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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 23, 2017	2017_566669_0028	033554-16	Complaint

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF LAMBTON
789 Broadway Street WYOMING ON N0N 1T0

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

LAMBTON MEADOWVIEW VILLA
3958 PETROLIA LINE R. R. #4 PETROLIA ON N0N 1R0

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

ANDREA DIMENNA (669)

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): October 12, 13, 16 and 17, 2017.

During the course of the inspection, the inspector(s) spoke with residents, a family member, the Acting Administrator, the Director of Nursing and Personal Care (DONPC), the Resident Assessment Instrument (RAI) Coordinator, a Ward Clerk, a Registered Nurse (RN), three Registered Practical Nurses (RPNs), and four Personal Support Workers (PSWs).

During the course of the inspection, the Inspector made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. The Inspector observed resident/staff interactions, infection prevention and control practices, and the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knew of, or that was reported was immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff ,or (iii) anything else provided for in the regulations.

This inspection was conducted as a result of a Complaint received by the Ministry of Health and Long-Term Care (MOHLTC) on a specified date, which alleged that a resident physically abused another resident.

Section 2 (1) of Ontario Regulation 79/10 defines physical abuse as: (a) the use of physical force by anyone other than a resident that causes physical injury or pain, (b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another resident.

During an interview with an identified resident's Power of Attorney (POA), they stated that the resident was abused by another resident on a specified date during an unwitnessed incident, and that the the incident resulted in harm to the identified resident. The resident's POA added that allegedly abusive resident also abused other residents following the aforementioned incident.

The home's policy, Prevention of Abuse and Neglect to Residents (Index No. 2-8-18), last reviewed November 2016, stated that all management that received or had

an alleged, suspected or witnessed incident of abuse should investigate the incident.

The identified resident’s clinical record was reviewed and revealed progress notes by a RPN that stated there was a suspected incident of resident-to-resident abuse. Another progress note by a RN stated they notified the identified resident’s POA and the DONPC about the incident. A following note by DONPC stated that the DONPC met with the identified resident’s family to discuss the incident, and another note by the home’s previous administrator, stated that a call was placed to the identified resident’s POA regarding concerns over the allegedly abusive resident.

The allegedly abusive resident's progress notes were reviewed and included a note that they abused another resident. The note continued that the DONPC was contacted. Another note stated that the allegedly abusive resident allegedly abused a third identified resident. The note stated that the administrator at the time was contacted. Another progress note stated that the allegedly abusive resident was witnessed abusing a fourth identified resident.

The home's Quality Improvement Council binder, which included investigation notes, was reviewed and did not contain any investigation notes related to the incidents of abuse by the allegedly abusive resident for any of the aforementioned incidents.

Two PSWs, three RPNs, the RAI Coordinator, and a RN were interviewed and all acknowledged that the allegedly abusive resident's identified actions toward other residents would be considered abuse.

A RPN was interviewed and recalled working during the incident when the allegedly abusive resident allegedly abused another resident. The RPN stated that they reported the incident to the RN, as it was considered abuse, even if it was not witnessed.

A RN was interviewed and recalled the incident when the allegedly abusive resident allegedly abused another resident. The RN stated they recalled notifying the DONPC of the incident, but acknowledged that they did not document that they notified the DONPC of the incident. The RN vaguely remembered another incident when the allegedly abusive resident abused another resident. The RN reviewed progress notes from this incident and noted that they did contact the DONPC, and that incident was considered abuse. The RN reviewed progress notes from another incident involving the allegedly abusive resident and two other residents, and acknowledged that all of these incidents were considered abuse.

The DONPC was interviewed and stated they were aware of the incident when the allegedly abusive resident allegedly abused the first identified resident, and acknowledged that this incident was alleged abuse. The DONPC stated that the allegedly abusive resident had additional incidents of aggression toward other residents on a specified date, and that they were unaware of the other incidents involving the allegedly abusive resident, but that they were considered abuse. The DONPC explained that when resident-to-resident abuse occurred or was suspected, they would review the documentation and may need to speak with the person reporting it, but there were usually no investigation notes. The DONPC acknowledged that any investigation notes would be in the Quality Improvement Council binder that the Inspector had reviewed.

The Acting Administrator was interviewed and stated that the home did not have any documentation that a formal investigation occurred for any of the incidents involving the allegedly abusive resident's altercations four identified residents from within a specified time period.

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident that the licensee knew of was immediately investigated.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. The home did not have a history of non-compliance in this section of the legislation. [s. 23. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may have occurred, immediately reported the suspicion and the information upon which it was 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 risk of harm.

This inspection was conducted as a result of a Complaint received by the MOHLTC on a specified date, which alleged that a resident physically abused multiple residents.

The home's policy, Prevention of Abuse and Neglect to Residents (Index No. 2-8-18), last reviewed November 2016, stated a mandatory report of any alleged, suspected or witnessed abuse would be submitted to the MOHLTC. The policy continued that the administrator or designate would notify the MOHLTC immediately upon becoming aware of the incident.

The identified resident's clinical record was reviewed and revealed progress notes by a RPN that stated there was a suspected incident of resident-to-resident abuse. Another progress note by a RN stated they notified the identified resident's POA and the DONPC about the incident. A following note by DONPC stated that the DONPC met with the identified resident's family to discuss the incident, and another note by the home's previous administrator, stated that a call was placed to the identified resident's POA

regarding concerns over the allegedly abusive resident.

The allegedly abusive resident's progress notes were reviewed and included a note that they abused another resident. The note continued that the DONPC was contacted. Another note stated that the allegedly abusive resident allegedly abused a third identified resident. The note stated that the administrator at the time was contacted. Another progress note stated that the allegedly abusive resident was witnessed abusing a fourth identified resident.

The home's Quality Improvement Council binder, which included investigation notes, was reviewed and did not contain any investigation notes related to the incidents of abuse by the allegedly abusive resident for any of the aforementioned incidents.

Two PSWs, three RPNs, the RAI Coordinator, and a RN were interviewed and all acknowledged that the allegedly abusive resident's identified actions toward other residents would be considered abuse.

A RPN was interviewed and recalled working during the incident when the allegedly abusive resident allegedly abused another resident. The RPN stated that they reported the incident to the RN, as it was considered abuse, even if it was not witnessed.

A RN was interviewed and recalled the incident when the allegedly abusive resident allegedly abused another resident. The RN stated they recalled notifying the DONPC of the incident, but acknowledged that they did not document that they notified the DONPC of the incident. The RN vaguely remembered another incident when the allegedly abusive resident abused another resident. The RN reviewed progress notes from this incident and noted that they did contact the DONPC, and that incident was considered abuse. The RN reviewed progress notes from another incident involving the allegedly abusive resident and two other residents, and acknowledged that all of these incidents were considered abuse.

The DONPC was interviewed and stated they were aware of the incident when the allegedly abusive resident allegedly abused the first identified resident, and acknowledged that this incident was alleged abuse. The DONPC stated that the allegedly abusive resident had additional incidents of aggression toward other residents on a specified date, and that they were unaware of the other incidents involving the allegedly abusive resident, but that they were considered abuse. The DONPC reported that they expected the incidents of abuse by the allegedly abusive resident toward other residents

that occurred during a specified time period, were submitted as Critical Incident System Reports.

The Acting Administrator was interviewed and acknowledged that the home did not notify the MOHLTC of the incidents related to alleged abuse by the allegedly abusive resident during a specified time period.

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

The severity was determined to be a level one as there was minimum risk. The scope of this issue was widespread during the course of this inspection. The home did not have a history of non-compliance in this section of the legislation. [s. 24. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home

was investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation commenced immediately.

This inspection was conducted as a result of a Complaint received by the MOHLTC on a specified date, in which a family member stated they verbally complained to the home, and the home did not investigate or resolve their complaint.

During an interview with an identified resident’s Power of Attorney (POA), they stated that the resident was abused by another resident on a specified date during an unwitnessed incident, and that the the incident resulted in harm to the identified resident. The POA noted that they verbally complained to the home multiple times, but the home did not investigate the incident of alleged abuse. The POA continued that they did not receive a timely response from the home regarding follow-up to the incident, and they were not satisfied with the way the home handled the complaint.

The home's Quality Improvement Council binder, which contained complaint forms and investigation notes related complaints, was reviewed and did not contain any documentation related to the POA's complaint.

The DONPC was interviewed and explained that any investigation notes related to a complaint would be in the Quality Improvement Council binder. The DONPC said that any complaints received by the home should be logged on a Suggestions, Concerns, and Complaints Form (SCCF), which was then reviewed and followed up with the resident’s family within 10 days. The DONPC continued that they would fill out a SCCF for a verbal complaint that could not be resolved immediately, and acknowledged that they had never filled out a SCCF before. The DONPC recalled receiving a verbal complaint from the identified resident’s POA related to the alleged abuse by the the allegedly aggressive resident. The DONPC acknowledged that they did not fill out a SCCF for this complaint, but that one should have been filled out. The DONPC explained that the home tried to resolve the concern but noted that the identified resident's POA was not satisfied with the home’s resolution to their concern.

The licensee has failed to ensure that every verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation commenced immediately.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home did not have a history of non-compliance in this section of the legislation. [s. 101. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated, resolved where possible, and response is provided within 10 business days of receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation commences immediately, to be implemented voluntarily.

Issued on this 9th day of January, 2018

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ANDREA DIMENNA (669)
Inspection No. / No de l'inspection :	2017_566669_0028
Log No. / No de registre :	033554-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 23, 2017
Licensee / Titulaire de permis :	THE CORPORATION OF THE COUNTY OF LAMBTON 789 Broadway Street, WYOMING, ON, N0N-1T0
LTC Home / Foyer de SLD :	LAMBTON MEADOWVIEW VILLA 3958 PETROLIA LINE, R. R. #4, PETROLIA, ON, N0N-1R0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angie Heinz

To THE CORPORATION OF THE COUNTY OF LAMBTON, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knew of, or that was reported was immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations.

This inspection was conducted as a result of a Complaint received by the Ministry of Health and Long-Term Care (MOHLTC) on a specified date, which alleged that a resident physically abused another resident.

Section 2 (1) of Ontario Regulation 79/10 defines physical abuse as: (a) the use of physical force by anyone other than a resident that causes physical injury or pain, (b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another

resident.

During an interview with an identified resident's Power of Attorney (POA), they stated that the resident was abused by another resident on a specified date during an unwitnessed incident, and that the the incident resulted in harm to the identified resident. The resident's POA added that allegedly abusive resident also abused other residents following the aforementioned incident.

The home's policy, Prevention of Abuse and Neglect to Residents (Index No. 2-8 -18), last reviewed November 2016, stated that all management that received or had knowledge of an alleged, suspected or witnessed incident of abuse should investigate the incident.

The identified resident's clinical record was reviewed and revealed progress notes by an RPN that stated there was a suspected incident of resident-to-resident abuse. Another progress note by an RN stated they notified the identified resident's POA and the DONPC about the incident. A following note by DONPC stated that the DONPC met with the identified resident's family to discuss the incident, and another note by the home's previous administrator, stated that a call was placed to the identified resident's POA regarding concerns over the allegedly abusive resident.

The allegedly abusive resident's progress notes were reviewed and included a note that they abused another resident. The note continued that the DONPC was contacted. Another note stated that the allegedly abusive resident allegedly abused a third identified resident. The note stated that the administrator at the time was contacted. Another progress note stated that the allegedly abusive resident was witnessed abusing a fourth identified resident.

The home's Quality Improvement Council binder, which included investigation notes, was reviewed and did not contain any investigation notes related to the incidents of abuse by the allegedly abusive resident for any of the aforementioned incidents.

Two PSWs, three RPNs, the RAI Coordinator, and a RN were interviewed and all acknowledged that the allegedly abusive resident's identified actions toward other residents would be considered abuse.

A RPN was interviewed and recalled working during the incident when the

allegedly abusive resident allegedly abused another resident. The RPN stated that they reported the incident to the RN, as it was considered abuse, even if it was not witnessed.

A RN was interviewed and recalled the incident when the allegedly abusive resident allegedly abused another resident. The RN stated they recalled notifying the DONPC of the incident, but acknowledged that they did not document that they notified the DONPC of the incident. The RN vaguely remembered another incident when the allegedly abusive resident abused another resident. The RN reviewed progress notes from this incident and noted that they did contact the DONPC, and that incident was considered abuse. The RN reviewed progress notes from another incident involving the allegedly abusive resident and two other residents, and acknowledged that all of these incidents were considered abuse.

The DONPC was interviewed and stated they were aware of the incident when the allegedly abusive resident allegedly abused the first identified resident, and acknowledged that this incident was alleged abuse. The DONPC stated that the allegedly abusive resident had additional incidents of aggression toward other residents on a specified date, and that they were unaware of the other incidents involving the allegedly abusive resident, but that they were considered abuse. The DONPC explained that when resident-to-resident abuse occurred or was suspected, they would review the documentation and may need to speak with the person reporting it, but there were usually no investigation notes. The DONPC acknowledged that any investigation notes would be in the Quality Improvement Council binder that the Inspector had reviewed.

The Acting Administrator was interviewed and stated that the home did not have any documentation that a formal investigation occurred for any of the incidents involving the allegedly abusive resident's altercations with four identified residents from within a specified time period.

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident that the licensee knew of was immediately investigated.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. The home did not have a history of non-compliance in

this section of the legislation. (669)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 01, 2017

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. 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 ensure that a person who has reasonable grounds to suspect that 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 has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may have occurred, immediately reported the suspicion and the information upon which it was 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 risk of harm.

This inspection was conducted as a result of a Complaint received by the MOHLTC on a specified date, which alleged that a resident physically abused multiple residents.

The home's policy, Prevention of Abuse and Neglect to Residents (Index No. 2-8 -18), last reviewed November 2016, stated a mandatory report of any alleged, suspected or witnessed abuse would be submitted to the MOHLTC. The policy

continued that the administrator or designate would notify the MOHLTC immediately upon becoming aware of the incident.

The identified resident's clinical record was reviewed and revealed progress notes by an RPN that stated there was a suspected incident of resident-to-resident abuse. Another progress note by an RN stated they notified the identified resident's POA and the DONPC about the incident. A following note by DONPC stated that the DONPC met with the identified resident's family to discuss the incident, and another note by the home's previous administrator, stated that a call was placed to the identified resident's POA regarding concerns over the allegedly abusive resident.

The allegedly abusive resident's progress notes were reviewed and included a note that they abused another resident. The note continued that the DONPC was contacted. Another note stated that the allegedly abusive resident allegedly abused a third identified resident. The note stated that the administrator at the time was contacted. Another progress note stated that the allegedly abusive resident was witnessed abusing a fourth identified resident.

The home's Quality Improvement Council binder, which included investigation notes, was reviewed and did not contain any investigation notes related to the incidents of abuse by the allegedly abusive resident for any of the aforementioned incidents.

Two PSWs, three RPNs, the RAI Coordinator, and a RN were interviewed and all acknowledged that the allegedly abusive resident's identified actions toward other residents would be considered abuse.

A RPN was interviewed and recalled working during the incident when the allegedly abusive resident allegedly abused another resident. The RPN stated that they reported the incident to the RN, as it was considered abuse, even if it was not witnessed.

A RN was interviewed and recalled the incident when the allegedly abusive resident allegedly abused another resident. The RN stated they recalled notifying the DONPC of the incident, but acknowledged that they did not document that they notified the DONPC of the incident. The RN vaguely remembered another incident when the allegedly abusive resident abused another resident. The RN reviewed progress notes from this incident and noted

that they did contact the DONPC, and that incident was considered abuse. The RN reviewed progress notes from another incident involving the allegedly abusive resident and two other residents, and acknowledged that all of these incidents were considered abuse.

The DONPC was interviewed and stated they were aware of the incident when the allegedly abusive resident allegedly abused the first identified resident, and acknowledged that this incident was alleged abuse. The DONPC stated that the allegedly abusive resident had additional incidents of aggression toward other residents on a specified date, and that they were unaware of the other incidents involving the allegedly abusive resident, but that they were considered abuse. The DONPC reported that they expected the incidents of abuse by the allegedly abusive resident toward other residents that occurred during a specified time period, were submitted as Critical Incident System Reports.

The Acting Administrator was interviewed and acknowledged that the home did not notify the MOHLTC of the incidents related to alleged abuse by the allegedly abusive resident during a specified time period.

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

The severity was determined to be a level one as there was minimum risk. The scope of this issue was widespread during the course of this inspection. The home did not have a history of non-compliance in this section of the legislation. (669)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 01, 2017

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 23rd day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Andrea DiMenna

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