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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELISSA CHISHOLM (188), DIANA STENLUND (163)
Inspection No. / No de l'inspection :	2012_099188_0006
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Feb 23, 24, Mar 9, 19, 20, 2012
Licensee / Titulaire de permis :	F. J. DAVEY HOME 733 Third Line East, Box 9600, Sault Ste Marie, ON, P6A-7C1
LTC Home / Foyer de SLD :	F. J. DAVEY HOME 733 Third Line East, Sault Ste Marie, ON, P6A-7C1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PETER J. MACLEAN

To F. J. DAVEY HOME, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. Dealing with complaints

Order / Ordre :

The licensee shall complete a comprehensive review and assessment of their complaint procedure and identify gaps in reporting, responding to and documenting complaints to ensure compliance with the requirements of the Long Term Care Homes Act and regulations. This review is to be completed by April 13, 2012 and will include, but not be limited to, how the home:

- maintains a documented record to include all verbal and written complaints, including those received by any staff member of the home from December 1, 2011;
- investigates and provides a response to every verbal and written complaint in accordance with the requirements of the LTCHA and regulations.
- Documents, reviews and analyzes the complaints for trends as required by the LTCHA and regulations

Following this review the licensee shall submit a report and an action plan to the Ministry identifying what was reviewed and what gaps were identified along with actions to address the gaps. The action plan will also contain timelines for completion of the actions required and identify who is accountable for the task. This report is to be submitted to LTC Homes Inspector Melissa Chisholm no later than April 27, 2012, for review and approval by the Inspector. The licensee will then be required to submit monthly progress reports to identify progress in achieving compliance with the Act and in accordance with the approved timelines.

Grounds / Motifs :

1. Inspectors 163 and 188 interviewed the EDNCS on February 23, 2012 to discuss allegations of abuse that were witnessed and reported. During the interview, the EDNCS identified that after receiving the letter that it was reviewed with a DON. The EDNCS identified action to investigate the complaint had not been taken and to her knowledge the DON has not taken any action to investigate the complaint. The EDNCS identified that she had not discussed the issue again with the DON and believes the staff member accused of abusing a resident continues to provide care to the resident. The EDNCS identified she has not been in contact with the complainant. The licensee failed to ensure that every written complaint made to the licensee concerning the care of a resident has been investigated, resolved were possible and a response provided. [O.Reg. 79/10, s.101(1)(1)] (188)
2. Inspectors 163 and 188 interviewed a DON, on February 23, 2012 to discuss allegations of abuse that were witnessed and verbally reported to the DON. During the interview, the DON identified that for the response she provide to the complainant did not include specifics on the investigation or include what action has been taken as a result. The licensee failed to ensure that, for every verbal complaint made to the licensee concerning the care of a resident, a response is provided to the person who made the complaint identifying what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief. [O.Reg. 79/10, s.101(1)(3)] (188)
3. Inspectors 163 and 188 interviewed the EDNCS on February 23, 2012 to discuss allegations of abuse that were witnessed and reported. The EDNCS identified that she had not had any contact with the complainant and that no response had been provided to the complainant at that time. The licensee failed to ensure that, for every written complaint made to the licensee concerning the care of a resident, a response is provided to the person who made the complaint identifying what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief. [O.Reg. 79/10, s.131(1)(3)] (188)
4. Inspectors 163 and 188 reviewed the home's documented record of complaints on February 23, 2012. Inspectors noted that the verbal complaint brought forward to the DON was not included in the home's documented record. Inspectors noted that the written complaint brought forward to the EDNCS was not included in the home's documented record. The licensee failed to ensure that a documented record of each verbal and written complaint is kept in the home. [O.Reg. 79/10, s.101(2)] (188)
5. Inspectors 163 and 188 reviewed the home's documented record of complaints on February 23, 2012. Inspector 188 noted that two written complaints to the home, with Inspector 188 copied on the emails, were not included in the home's documented record. The licensee failed to ensure that a documented record of each verbal and written complaint is kept in the home. [O.Reg. 79/10, s.101(2)] (188)
6. Inspectors 163 and 188 reviewed five complaints, all received in December 2011, from the home's documented record of complaints on February 23, 2012. Inspectors noted that two of the five complaints did not identify a response was provided to the complainant and a description of that response. Inspectors noted that four of the five complaints did not identify any response made by the complainant related to the home's response. The licensee failed to ensure that the documented record kept in the home includes the date a response is provided and a description of the response and any response made by the complainant. [O.Reg. 79/10, s.101(2)] (188)
7. Inspectors 163 and 188 spoke with the CEO/Administrator on February 23, 2012. Inspectors inquired about the quarterly review and analysis of complaints. The CEO reported that quarterly review and analysis of complaints was not undertaken. The licensee failed to ensure that the documented record of complaints received is reviewed and analyzed for trends at least quarterly and that the results of the review and analysis are taken into account in determining what improvement are required in the home and that a written record is kept of each review and of the improvements made in response. [O.Reg. 79/10, s.101(3)] (188)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 27, 2012

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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).

Order / Ordre :

The licensee shall ensure that their written policy to promote zero tolerance of abuse and neglect of residents is complied with. Specifically, the licensee shall develop and implement strategies to ensure how the licensee investigates, responds to, and reports allegations of abuse meets requirements of the LTCHA and regulations.

Grounds / Motifs :

1. One written notification of non-compliance under s.20 has previously been issued. (188)
2. Inspectors 163 and 188 interviewed a DON on February 23, 2012 to discuss allegations of abuse that were identified verbally to the DON. During the interview, the DON identified that the home's procedures for investigating and responding to allegations of abuse were not followed for these allegations. Inspectors 163 and 188 interviewed the Executive Director of Nursing Care Services (EDNCS) on February 23, 2012 related to the same allegations of abuse that were identified n a written letter. During the interview the home's procedure for investigating and responding to allegations of abuse was described and it was identified that the home's procedures were not followed for these allegations. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with. [LTCHA 2007, S.O. 2007, c.8, s.20 (1)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 20, 2012

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure every incident of alleged, suspected or witnessed incident of abuse of a resident by anyone is immediately investigation, that appropriate action is taken and any requirements that are provided for in the regulations for investigating and responding are complied with.

Grounds / Motifs :

1. One written notification of non-compliance under s.23 has previously been issued, including a voluntary plan of correction. (188)
2. Allegations of verbal abuse of a resident were brought forward by a complainant to a Director of Nursing (DON). The DON reported to inspectors 163 and 188 during an interview on February 23, 2012 that it was alleged that a staff member verbally abused a resident. This is supported by the DON's investigation notes reviewed by inspectors.

During an interview with inspectors the DON reported that their first action after hearing the allegations was to check on the resident. The DON was unable to recall the date the allegations were originally reported, however, identified that the staff member accused was working, caring for the resident, on the same day the allegations were brought forward. The DON reported that an interaction between the resident and staff member was observed by the DON. The DON's investigation notes, reviewed by inspectors, identify an interaction between the resident and the staff member; three days after the allegations were reported. The DON later identified, in the interview with inspectors, that the staff member was not working the day the allegations were brought forward and that the staff member wasn't interviewed until a few days later.

The DON reported that she spoke with the staff member accused of verbal abuse, who had denied all allegations. Inspectors reviewed the DON's interview notes from the discussion with the staff member (2 loose-leaf pages). The interview notes identify that the staff member admitted to using abusive language in front of the resident.

Inspector asked the DON to describe what was done as part of their investigation. The DON repeated that the first action taken was to check on the resident. The DON then identified that the staff member was off the day the allegations came forward and it was a few days later that the staff member and resident were interviewed. Inspectors asked the DON if the resident was able to recall the situation. The DON responded that while interviewing the resident, the resident was not asked about the specific situation but instead asked questions like, "how are things" and "how are the girls doing"? The DON further identified that the resident was asked if they felt safe.

Inspector 163 asked the DON if the Director, resident's substitute decision-maker, or police had been notified of the allegations of abuse. The DON reported that they were not notified. Inspector 163 asked if the home's Executive Director of Nursing Care Services (EDNCS) or Administrator had been notified of the allegations, the DON reported that they were not notified. Inspector 188 asked what the final results of the investigation were. The DON identified that the allegations were determined to be "unproven" and "not substantiated". Inspectors inquired if the staff member continued to provide care to the resident and the DON reported "yes". Inspector asked what steps the home has taken to prevent further situations like this. The DON identified the staff member was observed during one interaction with a resident; however, no further action had been taken. When asked by the inspector if the home's prevention of abuse policy had been followed with regard to investigating and reporting, the DON identified that it was not. The DON identified that the allegations had been brought forward to the home's EDNCS a few weeks prior.

Inspector 163 and 188 spoke with the EDNCS on February 23, 2012. It was confirmed that the EDNCS had been made aware of the allegations by the same complainant. Inspector 163 asked the EDNCS what action had been taken since receiving the allegations of abuse. The EDNCS identified that actions had not been taken related to the allegations. Inspector 188 asked if the staff member continued to provide care to the resident and the EDNCS identified, "probably". The EDNCS told the inspectors that no further discussion took place with the DON

and that no action had been taken since receiving the allegations. The EDNCS confirmed that the police and Ministry had not been notified. The EDNCS identified that usually the DON will investigate allegations, report findings and then appropriate actions are determined. The EDNCS identified that the proper procedures for investigating allegations of abuse were not followed in relation to the allegations of verbal abuse. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone is immediately investigated and that appropriate action is taken in response to every such incident. [LTCHA 2007, S.O. 2007, c.8, s.23(1)] (188)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 20, 2012

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the Director is immediately notified when a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident, or 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. The licensee shall ensure that the Director is immediately notified of any requirements under s.24 of the Act.

Grounds / Motifs :

1. Three written notifications of non-compliance under s.24 have previously been issued, including a voluntary plan of correction and a compliance order: CO-002, 2012-099188-0005 (188)
2. Allegations of verbal abuse of a resident were verbally brought forward to a DON. These allegations of verbal abuse were not immediately reported to the Director. Inspector 188 and 163 interviewed the DON who confirmed these allegations of abuse were not immediately, or ever, reported to the Director. The licensee failed to ensure that the Director is immediately notified of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(2)] (188)
3. Allegations of verbal abuse of a resident were brought forward to the EDRNS through a written letter. These allegations of abuse were not immediately reported to the Director. Inspector 188 and 163 interviewed the EDRNS who confirmed these allegations of abuse were not immediately, or ever, reported to the Director. The licensee failed to ensure that the Director is immediately notified of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(2)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 20, 2012

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that a resident's substitute decision-maker, if any, and any other person specified by the resident, 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.

Grounds / Motifs :

1. Three written notifications of non-compliance under s.97 have previously been issued, including a voluntary plan of correction and a compliance order: CO-003, 2012-099188-0005 (188)
2. Allegations of verbal abuse of a resident were brought forward. Investigation documentation does not identify the SDM for this resident was notified. Inspector 163 reviewed the health care record and noted notification of the SDM is not included. The licensee failed to ensure that the resident's SDM is notified within 12 hours of becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident. [O.Reg. 79/10, s.97(1)(b)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 20, 2012

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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 20th day of March, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : MELISSA CHISHOLM

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 23, 24, Mar 9, 19, 20, 2012	2012_099188_0006	Complaint

Licensee/Titulaire de permis

F. J. DAVEY HOME
733 Third Line East, Box 9600, Sault Ste Marie, ON, P6A-7C1

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

F. J. DAVEY HOME
733 Third Line East, Sault Ste Marie, ON, P6A-7C1

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

MELISSA CHISHOLM (188), DIANA STENLUND (163)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer, Executive Manager of Nursing Care Services, Director of Nursing, Registered Nursing staff, Personal Support Workers and residents.

During the course of the inspection, the inspector(s) observed staff interactions with residents, reviewed various policies and procedures, reviewed health care records and reviewed the home's documentation related to an abuse investigation and complaint procedures.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly;
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. Inspectors 163 and 188 spoke with the CEO/Administrator on February 23, 2012. Inspectors inquired about the quarterly review and analysis of complaints. The CEO reported that quarterly review and analysis of complaints was not undertaken. The licensee failed to ensure that the documented record of complaints received is reviewed and analyzed for trends at least quarterly and that the results of the review and analysis are taken into account in determining what improvement are required in the home and that a written record is kept of each review and of the improvements made in response. [O.Reg. 79/10, s.101(3)]
2. Inspectors 163 and 188 reviewed the home's documented record of complaints on February 23, 2012. Inspectors noted that the verbal complaint brought forward to the DON was not included in the home's documented record. Inspectors noted that the written complaint brought forward to the EDNCS was not included in the home's documented record. The licensee failed to ensure that a documented record of each verbal and written complaint is kept in the home. [O.Reg. 79/10, s.101(2)]
3. Inspectors 163 and 188 reviewed the home's documented record of complaints on February 23, 2012. Inspector 188 noted that two written complaints to the home, with Inspector 188 copied on the emails, were not included in the home's documented record. The licensee failed to ensure that a documented record of each verbal and written complaint is kept in the home. [O.Reg. 79/10, s.101(2)]
4. Inspectors 163 and 188 reviewed five complaints, all received in December 2011, from the home's documented record of complaints on February 23, 2012. Inspectors noted that two of the five complaints did not identify a response was provided to the complainant and a description of that response. Inspectors noted that four of the five complaints did not identify any response made by the complainant related to the home's response. The licensee failed to ensure that the documented record kept in the home includes the date a response is provided and a description of the response and any response made by the complainant. [O.Reg. 79/10, s.101(2)]
5. Inspectors 163 and 188 interviewed a DON, on February 23, 2012 to discuss allegations of abuse that were witnessed and verbally reported to the DON. During the interview, the DON identified that for the response she provide to the complainant did not include specifics on the investigation or include what action has been taken as a result. The licensee failed to ensure that, for every verbal complaint made to the licensee concerning the care of a resident, a response is provided to the person who made the complaint identifying what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief. [O.Reg. 79/10, s.101(1)(3)]
6. Inspectors 163 and 188 interviewed the EDNCS on February 23, 2012 to discuss allegations of abuse that were witnessed and reported. The EDNCS identified that she had not had any contact with the complainant and that no response had been provided to the complainant at that time. The licensee failed to ensure that, for every written complaint made to the licensee concerning the care of a resident, a response is provided to the person who made the complaint identifying what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief. [O.Reg. 79/10, s.131(1)(3)]
7. Inspectors 163 and 188 interviewed the EDNCS on February 23, 2012 to discuss allegations of abuse that were witnessed and reported. During the interview, the EDNCS identified that after receiving the letter that it was reviewed with a DON. The EDNCS identified action to investigate the complaint had not been taken and to her knowledge the DON has not taken any action to investigate the complaint. The EDNCS identified that she had not discussed the issue again with the DON and believes the staff member accused of abusing a resident continues to provide care to the resident. The EDNCS identified she has not been in contact with the complainant. The licensee failed to ensure that every written complaint made to the licensee concerning the care of a resident has been investigated, resolved were possible and a response provided. [O.Reg. 79/10, s.101(1)(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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

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. Inspectors 163 and 188 interviewed a DON on February 23, 2012 to discuss allegations of abuse that were identified verbally to the DON. During the interview, the DON identified that the home's procedures for investigating and responding to allegations of abuse were not followed for these allegations. Inspectors 163 and 188 interviewed the Executive Director of Nursing Care Services (EDNCS) on February 23, 2012 related to the same allegations of abuse that were identified n a written letter. During the interview the home's procedure for investigating and responding to allegations of abuse was described and it was identified that the home's procedures were not followed for these allegations. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with. [LTCHA 2007, S.O. 2007, c.8, s.20(1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. Allegations of verbal abuse of a resident were brought forward by a complainant to a Director of Nursing (DON). The DON reported to inspectors 163 and 188 during an interview on February 23, 2012 that it was alleged that a staff member verbally abused a resident. This is supported by the DON's investigation notes reviewed by inspectors.

During an interview with inspectors the DON reported that their first action after hearing the allegations was to check on the resident. The DON was unable to recall the date the allegations were originally reported, however, identified that the staff member accused was working, caring for the resident, on the same day the allegations were brought forward. The DON reported that an interaction between the resident and staff member was observed by the DON. The DON's investigation notes, reviewed by inspectors, identify an interaction between the resident and the staff member; three days after the allegations were reported. The DON later identified, in the interview with inspectors, that the staff member was not working the day the allegations were brought forward and that the staff member wasn't interviewed until a few days later.

The DON reported that she spoke with the staff member accused of verbal abuse, who had denied all allegations. Inspectors reviewed the DON's interview notes from the discussion with the staff member (2 loose-leaf pages). The interview notes identify that the staff member admitted to using abusive language in front of the resident.

Inspector asked the DON to describe what was done as part of their investigation. The DON repeated that the first action taken was to check on the resident. The DON then identified that the staff member was off the day the allegations came forward and it was a few days later that the staff member and resident were interviewed. Inspectors asked the DON if the resident was able to recall the situation. The DON responded that while interviewing the resident, the resident was not asked about the specific situation but instead asked questions like, "how are things" and "how are the girls doing"? The DON further identified that the resident was asked if they felt safe.

Inspector 163 asked the DON if the Director, resident's substitute decision-maker, or police had been notified of the allegations of abuse. The DON reported that they were not notified. Inspector 163 asked if the home's Executive Director of Nursing Care Services (EDNCS) or Administrator had been notified of the allegations, the DON reported that they were not notified. Inspector 188 asked what the final results of the investigation were. The DON identified that the allegations were determined to be "unproven" and "not substantiated". Inspectors inquired if the staff member continued to provide care to the resident and the DON reported "yes". Inspector asked what steps the home has taken to prevent further situations like this. The DON identified the staff member was observed during one interaction with a resident; however, no further action had been taken. When asked by the inspector if the home's prevention of abuse policy had been followed with regard to investigating and reporting, the DON identified that it was not. The DON identified that the allegations had been brought forward to the home's EDNCS a few weeks prior.

Inspector 163 and 188 spoke with the EDNCS on February 23, 2012. It was confirmed that the EDNCS had been made aware of the allegations by the same complainant. Inspector 163 asked the EDNCS what action had been taken since receiving the allegations of abuse. The EDNCS identified that actions had not been taken related to the allegations. Inspector 188 asked if the staff member continued to provide care to the resident and the EDNCS identified, "probably". The EDNCS told the inspectors that no further discussion took place with the DON and that no action had been taken since receiving the allegations. The EDNCS confirmed that the police and Ministry had not been notified. The EDNCS identified that usually the DON will investigate allegations, report findings and then appropriate actions are determined. The EDNCS identified that the proper procedures for investigating allegations of abuse were not followed in relation to the allegations of verbal abuse. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone is immediately investigated and that appropriate action is taken in response to every such incident. [LTCHA 2007, S.O. 2007, c.8, s.23(1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1.Allegations of verbal abuse of a resident were verbally brought forward to a DON. These allegations of verbal abuse were not immediately reported to the Director. Inspector 188 and 163 interviewed the DON who confirmed these allegations of abuse were not immediately, or ever, reported to the Director. The licensee failed to ensure that the Director is immediately notified of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(2)]
2. Allegations of verbal abuse of a resident were brought forward to the EDRNS through a written letter. These allegations of abuse were not immediately reported to the Director. Inspector 188 and 163 interviewed the EDRNS who confirmed these allegations of abuse were not immediately, or ever, reported to the Director. The licensee failed to ensure that the Director is immediately notified of abuse of a resident by anyone. [LTCHA 2007, S.O. 2007, c.8, s.24(2)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

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. Allegations of verbal abuse of a resident were brought forward. Investigation documentation does not identify the SDM for this resident was notified. Inspector 163 reviewed the health care record and noted notification of the SDM is not included. The licensee failed to ensure that the resident's SDM is notified within 12 hours of becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident. [O.Reg. 79/10, s.97(1)(b)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following subsections:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. A written complaint was received by the home on by the Executive Director of Resident Nursing Services. This written complaint letter identified concerns related to the care of a resident. This written complaint was not immediately forwarded to the Director. A copy of this written complaint was shared with the inspectors during this inspection. The licensee failed to ensure that a written complaint that has been received concerning the care of a resident is immediately forwarded to the Director. [LTCHA, 2007, S.O., 2007. c.8, s.22(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 ensuring written complaints that have been received concerning the care of a resident are immediately forwarded to the Director, to be implemented voluntarily.

Issued on this 20th day of March, 2012

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