Ontario

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 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
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 1, 2019	2019_786744_0030	011395-19, 016926-19	Critical Incident System

Licensee/Titulaire de permis

The Board of Management for the District of Manitoulin
70 Robinson Street Postal Bag 460 LITTLE CURRENT ON P0P 1K0

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

Manitoulin Centennial Manor Home for the Aged
70 Robinson Street Postal Bag 460 LITTLE CURRENT ON P0P 1K0

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

STEVEN NACCARATO (744)

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): October 15-17, 2019.

The following intakes were inspected during the Critical Incident System (CIS) inspection:
-One intake related to a critical incident that the home submitted to the Director regarding a fall of a resident resulting in an injury.
-One intake related to a critical incident that the home submitted to the Director regarding alleged staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurse (RN) and residents.

The Inspector also conducted a tour of the resident care areas, reviewed residents' health care records, home policies and procedures, investigation notes, mandatory training records, staff schedules and personnel records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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	Légende 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Neglect is defined in the Ontario Regulation 79/10, as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home submitted a Critical Incident (CI) report to the Director, which indicated that resident #001, #002 and #003 were alleged to have been neglected by Personal Support Worker (PSW) #104. The CI report further indicated that care was not provided for the residents.

A) Inspector #744 reviewed the home's investigation notes of the incident. The notes indicated that PSW #102 reported that care was not provided for resident #001, #002 and #003, on a specified day.

Inspector #744 reviewed the residents' care plans in place at the time of the incident, which indicated that the care not provided was required care for resident #001, #002 and #003.

Inspector #744 interviewed PSW #103 who stated that they observed the missed care for resident #003.

Inspector #744 reviewed resident #003's assessment notes created on the day after the incident, which indicated that the resident had an injury originating on the same day of the assessment.

In an interview with Inspector #744, RPN #107 indicted that they believed the injury of resident #003 was newly acquired as there was no report from the PSW staff of any related injury the day prior. RPN #107 further stated that not providing care was a factor in resident #003 acquiring the injury.

The licensee's policy titled "Zero Tolerance of Resident Abuse and Neglect Program", last updated June 2019, stated that "Extendicare is committed to providing a safe and secure environment in which all residents are treated with dignity and respect and protected from all forms of abuse or neglect at all times. Extendicare has a zero tolerance for abuse and neglect. Any form of abuse or neglect by any person, whether through

deliberate acts or negligence, will not be tolerated. Prevention of abuse and neglect is fundamental to the zero-tolerance program".

Inspector #744 further reviewed the investigation notes and found a letter to PSW #104 from the Director of Care (DOC), which stated that the actions of PSW #104 towards the home's residents could be considered resident neglect.

In an interview with Inspector #744, PSW #104 stated that they had completely neglected resident #002 and attempted care for resident #001 and #003 after observing that they required care; however, PSW #104 stated that they stopped attempting to provide care after resident #001 and #003 exhibited responsive behaviours. PSW #104 further stated that they failed to communicate with staff working on their shift that care was not being completed on all residents.

Inspector #744 interviewed both the DOC and Administrator. The Administrator stated that neglect of residents by PSW #104 was not acceptable. They further stated that PSW #104 should have asked for assistance and utilized the stop and go approach for residents #001, #002, and #003.

B)The licensee's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", last updated June 2019, stated that "Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to most senior Supervisor on shift at that time".

In an interview with Inspector #744, PSW #102 and PSW #103 stated that they had followed the home's policy for reporting neglect and reported the neglect of resident #001, #002 and #003 immediately to RPN #107.

Inspector #744 interviewed RPN #107 who stated that they were notified of the resident neglect early in the morning. They further stated that they considered reporting the incidents to management; however, they did not notify management until later in the day. They also stated that management should have been notified immediately of the neglect, but they were not familiar with the home's policy regarding neglect reporting.

In an interview with Inspector #744, the Administrator stated that they were approached by PSW #002 and PSW #003 and later RPN #107 about the incidents of neglect hours after the incident of neglect was discovered. The Administrator further stated that the

incidents of neglect should have been reported immediately. [s. 20. (1)]

Additional Required Actions:

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

Issued on this 1st day of November, 2019

[redacted]

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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) :	STEVEN NACCARATO (744)
Inspection No. / No de l'inspection :	2019_786744_0030
Log No. / No de registre :	011395-19, 016926-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 1, 2019
Licensee / Titulaire de permis :	The Board of Management for the District of Manitoulin 70 Robinson Street, Postal Bag 460, LITTLE CURRENT, ON, P0P-1K0
LTC Home / Foyer de SLD :	Manitoulin Centennial Manor Home for the Aged 70 Robinson Street, Postal Bag 460, LITTLE CURRENT, ON, P0P-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tamara Beam

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To The Board of Management for the District of Manitoulin, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the Long-Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee must:

a) The licensee shall ensure that the home's policy to promote zero tolerance of abuse and neglect is complied with by all staff, and that all residents are protected from further neglect by PSW #104.

b) Provide re-education to PSW #104 and RPN #107 on the home's zero tolerance of abuse policy, and education specific to the regulatory requirement to report abuse/neglect.

c) Maintain a documented record of the education provided, including the content of the education, when it occurred, and who provided the education.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Neglect is defined in the Ontario Regulation 79/10, as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home submitted a Critical Incident (CI) report to the Director, which indicated that resident #001, #002 and #003 were alleged to have been neglected by Personal Support Worker (PSW) #104. The CI report further indicated that care was not provided for the residents.

A) Inspector #744 reviewed the home's investigation notes of the incident. The notes indicated that PSW #102 reported that care was not provided for resident #001, #002 and #003, on a specified day.

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In an interview with Inspector #744, the Administrator stated that they were approached by PSW #002 and PSW #003 and later RPN #107 about the incidents of neglect hours after the incident of neglect was discovered. The Administrator further stated that the incidents of neglect should have been reported immediately.

The severity of the issue was determined to be a level three as there was actual harm or actual risk to the residents. The scope of the issue was a level three; widespread, as it was related to three out of three residents reviewed. The home had a level three compliance history, as they had previous non-compliance with the same section of the LTCHA, including:
- Compliance Order (CO), on May 11, 2017, compliance due date (CDD) June 8, 2017, cited in inspection report 2017_565612_0008.

(744)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 22, 2019

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 1st day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Steven Naccarato

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