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

Ministère de la Santé et des Soins de longue durée

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANA STENLUND (163)
Inspection No. / No de l'inspection :	2013_139163_0017
Log No. / Registre no:	S-000188-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 14, 2013
Licensee / Titulaire de permis :	MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED BOARD OF MANAGEMENT 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 :	CAROL MCIIVEEN

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

To MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED BOARD OF MANAGEMENT, 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. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee has shall ensure that the care (monitoring) of resident #188 as set out in their plan of care is provided to the resident as specified in the plan.

Grounds / Motifs :

1. A WN was previously issued during inspection #2011-099188-0028 in Nov 2011, and a WN and VPC during inspection #2013-139163-0006 in Mar 2013 with regards to s.6(7) of the Act.

Inspector noted from the health care records that during a four month period, resident #188, who has a diagnosis of dementia, had a documented history of sexual abuse towards other female residents and staff. Critical Incident (CI) documentation from that time period indicates that staff found a female resident with dementia calling for help, and observed that resident #188 was being sexually abusive toward that resident. The Critical Incident report and the resident's #188 plan of care outlines that the action taken by the home as a result of this occurrence included scheduled monitoring of resident #188. A subsequent incident of sexual abuse between resident #188 involving another female resident was documented about a week after the CI was reported to the Ministry. Inspector interviewed several staff including registered nurses, registered practical nurses, personal support workers and management about the monitoring outlined in the resident's health care record. All of the staff interviewed confirmed that the monitoring of resident #188 was not implemented as outlined in their plan of care. The licensee has not ensured the care set out in the plan of care is provided to the resident as specified in the plan. (163)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 17, 2013

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

Ministère de la Santé et des Soins de longue durée

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

Order # /
Ordre no : 002

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

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 prepare, submit and implement a plan to ensure that residents are protected from sexual abuse by resident #188. The plan is to be submitted to Diana Stenlund, Inspector, Ministry of Health and Long-Term Care, by June 18, 2013 (fax# 705-564-3133).

Grounds / Motifs :

1. Inspector reviewed a Critical Incident (CI) involving resident #188 who sexually abused a female resident. The female resident with dementia was found calling for help and resident #188 was observed being sexually abusive toward that resident. Inspector reviewed the health care record for resident #188 during a four month time period leading up to the date of the CI and noted that there were several documented incidents of sexual abuse toward other female residents. The inspector noted that the licensee did not take steps to protect other residents from sexual abuse during that time. The inspector also noted from the health care record that resident #188 was involved in another incident of sexual abuse toward a different female resident about a week after the CI was reported. The licensee has not ensured that residents are protected from sexual abuse by resident #188 (163)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 18, 2013

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.

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

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 14th day of June, 2013

Signature of Inspector / Signature de l'inspecteur : Diana Stenlund, #163

Name of Inspector / Nom de l'inspecteur : DIANA STENLUND

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
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 # / Registre no	Type of Inspection / Genre d'inspection
Jun 14, 2013	2013_139163_0017	S-000188-13	Critical Incident System

Licensee/Titulaire de permis

MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED BOARD OF MANAGEMENT
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

DIANA STENLUND (163)

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): June 6-7, 2013

During the course of the inspection, the inspector(s) spoke with acting Administrator, administrative staff, registered nursing staff, and personal support workers (PSWs)

During the course of the inspection, the inspector(s) walked through resident home areas, reviewed health care records and critical incident documentation, and observed resident behaviour.

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

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector noted from the health care records, that during a four month period, resident #188, who has a diagnosis of dementia, had a documented history of sexual abuse towards other female residents and staff. Critical Incident (CI) documentation from that time period indicates that staff found a female resident with dementia calling for help, and observed that resident #188 was being sexually abusive toward that resident. The Critical Incident report and the resident's #188 plan of care outlines that the action taken by the home as a result of this occurrence included scheduled monitoring of resident #188. A subsequent incident of sexual abuse between resident #188 involving another female resident was documented about a week after the CI was reported to the Ministry. Inspector interviewed several staff including registered nurses, registered practical nurses, personal support workers and management about the monitoring outlined in the resident's health care record. All of the staff interviewed confirmed that the monitoring of resident #188 was not implemented as outlined in their plan of care. The licensee has not ensured the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

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. 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. Inspector reviewed a Critical Incident (CI) involving resident #188 who sexually abused a female resident. The female resident with dementia was found calling for help and resident #188 was observed being sexually abusive toward that resident. Inspector reviewed the health care record for resident #188 during a four month time period leading up to the date of the CI and noted that there were several documented incidents of sexual abuse toward other female residents. The inspector noted that the licensee did not take steps to protect other residents from sexual abuse during that time. The inspector also noted from the health care record that resident #188 was involved in another incident of sexual abuse toward a different female resident about a week after the CI was reported. The licensee has not ensured that residents are protected from sexual abuse by resident #188. [s. 19. (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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. Inspector reviewed a Critical Incident (CI) involving resident #188 with regards to sexual abuse toward another female resident. During a four month period leading up to the date of the CI, there were several documented incidents where resident #188 sexually abused other female residents. Inspector and a management staff personnel reviewed the health care record for resident #188 and were unable to identify that prior to the CI, the home took steps to minimize the risk of such interactions between resident #188 and other residents; including identifying factors that could trigger such altercations and identifying and implementing interventions for such behaviours. The licensee has not ensured that steps are taken to minimize potentially harmful interactions between and among residents including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and identifying and implementing interventions. [s. 54. (b)]

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 steps are taken to minimize the risk of potentially harmful interactions, sexual in nature, between resident #188 and other residents, including identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and identifying and implementing interventions, to be implemented voluntarily.

Issued on this 3rd day of July, 2013

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

Diana Sturlund, #163