Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 10, 2015	2015_236572_0001	O-001145-14, O-000837-14, O-001178-14	Critical Incident System

Licensee/Titulaire de permis

MANORCARE PARTNERS II
6257 Main Street Stouffville ON L4A 4J3

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

FRIENDLY MANOR NURSING HOME
9756 County Road, #2 P.O. Box 305 DESERONTO ON K0K 1X0

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

BARBARA ROBINSON (572), KARYN WOOD (601)

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): January 6, 7 and 8, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents. The inspector(s) also toured the home, observed residents' care and services, reviewed resident health care records and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9(1)2. whereby the licensee has failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

On January 6, 2015, during a critical incident inspection, Inspector #572 noted that the hallway separation doors leading to and from the service wing area have an alarm, but not a lock. Residents and family members were walking in the home's hallway near the doors throughout the afternoon. The inspector walked through the hallway separation doors to find that the laundry area door and kitchen servery area door were both unlocked and that the areas were unsupervised. Each area has appliances and equipment as well as hazardous materials.

The Administrator responded to the alarm from the hallway separation door and was informed of the open, unsupervised areas. The Administrator confirmed that the door to the laundry area and the door to the kitchen servery area should be closed and locked when unsupervised.

On January 7, 2015, Inspector #572 again entered the unlocked hallway separation doors to find that the kitchen servery door was unlocked and that the area was unsupervised. The DOC was notified, and informed the Administrator.
On January 8, 2015 a new doorknob was observed being installed into the kitchen servery door to ensure that it locks automatically when closed. All other doors leading from the service hallway were locked.

The unlocked and unsupervised doors to the laundry and kitchen servery present a potential risk to residents in the home, particularly for those residents who exhibit behaviours such as wandering and/or exit-seeking.

Non-compliance was previously identified under O. Reg. 79/10, s. 9(1)2. during the RQI completed on April 7- 22, 2014, Inspection #2014_347197_0008. [s. 9. (1) 2.]

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. 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 has failed to comply with LTCHA 2007, s.19(1) whereby a resident was not protected from physical abuse.

Under O.Reg.79/10 s. 2(1), physical abuse is defined as "the use of physical force by anyone other than a resident that causes physical injury or pain".

A review of the healthcare record and Critical Incident #0934-000007-14 for Resident #3 indicated that the resident has multiple comorbidities. On a specified date, Resident #3 was striking out at staff as they assisted the resident. PSW #S109 observed PSW #S108 strike Resident #3 across the face and say "Don't hit" which resulted in pain for Resident #3. PSW #S109 reported the abuse to RN #S101. PSW #S108 was subsequently terminated from her employment with the home.

The licensee failed to protect a resident from physical abuse as evidenced by the following:
a) The licensee's Abuse Policy (HR A-1) was not complied with (as identified in WN #3).
b) The Director was not immediately notified of any alleged, suspected or witnessed incidents of abuse that resulted in harm or risk of harm to a resident (as identified in WN #4).
c) The appropriate police force was not immediately notified of every alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence (as identified in WN #6).
d) The SDM of Resident #3 was not immediately notified of every alleged, suspected or witnessed incidents of abuse (as identified in WN #5).
e) The licensee did not ensure that every alleged, suspected or witnessed incident of abuse by a resident was immediately investigated (as identified in WN #7). [s. 19. (1)]

2. The licensee has failed to comply with LTCHA 2007, s.19 (1) whereby a resident was not protected from emotional abuse.

Under O.Reg.79/10 s. 2(1), emotional abuse is defined as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A review of the healthcare record and Critical Incident #0934-000010-14 for Resident #5 indicates that the resident has multiple comorbidities.
Interviews on January 7, 2014 and documentation from the home relate that on a specified date, Resident #5 rang his/her call bell several times to ask for assistance. When PSW #S107 entered the room, Resident #3 was upset and stated that RN #S105 had thrown the call bell across his/her bed out of reach. When the resident did not move forward to prepare for the lift, RN #S105 pushed the resident forward as the resident was screaming and crying. Resident #5 told the DOC and staff the next day that RN #S105 had thrown his/her call bell and was treating him/her like an animal. PSW #S107 reported the incident to the DOC the next day as well. RN #S105 was subsequently disciplined by the home.

In an interview on January 7, 2015, RN #S105 stated that Resident #5 perceived her actions as abusive, but that she did not view her actions as such. She acknowledged that she was moving too quickly and did not allow the resident enough time, so she understands that Resident #5 could have perceived her actions as being rough and thus she is remorseful.

The licensee failed to protect a resident from emotional abuse as evidenced by the following:
a) The licensee's Abuse Policy (HR A-1) was not complied with (as identified in WN #3).
b) The Director was not immediately notified of any alleged, suspected or witnessed incidents of abuse that resulted in harm or risk of harm to a resident (as identified in WN #4).
c) The appropriate police force was not immediately notified of every alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence (as identified in WN #6).
d) The SDM of Resident #5 was not immediately notified of every alleged, suspected or witnessed incidents of abuse (as identified in WN #5).

Non-compliance was previously identified under LTCHA, 2007, s. 24(1) and O. Reg. 79/10, s. 97(1) during the RQI completed on April 7- 22, 2014, Inspection #2014_347197_0008 in relation to the reporting of incidents of abuse or neglect. [s. 19.

(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. 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 has failed to comply with LTCHA, 2007 s. 20 (1) whereby the licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A review of the healthcare record and Critical Incident #0934-000007-14 for Resident #3 indicated that the resident has multiple comorbidities. On a specified date, PSW #S109 observed PSW #S108 strike Resident #3 across the face which resulted in pain for Resident #3 and employment termination for PSW #S108.

A review of the home's Abuse Policy (HR A-1), last revised June 2014, indicates:
-Procedure 1- On becoming aware of abuse of suspected abuse, the person first having knowledge of this shall IMMEDIATELY inform the Administrator, the Director of Nursing or Supervisor in Charge.
-Procedure 5- The Supervisor to which an incident was reported will prepare an Incident Summary Report on MedeCare with the assistance of the individual who reported the incident, the affected individual(s) and any witnesses.
-Procedure 13- The Administrator, Director of Nursing, or designate will then inform the family or responsible party for the residents involved. The family or responsible party of the resident(s) must be notified immediately if it results in physical harm, injury or pain to the resident or if the incident causes distress that could potentially be detrimental to their

health.
-Procedure 14- All cases of abuse or suspected abuse that are suspected may constituted a criminal offence will be reported to the Ontario Provincial Police by the Administrator, Director of Nursing or Nurse in Charge.
Procedure 15- Based on the LTCHA, 2007 s. 24(1) requires that any person who has reasonable grounds to suspect that any abuse of a resident by anyone that resulted in harm or risk of harm to the resident must be reported to the Director immediately [phone numbers provided].
Procedure 16- Review the Abuse Decision Tree provided by the MOHLTC to determine whether a mandatory Critical Incident is required relating to abuse of a resident.

The incident of physical abuse was not immediately reported to the Director (as in WN #4), the police (as in WN #6) and the SDM of the resident (as in WN #5). The Supervisor in Charge did not prepare an Incident Summary Report on MedeCare as per the home's policy. The Supervisor in Charge did not immediately initiate an investigation of the abuse (as in WN #7).

In an interview on January 7, 2015, RN #S101 stated that he reported the incident to the DOC in a text message which she received the next morning.
In an interview on January 7, 2015, the DOC confirmed that RN #S101 was the Supervisor in Charge during the evening of the incident. As such, the home's expectation was that he should have completed the required notifications and actions as per the home's Abuse Policy and annual education session that the staff member attended. [s. 20. (1)]

2. A review of the healthcare record and Critical Incident #0934-000010-14 for Resident #5 indicates that the resident has multiple comorbidities.

Interviews on January 7, 2014 and documentation from the home relate that on a specified date, RN #S105 pushed Resident #5 forward to prepare for the lift as the resident was screaming and crying and threw his/her call bell out of reach which resulted in disciplinary action for RN #S105.

In an interview on January 7, 2015, RN #S105 stated that Resident #5 perceived her actions as abusive, but that she did not view her actions as such. She acknowledged that she was moving too quickly and did not allow the resident enough time, so she understands that Resident #5 could have perceived her actions as being rough and thus she is remorseful.

A review of the home's Abuse Policy (HR A-1), last revised June 2014, indicates:
-Procedure 1- On becoming aware of abuse of suspected abuse, the person first having knowledge of this shall IMMEDIATELY inform the Administrator, the Director of Nursing or Supervisor in Charge.
-Procedure 13- The Administrator, Director of Nursing, or designate will then inform the family or responsible party for the residents involved. The family or responsible party of the resident(s) must be notified immediately if it results in physical harm, injury or pain to the resident or if the incident causes distress that could potentially be detrimental to their health.
-Procedure 14- All cases of abuse or suspected abuse that are suspected may constituted a criminal offence will be reported to the Ontario Provincial Police by the Administrator, Director of Nursing or Nurse in Charge.
Procedure 15- Based on the LTCHA, 2007 s. 24(1) requires that any person who has reasonable grounds to suspect that any abuse of a resident by anyone that resulted in harm or risk of harm to the resident must be reported to the Director immediately [phone numbers provided].
Procedure 16- Review the Abuse Decision Tree provided by the MOHLTC to determine whether a mandatory Critical Incident is required relating to abuse of a resident.

The incident of physical abuse was not immediately reported to the Director (as in WN #4), the police (as in WN #6) and the SDM of the resident (as in WN#5). PSW #S107 stated that she was not able to report the abuse to the Supervisor in Charge since the Supervisor was the person involved in the incident, so the Administrator and DOC were not immediately informed of the abuse. [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 to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

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:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCH 2007, s. 24 (1)2 whereby the licensee did not ensure that an incident of abuse of a resident that resulted in harm or a risk of harm to the resident, was immediately reported to the Director.

A review of the healthcare record and Critical Incident #0934-000007-14 for Resident #3 indicated that the resident has multiple comorbidities. On a specified date, PSW #S109 observed PSW #108 strike Resident #3 across the face which resulted in pain for Resident #3 and employment termination for PSW #S108.

In an interview on January 7, 2015, RN #S101 stated that he reported the incident to the DOC in a text message which she received the next morning. He did not immediately notify the Director. The DOC confirmed that RN #S101, as the Supervisor in Charge, did not notify the Director and that she submitted the Critical Incident Report #0934-000007-14 the following day. [s. 24. (1)]

2. A review of the healthcare record and Critical Incident #0934-000010-14 for Resident #5 indicates that the resident has multiple comorbidities.

Interviews on January 7, 2014 and documentation from the home relate that on a specified date, RN #S105 pushed Resident #5 forward to prepare for the lift as the resident was screaming and crying and threw his/her call bell out of reach which resulted in disciplinary action for RN #S105.

In an interview on January 7, 2015, RN #S105 stated that Resident #5 perceived her actions as abusive, but that she did not view her actions as such. She acknowledged that she was moving too quickly and did not allow the resident enough time, so she understands that Resident #5 could have perceived her actions as being rough and thus she is remorseful.

In an interview on January 8, 2015, the DOC acknowledged that she was informed of the abuse on a specified date but the Critical Incident Report # 0934-000010-14 was not submitted until the next day. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that incidents of abuse of a resident that result in harm or a risk of harm to the resident are immediately reported to the Director, to be implemented voluntarily.

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:

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

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 97(1)(a) whereby the licensee did not ensure that the resident's substitute decision maker (SDM) was 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.

A review of the healthcare record and Critical Incident #0934-000007-14 for Resident #3 indicated that the resident has multiple comorbidities. On a specified date, PSW #S109 observed PSW #S108 strike Resident #3 across the face which resulted in pain for Resident #3 and employment termination for PSW #S108.

In an interview on January 7, 2015, RN #S101 stated that he reported the incident to the DOC in a text message which she received the next morning. He did not immediately notify the resident's SDM. The DOC confirmed that RN #S101, as the Supervisor in Charge, did not notify the resident's SDM and that she notified the resident's SDM the next day. Documentation of the notification states that the SDMs of Resident #3 expressed concern that they were not notified of the abuse immediately. [s. 97. (1) (a)]

2. A review of the healthcare record and Critical Incident #0934-000010-14 for Resident #5 indicates that the resident has multiple comorbidities.
Interviews on January 7, 2014 and documentation from the home relate that on a specified date, RN #S105 pushed Resident #5 forward to prepare for the lift as the resident was screaming and crying and threw his/her call bell out of reach which resulted in disciplinary action for RN #S105.

In an interview on January 7, 2015, RN #S105 stated that Resident #5 perceived her actions as abusive, but that she did not view her actions as such. She acknowledged that she was moving too quickly and did not allow the resident enough time, so she understands that Resident #5 could have perceived her actions as being rough and thus she is remorseful.

In an interview on January 8, 2015, the DOC acknowledged that she was informed of the abuse on a specified date but she did not notify the SDM of Resident #5 until the following day. [s. 97. (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 to ensure that the resident's substitute decision maker is 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 98 whereby the licensee did not ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

A review of the healthcare record and Critical Incident #0934-000007-14 for Resident #3 indicated that the resident has multiple comorbidities. On a specified date, PSW #S109 observed PSW #S108 strike Resident #3 across the face which resulted in pain for Resident #3 and employment termination for PSW #S108.

In an interview on January 7, 2015, RN #S101 stated that he reported the incident to the DOC in a text message which she received the following morning. He did not immediately notify the police. The DOC confirmed that RN #S101, as the Supervisor in Charge, did not notify police and that she notified the police the next day. [s. 98.]

2. A review of the healthcare record and Critical Incident #0934-000010-14 for Resident #5 indicates that the resident has multiple comorbidities.
Interviews on January 7, 2014 and documentation from the home relate that on a specified date, RN #S105 pushed Resident #5 forward to prepare for the lift as the resident was screaming and crying and threw his/her call bell out of reach which resulted in disciplinary action for RN #S105.

In an interview on January 7, 2015, RN #S105 stated that Resident #5 perceived her actions as abusive, but that she did not view her actions as such. She acknowledged that she was moving too quickly and did not allow the resident enough time, so she understands that Resident #5 could have perceived her actions as being rough and thus she is remorseful.

In an interview on January 8, 2015, the DOC acknowledged that she was informed of the abuse on a specified date but she did not consider that this incident would result in criminal charges so she did not notify the police. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #7: 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. The licensee failed to comply with LTCH 2007, s. 23 (1)(a)(i) whereby the licensee did not ensure that every alleged, suspected or witnessed incident of abuse by a resident was immediately investigated.

A review of the healthcare record and Critical Incident #0934-000007-14 for Resident #3 indicated that the resident has multiple comorbidities. On a specified date, PSW #S109 observed PSW #S108 strike Resident #3 across the face which resulted in pain for Resident #3 and employment termination for PSW #S108.

In an interview on January 7, 2015, RN #S101 stated that he reported the incident to the DOC in a text message which she received the following morning. He did not immediately initiate an investigation. The DOC confirmed that RN #S101, as the Supervisor in Charge, did not immediately investigate the abuse and that she initiated the investigation of abuse the next day. [s. 23. (1) (a)]

Issued on this 10th day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	BARBARA ROBINSON (572), KARYN WOOD (601)
Inspection No. / No de l'inspection :	2015_236572_0001
Log No. / Registre no:	O-001145-14, O-000837-14, O-001178-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 10, 2015
Licensee / Titulaire de permis :	MANORCARE PARTNERS II 6257 Main Street, Stouffville, ON, L4A-4J3
LTC Home / Foyer de SLD :	FRIENDLY MANOR NURSING HOME 9756 County Road, #2, P.O. Box 305, DESERONTO, ON, K0K-1X0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Long

To MANORCARE PARTNERS II, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii.equipped with a door access control system that is kept on at all times, and
   iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee will prepare, submit, and implement a plan for achieving compliance with the requirement that all resident accessible doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff in accordance with O. Reg. 79/10, s. 9(1)2. The focus of this non-compliance is primarily, but not entirely, related to doors to the laundry area and the kitchen servery area.

The plan must identify actions to achieve as well as to sustain compliance with O. Reg. 79/10, s.9 (1)2. including an audit of the laundry and kitchen servery doors on a daily basis for one month that clearly indicates the corrective action taken for the identified deficiencies. The audits and selected corrective actions are to be submitted weekly to the inspector.

The plan and subsequent weekly audits with corrective actions shall be submitted in writing by fax to Inspector, Barbara Robinson at 613-569-9670 on or before February 20, 2015.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9(1)2. whereby the licensee has failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

On January 6, 2015, during a critical incident inspection, Inspector #572 noted that the hallway separation doors leading to and from the service wing area have an alarm, but not a lock. Residents and family members were walking in the home's hallway near the doors throughout the afternoon. The inspector walked through the hallway separation doors to find that the laundry area door and kitchen servery area door were both unlocked and that the areas were unsupervised. Each area has appliances and equipment as well as hazardous materials.

The Administrator responded to the alarm from the hallway separation door and was informed of the open, unsupervised areas. The Administrator confirmed that the door to the laundry area and the door to the kitchen servery area should be closed and locked when unsupervised.

On January 7, 2015, Inspector #572 again entered the unlocked hallway separation doors to find that the kitchen servery door was unlocked and that the area was unsupervised. The DOC was notified, and informed the Administrator. On January 8, 2015 a new doorknob was observed being installed into the kitchen servery door to ensure that it locks automatically when closed. All other doors leading from the service hallway were locked.

The unlocked and unsupervised doors to the laundry and kitchen servery present a potential risk to residents in the home, particularly for those residents who exhibit behaviours such as wandering and/or exit-seeking.

Non-compliance was previously identified under O. Reg. 79/10, s. 9(1)2. during the RQI
completed on April 7- 22, 2014, Inspection #2014_347197_0008. (572)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 10, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to include the following:

1) The development of a monitoring process to ensure that:
a) Every incident of alleged, suspected or witnessed incident of abuse is immediately investigated in accordance with LTCHA, 2007 s. 23.
b) The resident's SDM is immediately notified of every incident of alleged, suspected or witnessed incident of abuse in accordance with O. Regs 79/10 s. 97.
c) The Director is immediately notified if there are reasonable grounds to suspect abuse of a resident that resulted in harm or risk of harm to a resident in accordance with LTCHA, 2007 s. 24.
d) The appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that may constitute a criminal offense in accordance with O. Regs 79/10, s. 98.
e) A written report is submitted to the Director with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone, in accordance with O. Regs 79/10, s. 104, which shall include:
i) A description of the incident and the individuals involved.
ii) Action taken in response to the incident.
iii) Analysis and follow up action.
iv) The name and title of the person making the report.
v) The results of every investigation undertaken in response to an alleged, suspected or witnessed incident of abuse.

2) Staff education content to include:
a) Identification of incidents/actions that constitute abuse as defined in O.Reg.79/10
s. 2(1) with a focus on residents who have cognitive impairment.
b) Legislated requirements related to incidents of all incidents of alleged, suspected or
witnessed incidents of abuse of a resident, as noted above.

The plan shall identify the time line for completing the tasks as well as the person responsible for completing the tasks.

The plan shall be submitted by fax to 613-569-9670 with attention to Barbara Robinson, LTC Homes Inspector, on or before February 20, 2015.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA 2007, s.19 (1) whereby a resident was not protected from emotional abuse.

Under O.Reg.79/10 s. 2(1), emotional abuse is defined as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A review of the healthcare record and Critical Incident #0934-000010-14 for Resident #5 indicates that the resident has multiple comorbidities. Interviews on January 7, 2014 and documentation from the home relate that on a specified date, Resident #5 rang his/her call bell several times to ask for assistance. When PSW #S107 entered the room, Resident #5 was upset and stated that RN #S105 had thrown the call bell across his/her bed out of reach. When the resident did not move forward to prepare for the lift, RN #S105 pushed the resident forward as the resident was screaming and crying. Resident #5 told the DOC and staff the next day that RN #S105 had thrown his/her call bell and was treating him/her like an animal. PSW #S107 reported the incident to the DOC the next day as well. RN #S105 was subsequently disciplined by the home.

In an interview on January 7, 2015, RN #S105 stated that Resident #5 perceived her actions as abusive, but that she did not view her actions as such. She acknowledged that she was moving too quickly and did not allow the resident enough time, so she understands that Resident #5 could have perceived her actions as being rough and thus she is remorseful.

The licensee failed to protect a resident from emotional abuse as evidenced by the following:
a) The licensee's Abuse Policy (HR A-1) was not complied with (as identified in WN #3).
b) The Director was not immediately notified of any alleged, suspected or witnessed incidents of abuse that resulted in harm or risk of harm to a resident (as identified in WN #4).
c) The appropriate police force was not immediately notified of every alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence (as identified in WN #6).

d) The SDM of Resident #5 was not immediately notified of every alleged, suspected or witnessed incidents of abuse (as identified in WN #5).

Non-compliance was previously identified under LTCHA, 2007, s. 24(1) and O. Reg. 79/10, s. 97(1) during the RQI completed on April 7- 22, 2014, Inspection #2014_347197_0008 in relation to the reporting of incidents of abuse or neglect.
(572)

2. The licensee has failed to comply with LTCHA 2007, s.19(1) whereby a resident was not protected from physical abuse.

Under O.Reg.79/10 s. 2(1), physical abuse is defined as "the use of physical force by anyone other than a resident that causes physical injury or pain".

A review of the healthcare record and Critical Incident #0934-000007-14 for Resident #3 indicated that the resident has multiple comorbidities. On a specified date, Resident #3 was striking out at staff as they assisted the resident. PSW #S109 observed PSW #S108 strike Resident #3 across the face and say “Don’t hit” which resulted in pain for Resident #3. PSW #S109 reported the abuse to RN #S101. PSW #S108 was subsequently terminated from her employment with the home.

The licensee failed to protect a resident from physical abuse as evidenced by the following:
a) The licensee’s Abuse Policy (HR A-1) was not complied with (as identified in WN #3).
b) The Director was not immediately notified of any alleged, suspected or witnessed incidents of abuse that resulted in harm or risk of harm to a resident (as identified in WN #4).
c) The appropriate police force was not immediately notified of every alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence (as identified in WN #6).
d) The SDM of Resident #3 was not immediately notified of every alleged, suspected or witnessed incidents of abuse (as identified in WN #5).
e) The licensee did not ensure that every alleged, suspected or witnessed incident of abuse by a resident was immediately investigated (as identified in WN #7).
(572)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 20, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 10th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Barbara Robinson

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