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

Toronto Service Area Office
5700 Yonge Street 5th Floor
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5700 rue Yonge 5e étage
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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 25, 29, 2016	2016_336620_0010	004780-16	Critical Incident System

Licensee/Titulaire de permis

IOOF SENIORS HOMES INC.
20 Brooks Street BARRIE ON L4N 5L3

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

ALAIN PLANTE (620)

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): February 16, 17, 18, 19, 22, 23, 24, 25, 2016

Inspector reviewed Critical Incident (CI) #004780-16 related to an allegation of staff to resident emotional abuse.

The inspector further reviewed residents' health records, various policies, procedures, programs, employee records, and a number of the home's investigation documents. The Inspector also observed the delivery of resident care, and staff to resident interactions.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), a Resident Care Administrative Assistant (RCAA), Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), a resident's family members, and a resident.

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

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #901	2016_336620_0010	620

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse.

Inspector #620 reviewed a Critical Incident Report (CI) related to an allegation involving staff to resident emotional abuse. A family member reported this allegation to the home. The family member of resident #018 reported that Personal Support Worker #132 (PSW) had emotionally abused the resident by placing an item in close proximity to the resident's face which caused the resident to shout, "No, get away" while they swung their arms at PSW #132 and the item they were holding.

Inspector #620 interviewed PSW #132, who confirmed they placed an item in close proximity to resident #018's face to initiate range of motion exercises. They stated that they ceased the use of the item when they witnessed the reaction of resident #018. PSW #132 said they knew that resident #018 had a fear of the item and that they were aware of the fear for at least six months before the incident had occurred. PSW #132 confirmed this action constituted emotional abuse. PSW #132 stated that all senior staff on the unit were aware that resident #018 feared the particular item.

A review of PSW # 132's employee record revealed that the licensee hired PSW #132 without a criminal reference check, including a vulnerable sector screen, conducted within six months before the date of hire contrary to s. 75 of the Long-Term Care Homes Act, 2007 (LTCHA) and s. 215 of Ontario Regulation 79/10 under the LTCHA. PSW #132 provided the home with a receipt for a vulnerable sector screen criminal reference check. The vulnerable sector screen criminal reference check that PSW #132 submitted to the home was not complete. It did not include the results of the vulnerable sector screen or validation from the Barrie Police Services. The employee record also contained a second vulnerable sector screen criminal reference check, which was two years before PSW #132's date of hire at this home.

Inspector # 620 interviewed the Director of Care (DOC). The DOC confirmed that PSW #132 had emotionally abused resident #018 as determined through the home's internal

investigation. The DOC stated that the licensee disciplined PSW #132.

Inspector #620 and the DOC reviewed the vulnerable sector screen documents from PSW #132's employee record. The DOC then confirmed, that they were unaware until the review of the documents that PSW #132's employee record contained a criminal reference check that was not conducted within six months before PSW #132 was hired. They also confirmed that they were unaware that the document did not include the results of the vulnerable sector screen or validation from the Barrie Police Services. The DOC stated that it was the home's expectation that all PSWs would have a criminal reference check including a vulnerable sector screen conducted within six months before being hired, and that this had not occurred for PSW #132.

The DOC stated that they had no record to support that PSW #132 had received Zero Tolerance of Abuse Policy Training. The DOC could only confirm that PSW #132 had watched a video entitled, "One is One Too Many." The DOC stated that the video represented the entirety of the home's Zero Tolerance of Abuse Training, and that there was no staff training specific to the home's Zero Tolerance of Abuse Policy. The DOC stated that no records of staff training for Zero Tolerance of Abuse Policy had been documented by the home.

Inspector # 620 interviewed the Resident Care Administrative Assistant (RCAA). The RCAA confirmed that PSW #132 was currently still scheduled to return to work. PSW #132 was also on the call-in roster for unscheduled shifts.

Inspector # 620 interviewed the DOC. The DOC confirmed that PSW #132 was still scheduled to work in the home and that they remained on the call-in roster for shifts that may become available. The DOC confirmed that they had not sought a current and valid vulnerable sector screen criminal reference check from PSW #132 following notification by Inspector #620 of the absence of the document. The DOC also confirmed there was no plan to provide PSW #132 any further training related to the home's abuse policy upon their return to work. The home had no plan put in place to ensure the safety of resident #018 or any other resident in the home. The DOC confirmed that when PSW #132 returns to work, PSW #132 could be assigned to provide unsupervised care to resident #018; this was further confirmed by a staff member responsible for scheduling.

Inspector #620 interviewed an Officer and Supervisor of Records from the Barrie Police Services. The Officer confirmed that the vulnerable sector criminal reference document provided to the home by PSW #132 was not complete; furthermore, the document could

not be utilized to identify whether PSW #132 had a negative or positive result on the criminal reference check for vulnerable sector screen. [s. 19. (1)]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 1st day of March, 2016

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
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Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALAIN PLANTE (620)
Inspection No. / No de l'inspection :	2016_336620_0010
Log No. / Registre no:	004780-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 25, 29, 2016
Licensee / Titulaire de permis :	IOOF SENIORS HOMES INC. 20 Brooks Street, BARRIE, ON, L4N-5L3
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

To IOOF SENIORS HOMES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prohibit PSW #132 from having any contact with resident #018 or any other residents in the home until:

a) the licensee is in possession of a valid and current, within the last six months, criminal reference check, including a vulnerable sector screen, for PSW #132;

b) the licensee is satisfied based on the criminal reference check, including a vulnerable sector screen, that PSW #132 is suitable to be a staff member and to have contact with and provide direct care to residents; and

c) if the licensee is satisfied that PSW #132 is suitable to have contact with and provide direct care to residents, before PSW #132 has contact with any residents the licensee must:

i) ensure that PSW #132 has completed training on the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under s. 24 of the Act, abuse recognition and prevention, mental health issues, including caring for persons with dementia; and

ii) develop a plan to ensure the safety of resident #018 and all residents in the home.

Grounds / Motifs :

1. The licensee failed to ensure that residents were protected from abuse.

Inspector #620 reviewed a Critical Incident Report (CI) related to an allegation involving staff to resident emotional abuse. A family member reported this

allegation to the home. The family member of resident #018 reported that Personal Support Worker #132 (PSW) had emotionally abused the resident by placing an item in close proximity to the resident's face which caused the resident to shout, "No, get away" while they swung their arms at PSW #132 and the item they were holding.

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A review of PSW # 132's employee record revealed that the licensee hired PSW #132 without a criminal reference check, including a vulnerable sector screen, conducted within six months before the date of hire contrary to s. 75 of the Long-Term Care Homes Act, 2007 (LTCHA) and s. 215 of Ontario Regulation 79/10 under the LTCHA. PSW #132 provided the home with a receipt for a vulnerable sector screen criminal reference check. The vulnerable sector screen criminal reference check that PSW #132 submitted to the home was not complete. It did not include the results of the vulnerable sector screen or validation from the Barrie Police Services. The employee record also contained a second vulnerable sector screen criminal reference check, which was two years before PSW #132's date of hire at this home.

Inspector # 620 interviewed the Director of Care (DOC). The DOC confirmed that PSW #132 had emotionally abused resident #018 as determined through the home's internal investigation. The DOC stated that the licensee disciplined PSW #132.

Inspector #620 and the DOC reviewed the vulnerable sector screen documents from PSW #132's employee record. The DOC then confirmed, that they were unaware until the review of the documents that PSW #132's employee record contained a criminal reference check that was not conducted within six months before PSW #132 was hired. They also confirmed that they were unaware that the document did not include the results of the vulnerable sector screen or validation from the Barrie Police Services. The DOC stated that it was the

home's expectation that all PSWs would have a criminal reference check including a vulnerable sector screen conducted within six months before being hired, and that this had not occurred for PSW #132.

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Inspector #620 interviewed an Officer and Supervisor of Records from the Barrie Police Services. The Officer confirmed that the vulnerable sector criminal reference document provided to the home by PSW #132 was not complete; furthermore, the document could not be utilized to identify whether PSW #132 had a negative or positive result on the criminal reference check for vulnerable sector screen. (620)

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

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

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 25th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alain Plante

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