Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 17, 2013	2013_214146_0064	H-000305-13,H-000750-13	Complaint

Licensee/Titulaire de permis

DEEM MANAGEMENT SERVICES LIMITED
2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5

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

HAMILTON CONTINUING CARE
125 WENTWORTH STREET SOUTH, HAMILTON, ON, L8N-2Z1

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

BARBARA NAYKALYK-HUNT (146)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 20, 21, 22, 25, 2013

This complaint inspection was conducted concurrently with Critical Incident (CI) inspection H-001964-12 Inspection #2013-214146-0063. Areas of non-compliance common to both inspections related to the CI inspection related to skin, wound and documentation are addressed in this report.

During the course of the inspection, the inspector(s) spoke with the administrator/Director of Care (DOC), environmental and program manager, registered staff, Personal Support Workers (PSW's), office staff, residents and family members.

During the course of the inspection, the inspector(s) toured the home, reviewed policies related to skin and wound, pain and continence care, reviewed resident health records and the home's complaint log.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Falls Prevention

Pain

Responsive Behaviours

Skin and Wound Care

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 O.Reg 79/10, s. 50. Skin and wound care

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Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that, (a) a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, (i) within 24 hours of the resident's admission
Resident #006 was admitted to the home in August 2012 after surgery. A skin assessment was not completed within 24 hours of admission. The assessment was done on 10 days later as confirmed by registered staff, the administrator/DOC and the home's internal investigation notes. [s. 50. (2) (a) (i)]

2. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.
Resident #006 was admitted to the home in August 2012 with a wound. The transfer record indicated that the wound was to be cleansed daily with normal saline and dressed. However, no interventions related to the wound were implemented to promote healing or to prevent infection until two weeks later, when the progress notes stated that the wound had deteriorated. This information was confirmed by the health record, registered staff, the administrator/DOC and the home's internal investigation notes. [s. 50. (2) (b) (ii)]

3. The licensee of a long-term care home did not ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
(A) Resident #004 was assessed as having altered skin integrity in March 2013. The altered skin integrity was treated for one week. No follow-up/weekly assessment was completed. This information was confirmed by registered staff and the health record.
(B) Resident #004 was assessed in April 2013 with a staged ulcer. Weekly assessments were not completed weekly in April and May. The wound deteriorated. This information was confirmed by registered staff and the health record. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 (a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, (i) within 24 hours of the resident's admission;
and
(2)b(iv) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to respect and promote the residents' right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity.
A) Resident #002 passed away in November 2013 and was left in a semi private room with the privacy curtain drawn with room mate resident #003, a cognitively impaired resident, for approximately 21 hours. Staff confirmed that resident #003 knew the deceased resident was behind the curtain as determined by resident #003's pointing at the curtain. The health record indicated resident #003 was agitated and exit seeking. Health record task charting for the date in November indicated that resident #003 demonstrated repetitive verbalization, calling out for help during the time the deceased room mate was in the next bed. A review of 30 days of the task charting before and after the date revealed that this documentation was the only time the resident demonstrated this behaviour. According to office staff, there was an empty bed available on the date. According to a registered staff member, the deceased resident could have been moved into the hairdressing room for the night. There was no attempt to respect resident #003's right to be treated with dignity and respect. This information was confirmed by the health record, staff members and the administrator/DOC.
(B) Resident #001 acts as own power of attorney (POA) and leaves the home several times per week to visit family. On one such occasion in August 2013, staff were reluctant to allow the resident to leave the home's premises but the resident did anyway. The resident came back safely 15 minutes later accompanied by a family member. The nurse spoke to the family member and expressed concern that the resident should not be leaving the home unaccompanied for safety reasons not mentioned. The nurse then stated to the family member, according to the nurse's charting, that the family member "should be the POA so this situation doesn't happen again." In an interview with the inspector in November 2013, the resident firmly stated the intent to remain own POA. The health record indicated that the resident's cognitive testing scored a 30 out of 30. The administrator/DOC confirmed that the nurse's documented statement to the family member was not respectful of the resident's right to be treated with courtesy and respect. [s. 3. (1) 1.]

2. The licensee did not ensure that the following rights of residents were fully respected and promoted: 5. Every resident has the right to live in a safe and clean environment.
In August 2013, a PSW found resident #006 sitting dangling off the foot of the bed. The PSW left the resident unattended in this position to get some assistance. When

the PSW returned, the resident had fallen on the floor with no injury. This information was confirmed by the health record. The administrator/DOC confirmed that the home's expectations are that the PSW should have stayed with the resident to ensure safety and used the call bell to call for assistance. [s. 3. (1) 5.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 following rights of residents are fully respected and promoted:
5. every resident has the right to live in a safe and clean environment, to be implemented voluntarily.

WN #3: 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).

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

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care set out clear directions to staff and others who provided direct care.
The written care plan directed that resident #001 was to have a shower rather than a tub bath because the resident had been assessed as being unsafe in the tub. The kardex care plan and the Point of Care task list directed staff that resident preferred a tub bath. A PSW stated that the resident gets a tub bath or whatever the resident prefers. The resident confirmed that the resident has been showered, however, the two different directions in the plan of care were confusing. The administrator/DOC confirmed that the expectation is that the resident be showered and not tub bathed. The administrator/DOC confirmed that the directions to staff were unclear. [s. 6. (1) (c)]

2. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary.
Resident #004 complained of pain 20 documented times between February 2013 and April 2013. The plan of care was not revised to add any pain interventions until April 2013. This information was confirmed by the health record and the administrator/DOC. [s. 6. (10) (b)]

3. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (c) care set out in the plan has not been effective.
Resident #004's care plan indicated the resident was at risk for falls in February 2013. Resident #004 experienced seven falls in five and a half weeks in March and April 2013 indicating that the interventions were not effective. The care plan interventions were not revised until late April 2013. This information was confirmed by the health record and the Administrator/DOC. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary; or (c) care set out in the plan has not been effective, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.
(A) The health record of resident #004 indicated that an analgesic was given on five occasions in March and April 2013. There was no documentation to indicate why the medication was given or of the resident's response to the intervention. The DOC confirmed that such documentation is the expectation of the home.
B) The Medication Administration Record (MAR) of resident #004 directed that pain monitoring was to be assessed and level of pain to be charted every four hours and the following month's MAR directed that pain assessments be completed and charted every week. The pain assessments were not documented as directed. This information was confirmed by the health record and the Administrator/DOC.
(C) Resident #002 passed away in November 2013. The actual date and time the deceased resident was picked up by the funeral home, that is, left the home, was not documented. The DOC confirmed that the expectation of the home is that this information must be documented on the resident's health record. This information was confirmed by the health record, Administrator/DOC and office staff. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee did not ensure that when a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.
(A) Resident #004 experienced two falls in March 2013 approximately four hours apart and a fall in May 2013. No post-fall assessments were conducted using a clinically appropriate tool after any of these falls. This information was confirmed by the health record and registered staff. [s. 49. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee did not ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.
Resident #004 was assessed with the home's pain assessment tool in February 2013 after the resident had complained of pain on three dates the previous week. The assessment tool indicated he had no pain. Resident #004 continued to complain of unrelieved pain on ten more documented occasions in late February and March 2013 at which time routine analgesic was ordered. The resident continued to complain of pain and asked for the physician to assess the pain on late March 2013. In April 2013, a stronger analgesic was ordered routinely. The pain assessment tool was not used after any of the complaints of unrelieved pain or when the analgesics were added and/or changed. This information was confirmed by the Administrator/DOC and the health record. [s. 52. (2)]

Issued on this 17th day of December, 2013

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

BARBARA NAYKALYK-Hurl

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 NAYKALYK-HUNT (146)
Inspection No. / No de l'inspection :	2013_214146_0064
Log No. / Registre no:	H-000305-13,H-000750-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 17, 2013
Licensee / Titulaire de permis :	DEEM MANAGEMENT SERVICES LIMITED 2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5
LTC Home / Foyer de SLD :	HAMILTON CONTINUING CARE 125 WENTWORTH STREET SOUTH, HAMILTON, ON, L8N-2Z1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Enesia Malapela

To DEEM MANAGEMENT SERVICES 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 :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents exhibiting altered skin integrity (ii) receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required. The plan is to be submitted to Barb Naykalyk-Hunt by end of business day January 10, 2014 by mail at 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7 or by e-mail to barbara.naykalyk-hunt@ontario.ca.

Grounds / Motifs :

1. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.
Resident #006 was admitted to the home in August 2012 with a wound. The transfer record indicated the wound was to be cleansed daily with normal saline and dressed. However, no interventions related to the wound were implemented to promote healing or to prevent infection until two weeks later, when the progress notes stated that the wound had deteriorated. This information was confirmed by the health record, registered staff, the DOC and the home's internal investigation notes.
(146)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 10, 2014

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. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according

to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Grounds / Motifs :

1. The licensee failed to respect and promote the residents' right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity. Previously issued 2012-04-12 as a VPC, and 2013-01-10 as a VPC.
A) Resident #002 passed away in November 2013 and was left in a semi private room with the privacy curtain drawn with roommate resident #003, a cognitively impaired resident, in the same room for approximately 21 hours. Staff confirmed that resident #003 knew the deceased resident was behind the curtain as determined by resident #003's pointing at the curtain. The health record indicated that resident #003 was agitated and exit seeking. Health record task charting for the same day indicated that resident #003 demonstrated repetitive verbalization, calling out for help during the time the deceased roommate was in the next bed. A review of 30 days of the task charting before and after the date revealed that this documentation was the only time the resident demonstrated this behaviour. According to office staff, there was an empty bed available on the date. According to a registered staff member, the deceased resident could have been moved into the hairdressing room for the night. There was no attempt to respect resident #003's right to be treated with dignity and respect. This information was confirmed by the health record, staff members and the administrator/DOC
(B) Resident #001 acts as own power of attorney (POA) and leaves the home several times per week to visit family. On one such occasion in August 2013, staff were reluctant to allow the resident to leave the home's premises but the resident did anyway. The resident came back safely 15 minutes later accompanied by a family member. The nurse spoke to the family member and expressed concern that the resident should not be leaving the home unaccompanied for safety reasons not mentioned. The nurse then stated to the family member, according to the nurse's charting, that the family member "should be the POA so this situation doesn't happen again." In an interview with the inspector in November 2013, the resident was quite firm in a statement that the resident wished to remain his/her own POA . The health record indicated that the resident's cognitive testing scored a 30 out of 30. The DOC confirmed that the nurse's documented statement to the family member was not respectful of the resident's right to be treated with courtesy and respect. (146)

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 27, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board

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

and the Director

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 17th day of December, 2013

Signature of Inspector / Signature de l'inspecteur : BARB NAYKALYK-HUNT

Name of Inspector / Nom de l'inspecteur : BARBARA NAYKALYK-HUNT

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