Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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
Jun 02, 2014;	2014_299559_0005 (A1)	T-043-14	Resident Quality Inspection

Licensee/Titulaire de permis

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

ODD FELLOW AND REBEKAH HOME
10 BROOKS STREET, BARRIE, ON, L4N-5L3

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

ANN HENDERSON (559) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): March 5, 6, 7,10, 26, 27, 28, 31, April 1, 2, 3, 4, 7 , 8, 2014.

During the course of the inspection, the following critical incident inspections were completed:

T-331-13, T-449-13, T-717-13, T-776-13, T- 296-14, T-297-14, T-300-14, T-363-14, T-412-14, C525-000009-14.

During the course of the inspection, the inspector(s) spoke with director of resident care (DRC), assistant director of care (ADRC), nurse practitioner (NP), nurse manager (NM), clinical resource nurse (CRN), director of food services (DFS), director of facilities and environment, director of program support and volunteer services, activationist, food service aide, chair of family council, resident council president, registered nursing staff, registered practical nurse (RPN), registered dietitian (RD), health care records staff, health care aides (HCA), housekeeping supervisor, family members and residents.

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, conducted dining observations, conducted tour of the home, observed medication storage areas, reviewed homes policies related to abuse, falls prevention, responsive behavior, complaints, continence care, infection control and prevention, dietary services, maintenance and laundry, reviewed resident council meeting minutes, staff educational records, staffing schedule and resident activity calendar.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Infection Prevention and Control

Medication

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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. 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 ensure that 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:
Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or the risk of harm to the resident.

Long Term Care Homes Act, 2007 s. 24. (1) has been the subject of two previous written requests to the licensee to prepare a written plan of correction for achieving compliance, to be implemented voluntarily (inspection #2014_299559_0002 from February 24, 2014 and inspection #2013_109153_0016 from July 12, 2013). [s. 24. (1)]

2.A registered staff member reported to the DRC and ADRC via email that two residents care needs had been neglected by the evening nurse. The DRC confirmed that the care needs for these residents had been neglected as indicated. The DRC had failed to report the neglect immediately as required. [s. 24. (1)]

3. An interview with the DRC indicated that he/she was notified via email from a family member of an alleged verbal abuse towards two residents. The DRC confirmed that verbal abuse had occurred and failed to report the information to the Director immediately as required. [s. 24. (1)]

4. A staff member reported that he/she had witnessed an incident of verbal abuse by a HCA towards a resident. An interview with DFS confirmed receipt of the written verbal abuse allegation and indicated that he/she forwarded the information on the same day to the DRC. An interview with the DRC confirmed receipt of the information and he/she had failed to notify the Director immediately as required. [s. 24. (1)]

5. A staff member reported that he/she had witnessed an incident of verbal abuse by a HCA towards a resident. An interview with DFS confirmed receipt of the written verbal abuse allegation and indicated that he/she forwarded the information on the same day to the DRC. An interview with the DRC confirmed receipt of the information and he/she had failed to notify the Director immediately as required. [s. 24. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents' rights to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted.

A resident indicated in an interview that he/she was spoken to inappropriately during care by an identified HCA. The HCA indicated in an interview that he/she stated, "big men don't cry" to the resident, during care on an unspecified date, however, indicated that he/she meant for this comment to be taken as a joke. The DRC indicated that the resident reported the incident and the HCA confirmed that he/she had spoken to the resident inappropriately. The HCA no longer provides care to the resident and has since been disciplined. [s. 3. (1) 1.]

2. Staff interviews revealed that a resident was not treated with courtesy and respect in the dining room. A HCA was witnessed talking to the resident in a scolding tone and

becoming quite impatient with the resident. The resident was told sit down. When the resident did not listen, the HCA put his/her hand on the resident's shoulder pushing the resident forward and the HCA increased the volume in his/her voice repeatedly saying "go, go, go" in an unpleasant tone. The DRC confirmed in an interview that the incident had occurred and the HCA was disciplined. [s. 3. (1) 1.]

3. Staff interview revealed that a resident was not treated with courtesy and respect in the dining room. A HCA was witnessed talking to the resident in a harsh tone telling the resident to eat his/her dinner. When the resident responded that he/she did not want to eat the meal, the identified HCA raised his/her voice and stated "you're going to sit there until you eat it". The DRC confirmed in an interview that the resident was not treated with respect and courtesy and that the HCA was disciplined. [s. 3. (1) 1.]

4. Staff interviews revealed that a HCA spoke inappropriately to two resident in the dining room. The HCA made comments about a resident's name and the language they were speaking and was disrespectful to both residents. The DRC confirmed in an interview that the residents were not treated with dignity and respect and the HCA was disciplined. [s. 3. (1) 1.]

5. The licensee failed to ensure that the resident was cared for in a manner consistent with his or her needs.

The DRC and ADRC received an email that a registered nurse failed to care for a resident in a manner consistent with his/her needs. The resident was on isolation precautions for an upper respiratory infection and required his/her temperature to be taken at least once during a shift. The registered nurse confirmed that he/she did not check the residents temperature. The registered nurse on nights documented that the resident was febrile at 10:30 p.m. and administered medication as ordered. The NM confirmed that the nurse had not checked the resident's temperature to know if he/she was febrile and required medication. [s. 3. (1) 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 the residents' 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 is fully respected and promoted, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Record review revealed that a resident is at risk of falls. The plan of care directs staff to attach a posey alarm and the call bell to his/her clothes when the resident is in bed. The resident had a fall from his/her bed and the progress notes revealed that the posey alarm and call bell were not attached to resident's clothing. A registered nursing staff interview confirmed the resident did not have his/her posey alarm and call bell attached to his/her clothing at the time of the fall. [s. 6. (7)]

2. During a lunch observation, HCAs were observed to serve desserts to residents without consulting the diet roster to verify residents' diet orders. A resident was served a regular sized piece of the berry crumble. The diet roster indicated that the resident's diet is modified diabetic, regular, with 1.5X portions at meals. The therapeutic spreadsheet indicated that a half piece of berry crumble was the portion size for the modified diabetic regular diet. The home's registered dietitian confirmed that the resident should have been served a half portion of the berry crumble. The home's director of food services indicated that the HCA's are to consult the diet roster to ensure the correct food items are served to residents based on their diet orders. [s. 6. (7)]

3. The written plan of care for a resident directs staff to attach a posey alarm to the resident while he/she is seated in a wheelchair or a recliner chair. The resident was seated in the dining room at lunch. The posey alarm was attached to the resident's

wheelchair but not affixed to the resident's shirt. A HCA confirmed it should be attached to the resident's shirt and immediately affixed the device. On an identified date, at 3:42 p.m. the resident was seated in a recliner chair in his/her room with no alarm affixed to the resident. The nurse confirmed an alarm should be in place and placed a hard wire alarm on the seat of the recliner chair. [s. 6. (7)]

4. The written plan of care for a resident directs staff to remove dentures and clean them after meals. After the lunch meal on an identified date, a HCA confirmed that the resident had not had his/her dentures cleaned after the meal. Four HCAs stated that mouth care is only offered to the resident in the morning and evening. Two of the HCAs were unaware that the resident had dentures and stated that he/she required his/her natural teeth to be brushed. The ADRC confirmed that the resident should have his/her dentures removed from mouth and cleaned after every meal and that care had not been provided as per the written plan of care. [s. 6. (7)]

5. An interview with the RD indicated that a resident was assessed to have increased nutritional needs related to wound healing. On an identified date, the RD ordered 125ml of diabetic resource three times per day. Clinical record review revealed that the resident did not receive 125ml of diabetic resource three times per day between two identified dates. An interview with DRC confirmed that the resident had not received the 125 ml of diabetic resource as ordered and the supplement was discontinued in error by the pharmacy. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviors, including responsive behaviors.

Staff interviews revealed that the resident has responsive behaviors with aggression. A HCA revealed the resident wandered into another resident's room who was ill and in isolation. Staff had to move the isolated resident out of his/her room and to leave the resident in the room as the HCAs were scared and unable to redirect the resident. Identified staff members indicated that they had sustained injuries during care and had not performed care with the resident as he/she was unpredictable and aggressive. Staff revealed that there were no interventions developed and implemented to safely manage care for this resident. The NP and CRN confirmed that there were no interventions developed and implemented to respond to the resident's behaviors. [s. 55. (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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviors, including responsive behaviors, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home; 2007, c. 8, s. 15 (1).
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and 2007, c. 8, s. 15 (1).
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, the home, is maintained in a safe condition and in a good state of repair.

The inspector observed that there was damage to the walls under the windows in a dining room and a hole in the wall behind the door in a resident room. An interview with the director of facilities and environment confirmed the damage and that the identified areas were not in a good state of repair. [s. 15. (2) (c)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system is available at each bed used by residents.

During the course of this inspection, the residents were observed to reside in the same room with call bell only accessible to one of residents while in bed. A HCA and the DRC confirmed that the other resident does not have a call bell available at his/her bed. [s. 17. (1) (d)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident is bathed, at a minimum, twice a week by the method of his/her choice.

The plan of are for a resident indicated that he/she is to receive a bath on Tuesday and Saturday of each week. Staff are directed to bathe the resident on Tuesdays and the family are to provide the Saturday bath. A record review for the resident indicated that on identified dates staff have documented that either the resident refused to be bathed or that bathing was not applicable. Staff interviews confirmed that the resident is never offered the Tuesday bath due to his aggression and unpredictability. The DRC confirmed that the resident only receives one bath per week and not the two required baths. [s. 33. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident is offered a minimum of three meals daily.

An interview with a resident confirmed that, the resident requested a lunch tray in his/her room as he/she was not feeling well. An interview with an identified RPN indicated he/she directed an identified HCA to not give the resident a lunch tray. The HCA was directed to inform the resident to go to the dining room for lunch as there were too many residents requesting tray service. The DRC confirmed in an interview that the resident did not receive lunch. [s. 71. (3) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is immediately informed in as much detail as is possible in the circumstances, of the following incident in the home, followed by the report required under subsection (4): An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

An enteric disease outbreak was declared by Public Health on March 7, 2014. The licensee notified the Director on March 11, 2014, this was confirmed by the DRC. [s. 107. (1) 5.]

Issued on this 2 day of June 2014 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Ann Henderson, Val Johnston, Val Pimentel, Laura Brown-Huesken

Ministry of Health and Long-Term Care	Ministère de la Santé et des Soins de longue durée
Inspection Report under the Long-Term Care Homes Act, 2007	**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée**

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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
Jun 02, 2014;	2014_299559_0005 (A1)	T-043-14	Resident Quality Inspection

Licensee/Titulaire de permis

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

ODD FELLOW AND REBEKAH HOME
10 BROOKS STREET, BARRIE, ON, L4N-5L3

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

ANN HENDERSON (559) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Plan submission date changed

Issued on this 2 day of June 2014 (A1)

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

Ann Henderson, Laura Brown-Huesken, Valerie Johnston, Valerie Pimentel

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

Ministère 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : ANN HENDERSON (559) - (A1)

Inspection No. / No de l'inspection : 2014_299559_0005 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : T-043-14 (A1)

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

Report Date(s) / Date(s) du Rapport : Jun 02, 2014;(A1)

Licensee / Titulaire de permis :

LTC Home / Foyer de SLD : ODD FELLOW AND REBEKAH HOME
10 BROOKS STREET, BARRIE, ON, L4N-5L3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : DOREEN SAUNDERS

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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. The plan shall be submitted to Ann.Henderson@ontario.ca by June 16, 2014.

Grounds / Motifs :

(A1)
1. The licensee failed to ensure that 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:
Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or the risk of harm to the resident.

Long Term Care Homes Act, 2007 s. 24. (1) has been the subject of two previous written requests to the licensee to prepare a written plan of correction for achieving compliance, to be implemented voluntarily (inspection #2014_299559_0002 from February 24, 2014 and inspection #2013_109153_0016 from July 12, 2013). [s. 24. (1)] (559)

2. A registered staff member reported to the DRC and ADRC via email that resident #12 and #13 s care needs had been neglected by the evening nurse. The DRC confirmed that the care needs for residents #12 and #13 had been neglected as indicated. The DRC had failed to report the neglect to the Director immediately as required. [s. 24. (1)] (559)

3. An interview with the DRC indicated he she was notified of an alleged verbal abuse towards resident #34 and #35 by email from a family member. The family member indicated when the verbal abuse occurred. The DRC confirmed that verbal abuse occurred and had failed to report the information to the Director immediately as required. [s. 24. (1)] (557)

4. A staff member reported that he she had witnessed an incident of verbal abuse by a HCA towards resident #12. An interview with DFS confirmed receipt of the written verbal abuse allegation and indicated that he she forwarded the information on the same day to the DRC. An interview with the DRC confirmed receipt of the information and that he she had failed to notify the Director immediately as required. [s. 24. (1)] (559)

5. A staff member reported that he she had witnessed an incident of verbal abuse by a HCA towards resident #2. An interview with DFS confirmed receipt of the written verbal abuse allegation and indicated that he she forwarded the information on the same day to the DRC. An interview with the DRC confirmed receipt of the information that he she had failed to notify the Director immediately as required. [s. 24. (1)] (503) (559)

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

Jun 30, 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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Ministère 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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 2 **day of June 2014 (A1)**

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : ANN HENDERSON - (A1)

Service Area Office / Bureau régional de services : Toronto