Care confirmed that the additional incidents noted in the resident’s progress notes were not reported to the Director. Documentation did not reflect that all of the above incidents were investigated, and that the SDMs of the involved cognitively impaired residents were contacted for each incident.

Strategies were not revised on the resident's plan of care in relation to the abusive behaviours after the first incident, and further incidents occurred. The Behavioural Support Ontario RPN #132 confirmed that strategies on the resident’s plan of care were not revised after the first incident. The plan of care was updated nine days later.

Nine days after the initial incident the Physician directed staff to call the police if further incidents occurred. Another 13 incidents occurred between when the Physician directed staff to call the police and when the police were contacted.

A week later some strategies were revised; however, this was not effective in reducing the abusive behaviour and the plan of care was again not revised after that until the Physician intervened another week later.

After the Physician intervened and strategies were initiated, 10 incidents of abusive behaviour occurred. Additional strategies were approved for Resident #124; however, the strategies were not provided on all shifts required. The Director of Care confirmed that the strategies were not provided as per the resident's plan of

care as the home was unable to obtain staff to implement the strategies. Two incidents of abusive behaviour occurred on a day where the required strategies were not in place. The resident's written care plan (the document staff used to provide direction for the provision of care) did not include the requirement for the additional strategies, how the staff member was to provide the strategies, and how to address and de-escalate the responsive behaviours. PSW #130, who implemented some of the additional strategies, stated that they would be doing other activities with other residents in the same room and that the PSW would not be able to get to the resident in time to prevent the behaviours from occurring. The resident continued to abuse other residents after the strategies were initiated.

The family of resident #122 expressed concerns that the resident stated being afraid of another resident. There were six incidents of inappropriate behaviour between resident #124 and resident #122 over a one month period.

The licensee failed to ensure that residents at the home were protected from abuse by resident #124. [s. 19. (1)]

***Additional Required Actions:***

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

**(A1)(Appeal/Dir# DR# 065)**
**The following order(s) have been rescinded:CO# 001**

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

**Specifically failed to comply with the following:**

**s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

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

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that there was a written plan of care for resident #124 that set out the planned care for the resident in relation to additional strategies for responsive behaviours.

Resident #124 required additional strategies related to ongoing responsive behaviours and the strategies were to be in place over a one month period.

The Ministry of Health and Long-Term Care High Intensity Needs Fund Policy Manual For Long-Term Care Effective November 26, 2015 stated that the resident's plan of care must outline:
o Need for the additional strategies;
o Information about the incident or incidents that have led to the need for the additional strategies;
o Clear strategies to address and de-escalate responsive behaviours.

The resident's written care plan (the document staff used to provide direction for

the provision of care) did not include the requirement for the additional strategies, how the staff member was to provide the strategies, and techniques to use to address and de-escalate the responsive behaviours.

The additional strategies were required; however, eight additional incidents of inappropriate responsive behaviours occurred after additional strategies were added to the plan of care for the resident. PSW #130, who implemented some of the strategies, stated that they were running group activities in the lounge (with resident #124) while providing the additional strategies for resident #124 and that staff could not get to the resident in time to prevent the behaviours from occurring.

The Director of Care confirmed that the requirement for and provision of the additional strategies was not included in the resident's plan of care. [s. 6. (1) (a)]

2. The licensee failed to ensure that the care set out in the plan of care for resident #124 was provided to the resident as specified in the plan.

Resident #124 was approved for additional strategies to monitor responsive behaviours for all shifts (as per progress note). Records on the provision of the additional strategies reflected that they were not provided on all shifts as required. The Director of Care confirmed that the strategies were not provided as the home was unable to obtain staff to provide the strategies. Two incidents of inappropriate responsive behaviours occurred on a day where the strategies were not in place. Strategies were also not in place for another three shifts after that.

Care related to additional strategies for responsive behaviours for resident #124 was not provided to the resident as specified in the the plan. [s. 6. (7)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to resident #052 as specified in the plan.

Resident #052 was assessed by the Physiotherapist on two occasions. Based on those assessments, the resident required a positioning device while in bed to maintain proper positioning. The resident was in bed on most of the Long Term Care (LTC) Inspector's observations. The LTC Inspector observed the resident on four days and there was no positioning device in the resident's bed for proper positioning. The resident was observed with poor positioning when in bed. The resident's clinical record was reviewed and based on the Physiotherapy assessment on the noted dates, the progress notes, and the written plan of care,

the resident was expected to have the positioning device in place when in bed for proper positioning. Physiotherapist #123, RPN #108, and PSWs #114 and #115 confirmed the resident was expected to have the device in place to ensure proper positioning. Registered Practical Nurse (RPN) #108 and PSWs #114 and #115 confirmed that the care was not provided to the resident as specified in the plan of care. (527) [s. 6. (7)]

4. The licensee failed to ensure that resident #124 was reassessed and the plan of care reviewed and revised when the resident's care needs changed in relation to responsive behaviours.

Resident #124 started demonstrating responsive behaviours. The resident was not reassessed and their plan of care was not revised to include the responsive behaviours, triggers, interventions, until nine days after the initial responsive behaviour was identified. There were an additional nine incidents of responsive behaviours documented in the resident's progress notes while the plan of care was not revised.

The Behavioural Support Ontario (BSO) Lead #132 confirmed that the resident's plan of care was not revised after the resident had a change in their condition and started exhibiting inappropriate responsive behaviours. [s. 6. (10) (b)]

***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 with ensuring that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary and that the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.***

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

A) The home's policy, "Fall Prevention and Management NS 9-010", revised August 2016, identified under the environmental interventions/strategies to reduce the risk of falls, that when a resident was assessed as high risk for falls, that "the interdisciplinary team will: Place a "high risk" indicator (Oak Leaf Logo) on the chart, outside the resident's room, and on the walker/wheelchair."

Resident #052 was assessed by the interdisciplinary team as a high risk for falls and the plan of care was reviewed and revised; however, the staff did not implement the Oak Leaf Logo for resident #052, which would identify that the resident was high risk for falls. The resident's clinical record was reviewed and there was no Oak Leaf Logo. The name plate outside the resident's room and their wheelchair had no Oak Leaf Logo implemented. Registered Practical Nurse (RPN) #118 and RPN #108 were interviewed and confirmed that although they knew the resident was high risk for falls, they were supposed to place the Oak Leaf Logo on the resident's wheelchair, their name plate outside their room and on the resident's clinical record and had forgotten to do that. RPNs #108 and #118, and RN #116 confirmed they did not follow their Falls Prevention and Management policy. (527)

B) The home's medication fridges on the second and third floor units, which stored resident medication, were expected to be checked daily to include the time, temperature of the fridge, and the initials of the registered staff member checking the fridge. Staff were to document the information on the "Refrigerator Temperature Monitoring Log", Form #8.9.6.1, last modified in August 2014. The Refrigerator Temperature Monitoring Logs for all resident units were reviewed for August, September, and October, 2016, and there was inconsistent documentation on the log sheets. The Assistant Director of Care (ADOC) was interviewed and identified that the home did not have a specific policy regarding their process; however, the registered staff received communication that the temperatures must be checked in the medication fridges, and documented daily as indicated in the Registered Staff Meeting minutes dated April 7, 2016.

RN #121 and RPNs #103, #107, #110, and #122 were interviewed and identified that the medication fridge on their units were to be checked daily and signed off that the temperature was within 2 to 8 degrees Celsius, and if they had any concerns they were to report them to the Unit Coordinator, ADOC or DOC. The registered staff also indicated that they sometimes forgot to document even though they had checked the medication fridges. The home failed to ensure that the registered staff complied with their protocol for documenting the medication fridge checks on a daily basis. (527) [s. 8. (1) (b)]

***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 with ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.***

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**
**Specifically failed to comply with the following:**

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that where bed rails were used, that the resident's bed system was evaluated in accordance with prevailing practices to minimize risk to the residents.

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". Prevailing practices includes using generally accepted widespread practice as the basis for clinical decisions.

According the above HC document, bed systems are to be evaluated using an approved hand held tool designed to measure specific zones between the mattress and the bed rails. The frequency of evaluation is dependent on the age of the mattress and if any changes were made to the bed (i.e. mattress switched out, bed rails removed and replaced). The home's policy, "Bed Rails and Bed Entrapment 1 -206", effective March 2015, stated that with any mattress, bed rail or bed frame change for a resident, maintenance staff were to be contacted and would assess the zones of entrapment using the "Bed Entrapment Device" and the results would be recorded on the "Test Result Worksheet."

The Building Manager stated that all of the beds in the home were evaluated annually using the "bed entrapment device" to identify entrapment zones which could pose a risk to residents using one or more bed rails. The Building Manager also reported that bed systems were not re-evaluated if any changes were made to the bed. The process just before any new resident admission included the removal of bed rails. If after a period of time a resident was assessed as requiring a bed rail, one was applied, but the bed system was not measured using the "bed entrapment device".

The Building Manager confirmed that there had been changes to mattresses and bed rails since the annual entrapment zone evaluation conducted in December 2015 and January 2016; however, an evaluation of those beds using the "bed entrapment device" was not completed at that time and was not recorded on the "Test Result Worksheet". As a result, residents sleeping in beds that had not been evaluated for entrapment zones may be at risk of injury or entrapment if one or more bed rails were applied and were being used. [s. 15. (1) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's policy, "Abuse Policy GN 3-020", revised February 2015, identified that all individuals who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the home or staff that resulted in harm or a risk of harm to the resident occurred or may occur must immediately report the suspicion to the Ministry of Heath and Long Term Care by initiating a Critical Incident Report or by calling the Ministry's after hours emergency pager number. The policy directed staff to notify the resident's substitute decision maker and any other person specified by the resident; to immediately report to the police any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offense; to investigate every report of alleged, suspected or witnessed incident of resident abuse and to immediately protect all residents from further harm, conduct an investigation according to the home's procedure GN 3-030, and notify the resident and resident's SDM of the results of the investigation.

The home's policy, "Abuse Investigation GN 3-030" revised January 2015, identified that in all cases of abuse, any injuries would be assessed, immediate threats removed and medical attention provided as required. The policy directed staff to suspend a staff member as appropriate pending the outcome of the investigation; to initiate an investigation report detailing the incident, witnesses, contributing factors; interview competent parities to the incident; and to have persons involved provide a written account of the incident.

A ) The home did not follow their policy for the prevention of abuse and neglect of residents for an alleged staff to resident abuse incident towards resident #046. Resident #046 reported that they were abused by a staff member and that staff were not providing care appropriately. PSW #115 and #133 reported witnessing

an incident where PSW #134 was abusive towards resident #046.

The incident was reported to RPN #107 and RN #138 immediately; however, the home's policy was not followed by the registered staff until a week after the reported abuse. The staff member who was the alleged abuser was allowed to continue working with resident #046 and other residents after the incident was reported to the RPN and RN and the staff member was not sent home pending the investigation. An investigation was not immediately initiated, the resident and staff were not interviewed and did not provide written statements of the incident, the police were not notified, the resident's SDM was not immediately notified and the Ministry of Health and Long Term Care was not informed until management became aware of the incident a week later.

The RN #138 confirmed that the allegations had been reported to them; however, the incident was not reported as required and that the home's policy related to prevention of abuse and neglect was not followed.

The home did not comply with their prevention of abuse and zero tolerance policy for an allegation of staff to resident abuse against resident #046.

B) The licensee failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with for allegations of abuse of resident #132.

PSW #136 reported witnessing an abusive incident of resident #132 where PSW #136 alleged that PSW #137 abused the resident.

The home's policy, "Abuse Policy GN 3-020" was not followed by staff involved in the incident. The policy defined some examples of physical abuse which were consistent with what PSW #136 alleged was witnessed. The policy also directed staff to immediately report abuse of a resident by staff. The home's policy, "Abuse Investigation GN 3-030", revised January 2015, stated that the home had an internal reporting procedure, and therefore, when a staff member reported to a supervisor, that supervisor could make the required mandatory report; however, the staff member who witnessed the abuse must be involved (so that the report was made by both).

The incident was not reported immediately and was not reported until the next day. The PSW #136 who witnessed the incident did not report to the registered staff

during the shift and waited to report the incident to management the next day. The incident was also not reported by the accused staff member, PSW #137.

The home's prevention of abuse policy was not followed by staff and the abusive situation was not immediately reported to the home.

C) The licensee failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with for incidents of abuse by resident #124 towards other residents .

The home's "Abuse Policy GN 3-020", revised February 2015 and "Abuse Investigation GN 3-030", revised January 2015, identified that the following steps would be taken when abuse occurred: all individuals who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident must immediately report the suspicion to the Ministry of Health and Long Term Care through the Critical Incident system; staff were to notify the resident's substitute decision maker and any other person specified by the resident, immediately report to the police any alleged, suspected or witnessed incident of abuse that may constitute a criminal offense, immediately protect all residents from further harm, conduct an investigation according to procedure GN 3-030, submit a final report to the MOHTLC outlining the findings of the investigation and the corrective action taken, and notify the resident and resident's SDM of the results of the abuse investigation immediately upon the completion of the investigation. The policy also directed staff to arrange a care conference to assess the situation and determine appropriate interventions if the abuser was an incompetent resident.

An incident occurred where resident #124 was abusing another resident. A critical incident was submitted to the MOHLTC for the incident and the resident's SDM was notified. The Director was informed of two other incidents of abuse by resident #124 and other residents that occurred later the same month. All of the identified residents that resident #124 had abused had cognitive impairment. The Director was not immediately informed of the later two incidents and was informed one to two days after the incidents. The Director was not informed of any other critical incidents related to resident #124 abusing other residents between the reported incidents.

Review of resident #124's progress notes over a one month period after the initial incident was reported, reflected at least 26 incidents of abuse against other

residents and another 19 incidents of inappropriate behaviour. None of the incidents of abuse were reported to the Director at the Ministry of Health and Long Term Care. The Director of Care confirmed that the additional incidents noted in the resident's progress notes were not reported to the Director. Documentation did not reflect that all of the above incidents were investigated, and that the SDMs of the involved cognitively impaired residents were contacted for each incident. [s. 20. (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 with ensuring that without in any way restricting the generality of the duty provided for in section 19, that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with LTCHA, 2007, 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 :**

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident that the licensee knows of, or that is reported was immediately investigated.

According to interview notes, RPN #107 stated that resident #046 alleged that a staff member abused them. Two PSW's #115 and #133 also reported to RPN #107 that they had witnessed PSW #134 being abusive to the resident. The incident was reported to RN #138; however, an investigation into the allegations was not initiated until a week later when it was reported to Management at the home. The resident was not interviewed at the time of the allegations and none of the staff members involved were interviewed until a week after the incident was initially reported. [s. 23. (1) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that Every licensee of a long-term care home shall ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: abuse of a resident by anyone, to be implemented voluntarily.***

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**WN #7: 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. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,**
**(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).**
**(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the Registered Dietitian, who was a member of the staff of the home, completed a nutritional assessment for resident #052 when there was a significant change in the resident's health condition, and assessed the resident's nutritional status, including height, weight and any risks related to nutrition care, and hydration status, and any risks related to hydration.

Resident #052 was hospitalized and returned to the home. A referral to the Registered Dietitian (RD) was made after re-admission to the home and identified constipation. At the same time, progress notes by the Nurse Practitioner identified that the resident's primary concern was constipation and that the resident's medication for constipation was increased (dosage was doubled) and another medication was added. The resident had also started pain medications and had poor hydration since their return to the home.

The resident was reviewed by the RD; however, the constipation was not identified or addressed with nutritional strategies. The RD stated in the progress notes, that the resident was having bowel movements once daily and did not include an assessment of the identified constipation or changes to the resident's plan of care. During interview, the RD stated the constipation was overlooked and confirmed that there had not been an assessment of the constipation. [s. 26. (4) (a),s. 26. (4) (b)]

***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 with ensuring that a registered dietitian who is a member of the staff of the home, completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition, and assesses the matters referred to in paragraphs 13 and 14 of subsection (3), to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that for the Falls Prevention and Management Program a written record was kept relating to each evaluation under paragraph 3 that included 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.

The home had conducted an Annual Evaluation of their Falls Prevention Program on October 22, 2015. The annual evaluation was not interdisciplinary and included

only nursing staff, and there was inconsistency in the dates as to when the changes made were implemented. The changes not only reflected the changes in the previous 12 months of 2015, but there were also changes documented from 2012 and 2013. The changes that were planned for implementation in 2016 had no dates documented as to when those changes would be made. The DOC was interviewed and confirmed that the annual evaluation for the Falls Prevention Program only reflected that nursing staff were involved in the annual evaluation, and that the summary of the changes made, and the date of those changes were implemented were missing. (527)  [s. 30. (1) 1.]

2. The licensee failed to ensure that the Dietary Services and Hydration program was updated at least annually in accordance with evidence-based practices and, if there were none, with prevailing practices.

The "Best Practices for Nutrition, Food Service and Dining in Long Term Care Homes" document, written by the Ontario Long Term Care Action Group from Dietitians of Canada, June 2007 and revised April 2013, identified that homes should establish procedures for corrective actions, and documentation of the same, when fluid intake did not meet residents' requirements or when there was a change in the residents' hydration status.

The home's policy, "Fluid Monitoring & Hydration Risk #3-210", revised January 2016, directed nursing staff to flag residents who had consumed less than or equal to 50 percent (%) of their estimated fluid requirements for three consecutive days as high risk for dehydration, and to encourage fluid intake. Nursing staff were also required to send a referral to the Registered Dietitian (RD) for assessment of the poor hydration. The policy did not include actions to take when residents had a reduction in their hydration from their usual intake or when the resident's fluid consumption fell below their estimated fluid requirement but was more than 50% of estimated fluid requirement for a three day period.

The Nutrition Manager identified that the policy was developed using a risk identification tool from Dietitians of Canada. The tool included factors that reflected indicators of low, moderate and high risk for dehydration, however, it did not direct staff to limit assessment and interventions for poor hydration to only the high risk group.

The home's hydration policy referenced less than or equal to 50% of fluids over three consecutive days prior to assessment, interventions, and referral to the

Registered Dietitian. The hydration policy did not identify any assessment or implementation of strategies to prevent residents from moving from low and moderate risk of dehydration to the high risk category. Identification of residents who were not eating well and therefore, not receiving any hydration from the foods they were eating, was also not addressed in the home's policy.

The home's RD stated that the home's original hydration policy flagged residents consuming less than or equal to 70% of their estimated fluid requirements for assessment and referral. The the 50% of estimated fluid requirements for three consecutive days was initiated due to workload concerns with too many referrals when the threshold for referral was set at 70 % or less. The RD confirmed that an evaluation of the home's hydration program had not occurred prior to the reduction in threshold to 50% to determine why there were so many RD referrals related to poor hydration.

The home's policy was not based on best or prevailing practices for hydration and did not provide for methods to reduce or mitigate risks to residents.

Resident #052 was observed during stage one of this inspection and had physical signs and symptoms of dehydration. The resident's physical signs and symptoms of dehydration were not identified by staff on the resident's record.

The resident's plan of care identified a minimum fluid requirement per day. Prior to hospitalization the resident was consuming a daily fluid average close to their minimum requirement. After hospitalization the resident was consuming a daily average fluid intake that was significantly decreased and about 50% of their fluid intake prior to hospitalization. The resident was also noted to have additional health concerns that would be impacted by poor hydration status after hospitalization. The home's hydration policy would not have flagged the resident for assessment or referral until almost two weeks of significantly reduced food and fluid intake. The resident's plan of care was not revised in relation to the poor hydration until the resident was assessed by the Registered Dietitian. Strategies were not in place to mitigate the risks related to the resident's poor hydration and the resident was observed with signs and symptoms of dehydration during this inspection. When the resident's intake improved slightly, the resident would not have flagged for poor hydration, despite their intake being less than usual and less than their assessed requirement. [s. 30. (1) 3.]

3. The licensee failed to ensure that any actions taken with respect to a resident

under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #052 was assessed as low risk for falls based on the falls risk assessment; however, the resident had a history of previous falls. As a result of the resident's history of falls, and when the Fall Risk Committee made rounds, they reviewed the falls interventions and the plan of care and identified the resident had fall prevention strategies in place. The written plan of care was reviewed and revised at that time. The clinical record was reviewed and there was documentation to support the implementation of the falls prevention interventions. Documentation on the resident's written plan of care did not have these fall prevention interventions documented. RN #116, RPN #108 and PSWs #114 and #115 confirmed that the identified falls interventions were implemented and in place, although it was not documented on the written plan of care. RN #116 confirmed that the identified falls interventions should have been documented on the written plan of care. (527) [s. 30. (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 with ensuring r. 30(1)3 that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and***

***r. 30(2) that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.***

**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that actions were taken to meet the needs of resident #124 with responsive behaviours, including, assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

Resident #124 had a change in condition and started exhibiting responsive behaviours. Strategies were not revised on the resident's plan of care in relation to the responsive behaviours after the first incident and multiple incidents occurred. Nine days after the initial incident the Physician directed staff to call the police if further incidents occurred. Another 13 incidents occurred between when the Physician directed staff to call the police and when the police were contacted. Re-assessment of the resident and changes to strategies on the resident's plan of care did not occur when those strategies were ineffective and the responsive behaviours continued to occur.

The Behavioural Support Ontario (BSO) Lead #132 confirmed that resident #124 was not reassessed with revisions to the resident's plan of care for the ongoing responsive behaviours. The behaviours continued to occur after the behavioural strategies were revised without re-assessment and strategies to prevent recurrence of the responsive behaviours. [s. 53. (4) (c)]

***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 with ensuring that for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.***

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident was taken to a hospital.

The home had two residents who had falls; each fall required the resident to be transferred to the hospital for assessment. Both of the critical incidents were not reported to the Director no later than one business day after the occurrence of the incident.

A) Resident #161 had a fall,  sustained an injury, and was transferred to the hospital. The critical incident was not reported to the Director until 11 days after the incident.

(B) Resident #013 had a fall, was transferred to the hospital for assessment and returned to the home with a report that the resident did not sustain any injuries; however, the home initiated a significant change in status as the resident experienced pain and was cared for in bed for several days. The home was later notified by the hospital that the resident sustained an injury. The critical incident was not reported to the Director until 22 days after the incident occurred.

The DOC was interviewed and confirmed that they were delayed in reporting the critical incidents, and was aware that they should have been reported to the Director no later than one business, especially when the fall resulted in the resident being transferred to the hospital, and the resident had a significant change in their health condition. (527) [s. 107. (3) 4.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): An injury in respect of which a person is taken to hospital, to be implemented voluntarily.***

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies.

On October 5 and 6, 2016 the LTC Inspector observed the home's medication carts on each unit. The following was the outcome of the observations:

(i) On October 5, 2016, on the second floor, the medication cart had residents' personal belongings stored in the cart for safe keeping. There were: five pair of eye glasses; three empty eye glass cases; $60 dollars (2 - $10 and 1 small envelope sealed that identified there was $40 in the pouch); one ring; one HBC Rewards

card; one Disney card; two resident wrist watches; one tube of Nair face and upper lip hair removal cream; a packet of chocolate; and one iPad which the PSWs would use to document.

(ii) On October 6, 2016, the LTC Inspector observed the medication cart on a different unit on the second floor. The medication cart had a resident's upper dental plate stored in with the medications and locked in the medication drawer of the medication cart for safe keeping.

(iii) On October 6, 2016, the LTC Inspector observed the medication cart on the third floor. The medication cart had residents' belongings stored in among the medications and medication supplies. There were four silver bracelets; three packets of hearing aid batteries; three resident hearing aids; and an iPad that the PSWs would use at meal times.

(iv) On October 6, 2016, the LTC Inspector observed the medication cart on a different unit on the third floor. The medication cart had residents' belongings stored with the medications and medication supplies. Observed in the medication cart were six silver bracelets; one $10 bill; two residents' wrist watches; one residents' hearing aid; coins of money; two pair of eyeglasses; four packets of hearing aid batteries; and one iPad.

RPN #127 was interviewed regarding the home's policy related to storing residents' personal belongings in the medication cart. The RPN identified that they didn't know the detail, but did identify that it could be an infection issue. RPN #127 also informed the LTC Inspector that at bed time they stored resident #133's dentures in the medication cart for safe keeping, otherwise the resident would lose them. RPN #120 and #126 were also interviewed and confirmed that they were unsure if there was a policy related to storing resident belongings with the medications and medication supplies, and identified that it could be an infection issue. The RPNs indicated that this was the usual practice and had nowhere to store resident belongings for safe keeping.

The DOC was interviewed and indicated that they usually stored resident belongs in the medication carts because they always got lost. The DOC confirmed they had no policy that identified the home's practice for storing resident belongings in medication carts. The DOC confirmed that this was an infection prevention and control issue, and they needed to re-think their process. The home failed to ensure that drugs were stored in the medication cart that was used exclusively for drugs

and drug-related supplies. (527) [s. 129. (1) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.***

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**WN #12: 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 results of the analysis undertaken of every incident of abuse or neglect of a resident at the home were considered in the annual evaluation.

The home's annual evaluation of the prevention of abuse program for 2015 did not include analysis of any abuse incidents other than staff to resident abuse. The annual evaluation identified eight incidents of resident to resident abuse; however, an analysis of these incidents was not considered in the home's annual prevention of abuse evaluation. The Director of Care confirmed that an analysis of the resident to resident abuse incidents was not included in their annual evaluation for 2015. [s. 99. (c)]

**Issued on this 26 day of January 2017 (A1)(Appeal/Dir# DR# 065)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**
**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255


## Amended Public Copy/Copie modifiée du public de permis

**Name of Inspector (ID #) / Nom de l'inspecteur (No) :** Mary Nestor (Director) - (A1)(Appeal/Dir# DR# 065)

**Inspection No. / No de l'inspection :** 2016_191107_0012 (A1)(Appeal/Dir# DR# 065)

**Appeal/Dir# / Appel/Dir#:** DR# 065 (A1)

**Log No. / Registre no. :** 028163-16 (A1)(Appeal/Dir# DR# 065)

**Type of Inspection / Genre d'inspection:** Resident Quality Inspection

**Report Date(s) / Date(s) du Rapport :** Jan 26, 2017;(A1)(Appeal/Dir# DR# 065)

**Licensee / Titulaire de permis :** CORPORATION OF THE COUNTY OF DUFFERIN
151 Centre St, SHELBURNE, ON, L0N-1S4

**LTC Home / Foyer de SLD :** DUFFERIN OAKS
151 CENTRE STREET, SHELBURNE, ON, L0N-1S4

**Name of Administrator / Nom de l'administratrice ou de l'administrateur :** Valerie Quarrie

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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

**(A1)(Appeal/Dir# DR# 065)**
**The following Order has been rescinded:**

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007, 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).

## 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

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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

Director
c/o Appeals Coordinator
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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

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

**Issued on this 26 day of January 2017 (A1)(Appeal/Dir# DR# 065)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Mary Nestor (Director) - (A1)(Appeal/Dir# DR# 065)

**Service Area Office /**
**Bureau régional de services :** Hamilton