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 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 7, 2014	2014_282543_0020	S-000337-14	Critical Incident System

Licensee/Titulaire de permis

FINLANDIA NURSING HOME LIMITED
c/o Sudbury Finnish Rest Home, 233 Fourth Avenue, SUDBURY, ON, P3B-4C3

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

FINLANDIA HOIVAKOTI NURSING HOME LIMITED
233 FOURTH AVENUE, SUDBURY, ON, P3B-4C3

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

TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 31st, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Chief Clinical Officer, the Director of Care, Registered Nurses, Registered Practical Nurses and Personal Support Workers.

**During the course of the inspection, the inspector(s) directly observed the delivery of care and services to residents, conducted tour of all resident home areas, reviewed resident health care records, reviewed various home policies and procedures
reviewed staff education attendance records, reviewed critical incident reports sent to the Ministry of Health and Long-Term Care**

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

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. In 2014 an altercation occurred between two residents in the home; resident #001 and resident #002. On this day, resident #001 struck resident #002 after discovering that resident #002 was seated in their chair in the dining room. This resulted in an altercation which resulted in resident #001 falling. This fall resulted in resident #001 striking their head on the wall and being transferred to the hospital, where they died.

Inspector #543 reviewed resident #001's progress notes and identified that this resident displayed behaviours of physical and/or verbal aggression in previous months in 2014.

Inspector #543 reviewed resident #001's progress notes which described that the registered practical nurse (RPN) did a quick assessment while this resident was lying on the floor in the dining room. According to the progress notes, the RPN then moved this resident's head and shoulders slightly to the right for comfort. It was at this point that this resident began yelling that their neck was broken and would not move their limbs when asked. The progress notes also included the registered nurse's (RN) documentation of the incident. The RN noted that resident #001 was found in a wheelchair with a sling underneath them. The progress notes also included that this resident was unable to vocalize pain or move their arms or legs and appeared to sleep at times. As well, the progress notes described that this resident was unable to follow command and identified that resident #001 had swelling to the back of their head (3-4 inches in diameter). The RN instructed the RPN to call this resident's family, while the RN continued their assessment. Inspector #543 found no further documentation of this continued assessment.

The Inspector reviewed resident #001's care plan. The care plan identified that resident #001 had verbal and/or physical responsive behaviours related to their cognitive impairment, resulting in cursing and hitting. The goal identified in this resident's care plan was, that the resident will not strike others. This resident's care plan had not been updated to reflect that some of the previously displayed behaviours were triggered, when others sat in their spot in the dining room. This resident's care plan did not reflect similar incidents of aggression from previous months, nor did it identify any interventions to minimize the risk of altercations between resident #001 and other residents in the home.

Inspector #543 reviewed the home's Policy-Falls Prevention and Management (NM-S-3). This policy (specifically relating to post fall assessment) stated, that the registered staff will assess the resident's level of consciousness and any potential injury associated with the fall and initiate Head Injury Routine. According to the policy, this assessment is a nursing assessment based on clinical judgment, but should generally include assessment for pain, ROM to all extremities and assessment of areas that may obtain injury. This policy stated that the resident should be lifted using a mechanical lift with two trained staff members, and following any fall, the resident is

not to be assisted in getting up without a lift being used. This policy does not provide direction for circumstances such as the incident that occurred, whereby resident #001 sustained an injury that resulted in their death. There is no direction in this policy to guide direct care staff on the circumstances and variables that may dictate when or when not to move a resident who is potentially injured. This policy lacks clear direction regarding possible injuries and the potential for further risk to the resident.

Inspector #543 reviewed the home's Policy- Resident Abuse and Neglect-Zero Tolerance (ID-20). This policy, which is incorporated with the home's Standard of Employee Conduct, is reviewed during orientation and annually as part of the performance evaluation process. After reviewing the home's course completion history for Prevention of Abuse for the past 12 months, the inspector identified that not all direct care staff completed the annual training/retraining.

To summarize, resident #001 had a history of physical and/or verbal aggression towards other residents in the home, specifically related to others sitting in their chair in the dining room. This history was documented in resident #001's progress notes in the months previous to the incident. As described above, this aggression resulted in an altercation with resident #002, whereby resident #001 was injured, hospitalized and died. This resident's care plan identified physical and/or verbal responsive behaviours. However, it failed to include similar incidents from previous months, nor did it identify interventions to minimize these responsive behaviours or the risk of altercations between resident #001 and other residents in the home. This resident's progress notes, identified that this resident was moved after falling, and that the resident stated that they were severely injured. This resident was assessed by the RN in a wheelchair in the dining room, where the RN described that the resident could not vocalize pain, move their arms or legs and appeared to sleep at times. This RN's documentation described that they continued their assessment however no further documentation of this was found. The home's policy relating to Falls Prevention and Management (NM-S-3) did not provide direction to guide direct care staff of circumstance and/or variables that would dictate when or when not to move a resident who is potentially injured. This policy lacks clear direction regarding injuries and the potential for further risk to residents. Also, the licensee did not ensure that all direct care staff were retrained annually relating to their policy Resident Abuse and Neglect-Zero Tolerance.

Consequently, the licensee failed to ensure that this resident was free from neglect by the licensee or staff. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

1. In 2014 an altercation occurred between two residents in the home; resident #001 and resident #002. On this day, resident #001 struck resident #002 after discovering that resident #002 was seated in their chair in the dining room. This resulted in an altercation between resident #001 and #002 that led to resident #001 being transferred to hospital where they died.

Upon further review of resident #001's health care record, Inspector #543 identified a similar incident occurred. This resident struck another resident in the dining room. This altercation was also a result of resident #001 discovering another resident sitting in their chair in the dining room. Inspector #543 reviewed resident #001's progress notes and identified that this resident displayed behaviours of physical and/or verbal aggression in; the months prior to the incident.

The Inspector reviewed resident #001's care plan. The care plan identified that resident #001 had a problematic manner in which resident acts characterized by ineffective coping, verbally and physically responsive; related to cognitive and physical impairment resulting in cursing and hitting. The goal identified in this resident's care plan is, that the resident will not strike others. This resident's care plan had not been updated to reflect that some of the previously displayed behaviours were triggered, when others sat in their spot in the dining room. This resident's care plan did not reflect similar incidents of aggression from previous months, nor did it identify any interventions to minimize the risk of altercations between resident #001 and other residents in the home.

Consequently, the licensee failed to ensure that the plan of care set out clear direction to staff and others who provided direct care to resident #001. [s. 6. (1) (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 to ensure that the plan of care sets out clear directions to staff and others who provided direct care to the residents in the home, specifically related to the management of responsive behaviours, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. Resident #001's progress notes identified that the registered practical nurse (RPN) assessed this resident quickly, while this resident was lying on the floor. The RPN then moved this resident's head and shoulders slightly to the right for comfort. At this time the resident began yelling that they were severely injured, and would not move limbs to command. The injury the resident sustained was documented as such: "writer felt two bumps to the back of head. 1:lower right side, approx 3cm but 2.5cm and prodruding about 2cm by 2cm and raised about 1 cm. Both areas visible on head, reddened. Res. had no c/o pain when touched. No displacement of the neck noted. No abnormalities noted."

This resident's progress notes also identified, as documented by the RN on the unit at the time of the incident that they received a call from the RPN requesting an assessment on the resident. Resident #001 was found in a wheelchair with a sling

underneath them. It was documented that this resident was unable to vocalize pain and appeared to sleep at times. This resident stated the inability to move their arms or legs and was unable to vocalize specifics about the incident that had occurred. Documentation identified that this resident had swelling to back of head 3-4 inches in diameter. The recorder asked the RPN to call this resident's family while the recorder continued assessment. The inspector was unable to locate any documentation to support the "continued assessment".

Inspector #543 reviewed the home's Policy-Falls Prevention and Management (NM-S-3). This policy (specifically relating to post fall assessment) stated, that the registered staff will assess the resident's level of consciousness and any potential injury associated with the fall and initiate Head Injury Routine and that the assessment is a nursing assessment based on clinical judgment, but should generally include assessment for pain, ROM to all extremities and assessment of areas that may obtain injury. This policy stated that the resident should be lifted using a mechanical lift with two trained staff members, following any fall, the resident is not to be assisted in getting up without a lift being used. This policy does not provide direction in circumstances such as the incident that occurred in 2014; whereby resident #001 sustained an injury as a result of a fall. There was no direction in this policy to guide direct care staff on the circumstances, variables and that may dictate when or when not to move a resident who is potentially injured. This policy lacks clear direction regarding a resident’s possible injuries and the potential for further risk to the resident.

Consequently, the licensee failed to ensure that the licensee’s “Falls Prevention and Management” policy includes relevant policies, procedures, and protocols that provide for methods to reduce risk. [s. 30. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee’s “Falls Prevention and Management” policy includes relevant policies, procedures, and protocols that provide for methods to reduce risk, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. In 2014 an altercation occurred between two residents in the home; resident #001 and resident #002. On this day, resident #001 struck resident #002 after discovering that resident #002 was seated in their chair in the dining room. This resulted in an altercation between resident #001 and #002 that led to resident #001 sustaining a fall and being transferred to hospital where they died.

This resident's progress notes also identified a previous incident whereby residents' #001 and #002 had an "unwitnessed occurrence" in the dining room. Resident #001 "shot a towel at resident #002 and resident #002 shot a towel back at resident #001.When staff arrived into dining room there was towels and aprons being shot at both residents. Staff intervened and resident settled into their designated chairs."

Upon further review of resident #001's health care record, Inspector #543 identified that a previous incident occurred similar to the one that occurred in 2014. This resident struck another resident in the dining room. This altercation was also a result of resident #001 discovering another resident sitting in their chair in the dining room.

Inspector #543 reviewed resident #001's progress noted and identified that this resident displayed responsive behaviours of physical and/or verbal aggression in previous months prior to the incident.

The Inspector reviewed resident #001's care plan. The care plan identified that resident #001 had a problematic manner in which resident acts characterized by ineffective coping, verbally and physically responsive; related to cognitive and physical impairment resulting in cursing and hitting. The goal identified in this resident's care plan is, that the resident will not strike others. This resident's care plan was not updated to reflect the behaviour that occurred in the dining room in 2014; recognizing that this resident does not like it when others sit in their seat in the dining room.

Consequently, the licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions. [s. 54. (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 to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector #543 reviewed the home’s Policy- Resident Abuse and Neglect-Zero Tolerance (ID-20). This policy, which is incorporated with the home’s Standard of Employee Conduct, is reviewed by staff during orientation and annually as part of the performance evaluation process.

The Inspector spoke with the Chief Clinical Officer, who provided the home’s course completion history relating to staff training for Prevention of Abuse. This history, which covered the last 12 months identified that not all staff received training annually. Two direct care staff did not complete the required training.

Consequently, the licensee failed to ensure that all staff receive retraining annually related to the home’s policy- Resident Abuse and Neglect-Zero Tolerance (ID-20). [s. 76. (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 to ensure that all staff receive retraining annually relating to the home’s policy- Resident Abuse and Neglect-Zero Tolerance (ID-20), to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector #543 reviewed records of an investigation that was conducted by the Director of Care. This investigation was related to the altercation between resident #001 and #002 that occurred in 2014. These records,for two months in 2014 outline the incident as told by the direct care staff involved in the incident at the time.

The Inspector also reviewed the critical incident report submitted to the Director. This critical incident report was initiated on a particular day in 2014, was amended three days later and six days subsequent to the incident. The critical incident report did not identify any results of the investigation.

Consequently, the licensee failed to ensure that the results of the investigation related to neglect were reported to the Director. [s. 23. (1) (a)]

Issued on this 28th day of November, 2014

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2014_282543_0020
Log No. / Registre no:	S-000337-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 7, 2014
Licensee / Titulaire de permis :	FINLANDIA NURSING HOME LIMITED c/o Sudbury Finnish Rest Home, 233 Fourth Avenue, SUDBURY, ON, P3B-4C3
LTC Home / Foyer de SLD :	FINLANDIA HOIVAKOTI NURSING HOME LIMITED 233 FOURTH AVENUE, SUDBURY, ON, P3B-4C3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CLAIRE MCCHESNEY

To FINLANDIA NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

To achieve compliance with the duty to protect all residents from abuse and/or neglect by the licensee or staff, the licensee shall prepare, submit and implement a plan for achieving compliance to ensure:

- that the plan of care sets out clear direction to staff and others who provide direct care to residents living in the home. Specifically, the care plan must be current to reflect responsive behaviours residents are displaying. The care plan must be based on behaviour patterns as well as potential behavioural triggers and must identify interventions to manage responsive behaviours.

-that for all residents in the home who demonstrate or have demonstrated responsive behaviours of a physical and/or verbally abusive nature:
a) steps are taken to minimize the risk of altercations and,
b) interventions to manage these altercations or potential altercations are identified and implemented

-that all staff who provide direct care to residents residing in the home receive annual training/retraining in regards to the home's policy related to resident abuse and neglect

-that the home's Falls Prevention and Management (NM-S-3) and Resident Abuse and Neglect-Zero Tolerance (IS-20) policies and programs are relevant, include goals and objectives, include procedures and methods to reduce risk, monitor outcomes and that they are complied with.

This plan shall be submitted in writing to Tiffany Boucher, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133 or email tiffany.boucher@ontario.ca . This plan must be submitted by November 21st, 2014.

Grounds / Motifs :

1. In 2014 an altercation occurred between two residents in the home; resident #001 and resident #002. On this day, resident #001 struck resident #002 after discovering that resident #002 was seated in their chair in the dining room. This resulted in an altercation whereby, resident #001 fell. This fall resulted in resident #001 striking their head on the wall and being transferred to the hospital, where they died.

Inspector #543 reviewed resident #001's progress notes and identified that this resident displayed behaviours of physical and/or verbal aggression in previous months prior to the incident.

Inspector #543 reviewed resident #001's progress notes which described that the registered practical nurse (RPN) did a quick assessment while this resident was lying on the floor in the dining room. According to the progress notes, the RPN then moved this resident's head and shoulders slightly to the right for comfort. It was at this point that this resident began yelling that they were severely injured and would not move their limbs when asked. The progress notes also included the registered nurse's (RN) documentation of the incident. The RN noted that resident #001 was found in a wheelchair with a sling underneath them. The progress notes also included that this resident was unable to vocalize pain or move their arms or legs and appeared to sleep at times. As well, the progress notes described that this resident was unable to follow command and identified that resident #001 had swelling to the back of their head (3-4 inches in diameter). The RN instructed the RPN to call this resident's family, while the RN continued their assessment. Inspector #543 found no further documentation of this continued assessment.

The Inspector reviewed resident #001's care plan. The care plan identified that resident #001 had verbal and/or physical responsive behaviours related to their cognitive impairment, resulting in cursing and hitting. The goal identified in this resident's care plan was, that the resident will not strike others. This resident's care plan had not been updated to reflect that some of the previously displayed behaviours were triggered, when others sat in their spot in the dining room. This resident's care plan did not reflect similar incidents of aggression from previous months, nor did it identify any interventions to minimize the risk of altercations between resident #001 and other residents in the home.

Inspector #543 reviewed the home's Policy-Falls Prevention and Management (NM-S-3). This policy (specifically relating to post fall assessment) stated, that the registered staff will assess the resident's level of consciousness and any potential injury associated with the fall and initiate Head Injury Routine. According to the policy, this assessment is a nursing assessment based on clinical judgment, but should generally include assessment for pain, ROM to all extremities and assessment of areas that may obtain injury. This policy stated that the resident should be lifted using a mechanical lift with two trained staff members, and following any fall, the resident is not to be assisted in getting up

without a lift being used. This policy does not provide direction for circumstances such as the incident that occurred in 2014 whereby resident #001 sustained an injury that resulted in their death. There is no direction in this policy to guide direct care staff on the circumstances and variables that may dictate when or when not to move a resident who is potentially injured. This policy lacks clear direction regarding possible injuries and the potential for further risk to the resident.

Inspector #543 reviewed the home's Policy- Resident Abuse and Neglect-Zero Tolerance (ID-20). This policy, which is incorporated with the home's Standard of Employee Conduct, is reviewed during orientation and annually as part of the performance evaluation process. After reviewing the home's course completion history for Prevention of Abuse for the past 12 months, the inspector identified that not all direct care staff completed the annual training/retraining.

To summarize, resident #001 had a history of physical and/or verbal aggression towards other residents in the home, specifically related to others sitting in their chair in the dining room. This history was documented in resident #001's progress notes in previous months prior to the incident. As described above, in July, 2014 this aggression resulted in an altercation with resident #002, whereby resident #001 was injured, hospitalized and died. This resident's care plan identified physical and/or verbal responsive behaviours. However, it failed to include similar incidents from previous months, nor did it identify interventions to minimize these responsive behaviours or the risk of altercations between resident #001 and other residents in the home. This resident's progress notes identified that this resident was moved after falling, and that the resident stated that their neck was broken. This resident was assessed by the RN in a wheelchair in the dining room, where the RN described that the resident could not vocalize pain, move their arms or legs and appeared to sleep at times. This RN's documentation described that they continued their assessment however no further documentation of this was found. The home's policy relating to Falls Prevention and Management (NM-S-3) did not provide direction to guide direct care staff of circumstance and/or variables that would dictate when or when not to move a resident who is potentially injured. This policy lacks clear direction regarding injuries and the potential for further risk to residents. Also, the licensee did not ensure that all direct care staff were retrained annually relating to their policy Resident Abuse and Neglect-Zero Tolerance.

Consequently, the licensee failed to ensure that this resident was free from

neglect by the licensee or staff.
(543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 19, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

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

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

Ministry of Health and Long-Term Care	Ministére de la Santé et des Soins de longue durée
Order(s) of the Inspector	**Ordre(s) de l'inspecteur**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8	Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

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

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

Issued on this 7th day of November, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Tiffany Boucher

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