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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
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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
Aug 28, 2018	2018_657681_0016	017953-18	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Waters Edge Care Community
401 William Street NORTH BAY ON P1A 1X5

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

STEPHANIE DONI (681)

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): July 30 - 31, 2018. Additional off-site inspection activities were completed on August 9, 2018.

The following intake was inspected on during this Critical Incident System inspection:
- One intake related to an allegation of resident abuse.

A Complaint inspection #2018_657681_0018, was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), Nurse Practitioner (NP), Resident Relation Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

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)**

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 has failed to ensure that residents were protected from abuse by anyone.

A critical incident (CI) report was submitted to the Director related to an allegation of visitor to resident abuse. The CI report indicated that RPN #103 and PSW #113 found resident #002 in an inappropriate condition and the resident was voicing complaints of pain.

Inspector #681 reviewed the home's investigation notes related to the incident, which included a written statement from RPN #103. RPN #103's statement indicated that resident #002 had a visitor and when RPN #103 saw resident #002's visitor leave, they went to check on resident #002 and found them in an inappropriate condition. Resident #002 was also voicing complaints of pain.

During an interview with PSW #108, they stated that resident #002's visitor would visit the home and that they usually visited in a specified area of the home. PSW #108 stated that on the date of the incident, resident #002's visitor visited with the resident in a specified area of the home, as per usual.

During an interview with RPN #103, they stated that resident #002 visited with their visitor in the specified area of the home on the date of the incident. RPN #103 stated that they saw resident #002's visitor leave and went to check on the resident. RPN #103 stated that the resident was found in an inappropriate condition and that they were complaining of pain.

Inspector #681 reviewed resident #002's current care plan, which indicated that when resident #002's visitor was visiting the home, they were to visit in a different area of the home then where PSW #108 and RPN #103 had observed.

On a particular date and time, Inspector #681 observed resident #002 sitting with their visitor in a specified area of the home (the area identified in the care plan). The Inspector observed that all staff and other residents were in other specified areas of the home.

On another particular date and time, Inspector #681 walked between two specified locations of the home (one area as identified in the care plan). During this time, all staff and residents were in another specified location of the home and Inspector #681 did not see or hear any staff, residents, or visitors.

During an interview with the DOC, they stated that the home did not have enough information to determine what occurred on the date of the incident. However, the DOC stated that the home knew that resident #002's visitor was the last person to interact with

resident #002.

During an interview with the Executive Director, they stated that the outcome of the home's investigation was still pending and that the incident was unwitnessed. The Executive Director stated that the only information that the home had was that resident #002 was found in an inappropriate condition. The Executive Director indicated that the home recommended to resident #002's visitor that they only visit the resident in specified areas of the home (one being the same area as identified in the care plan). However, the Executive Director acknowledged that one specified home area (identified in the care plan) was often unoccupied during a particular time of the day. The Executive Director stated that, with the exception of a specified intervention following visits from resident #002's visitor, the home was not doing anything differently to protect the resident from abuse.

The licensee has failed to ensure that resident #002 was protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

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

Issued on this 19th day of September, 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) :	STEPHANIE DONI (681)
Inspection No. / No de l'inspection :	2018_657681_0016
Log No. / No de registre :	017953-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 28, 2018
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Waters Edge Care Community 401 William Street, NORTH BAY, ON, P1A-1X5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Hoss Notarkesh

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, 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. 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 must be compliant with s. 19. (1) of the Long Term Care Homes Act (LTCHA).

Specifically, the licensee must ensure that resident #002 and all other residents, are protected from abuse by anyone.

Grounds / Motifs :

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

A critical incident (CI) report was submitted to the Director related to an allegation of visitor to resident abuse. The CI report indicated that RPN #103 and PSW #113 found resident #002 in an inappropriate condition and the resident was voicing complaints of pain.

Inspector #681 reviewed the home's investigation notes related to the incident, which included a written statement from RPN #103. RPN #103's statement indicated that resident #002 had a visitor and when RPN #103 saw resident #002's visitor leave, they went to check on resident #002 and found them in an inappropriate condition. Resident #002 was also voicing complaints of pain.

During an interview with PSW #108, they stated that resident #002's visitor would visit the home and that they usually visited in a specified area of the home. PSW #108 stated that on the date of the incident, resident #002's visitor visited with the resident in a specified area of the home, as per usual.

During an interview with RPN #103, they stated that resident #002 visited with

their visitor in the specified area of the home on the date of the incident. RPN #103 stated that they saw resident #002's visitor leave and went to check on the resident. RPN #103 stated that the resident was found in an inappropriate condition and that they were complaining of pain.

Inspector #681 reviewed resident #002's current care plan, which indicated that when resident #002's visitor was visiting the home, they were to visit in a different area of the home then where PSW #108 and RPN #103 had observed.

On a particular date and time, Inspector #681 observed resident #002 sitting with their visitor in a specified area of the home (the area identified in the care plan). The Inspector observed that all staff and other residents were in other specified areas of the home.

On another particular date and time, Inspector #681 walked between two specified locations of the home (one area as identified in the care plan). During this time, all staff and residents were in another specified location of the home and Inspector #681 did not see or hear any staff, residents, or visitors.

During an interview with the DOC, they stated that the home did not have enough information to determine what occurred on the date of the incident. However, the DOC stated that the home knew that resident #002's visitor was the last person to interact with resident #002.

During an interview with the Executive Director, they stated that the outcome of the home's investigation was still pending and that the incident was unwitnessed. The Executive Director stated that the only information that the home had was that resident #002 was found in an inappropriate condition. The Executive Director indicated that the home recommended to resident #002's visitor that they only visit the resident in specified areas of the home (one being the same area as identified in the care plan). However, the Executive Director acknowledged that one specified home area (identified in the care plan) was often unoccupied during a particular time of the day. The Executive Director stated that, with the exception of a specified intervention following visits from resident #002's visitor, the home was not doing anything differently to protect the resident from abuse.

The licensee has failed to ensure that resident #002 was protected from abuse by anyone.

The severity of this issue was determined to be a level two, as there was the potential for actual harm to resident #002. The scope of the issue was a level one, as it only related to one resident. The home had a level three compliance history, as they had related non-compliance with this section of the LTCHA that included:

-compliance order (CO) issued September 2, 2016, with a compliance due date (CDD) of November 4, 2016, (#2016_332575_0014). (681)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 14, 2018

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 28th day of August, 2018

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 : Stephanie Doni

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