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 403
SUDBURY, ON, P3E-6A5
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Bureau régional de services de Sudbury
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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
Sep 10, 2014	2014_376594_0008	S-000282-14	Complaint

Licensee/Titulaire de permis

584482 ONTARIO INC
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

MANITOULIN LODGE
3 MAIN STREET, P. O. BOX 648, GORE BAY, ON, P0P-1H0

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

MONIKA GRAY (594)

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): July 28 and 29, 2014

This inspection was conducted concurrently with Follow Up inspection 2014_376594_0009.

During the course of the inspection, the inspector(s) spoke with Residents (including resident involved in the critical incident) Personal Support Workers (PSWs), Registered Practical Nurse (RPN), Director of Care (DOC)and the Administrator.

During the course of the inspection, the inspector(s) conducted a daily walk through of the resident care areas, observed staff to resident interactions, reviewed resident health care records, reviewed the home's Abuse policy, reviewed an employee record and reviewed some policies and procedures.

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 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 resident #001 was protected from abuse by anyone in the home in that on June 10, 2014 a critical incident reported to the Director stated that resident #001 was heard shouting "get out of here" by staff #S-103. Staff #S-103 entered resident #001's room and found staff #S-100 and #S-102, and heard resident #001 shout "I hate you" and staff #S-100 reply "I hate you too".

The inspector reviewed staff #S-100 employee record which identified a previous alleged abuse incident in 2013 by staff #S-100 toward resident #001, where staff #S-100 was alleged to have hit resident #001. This critical incident was reported to the Director in 2013 and stated action taken to prevent recurrence, 'staff #S-100 to work with their assigned co-worker and have the assigned co-worker provide care to resident #001 to avoid any further issues.' Further review of staff #S-100 employee record by the inspector, identified a positive Vulnerable Sector Screening search which was obtained after staff #S-100 was hired.

Given a positive criminal reference check, a previous alleged abuse incident toward resident #001 in 2013 and a witnessed abuse incident toward resident #001 on June 10, 2014, the licensee did not ensure resident #001 was protected from abuse by staff #S-100. [s. 19. (1)]

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 O.Reg 79/10, s. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (1) This section applies where a criminal reference check is required before a licensee hires a staff member or accepts a volunteer as set out in subsection 75 (2) of the Act. O. Reg. 79/10, s. 215 (1).

Findings/Faits saillants :

1. The inspector reviewed staff #S-100 employee record which identified a positive Vulnerable Sector Screening search. The licensee failed to ensure a criminal reference check is required before hiring a staff member. Staff #S-100 was hired in January 2013 and their criminal reference check was dated March 2013. The DOC validated that the criminal reference check was obtained after hiring staff #S-100. [s. 215. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. Inspector reviewed the health care record for resident #001 for the period of June 01, 2014 to June 30, 2014 for documentation related to a critical incident reported to the Director. There was no documentation related to an incident of abuse toward resident #001 by staff #S-100 on June 10, 2014 within the resident record.

On July 29, 2014 Inspector interviewed the DOC who verified that no documentation was completed in resident #001's health care record related to the June 10, 2014 incident and confirmed incidents involving resident care are to be documented in the resident record.

Inspector reviewed the home's policy titled Resident Rights, Care and Services – Zero Tolerance – Staff Acknowledgement, which states, 'not but limited to, upon receiving a report of resident abuse or neglect, the Administrator or Director of Care will complete thorough documentation in the resident's record'.

The licensee failed to ensure that resident #001's written record was kept up to date at all times. [s. 231. (b)]

Issued on this 12th day of September, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
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) :	MONIKA GRAY (594)
Inspection No. / No de l'inspection :	2014_376594_0008
Log No. / Registre no:	S-000282-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 10, 2014
Licensee / Titulaire de permis :	584482 ONTARIO INC 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	MANITOULIN LODGE 3 MAIN STREET, P. O. BOX 648, GORE BAY, ON, P0P-1H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DEBBIE WRIGHT

To 584482 ONTARIO INC, 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)

Linked to Existing Order / Lien vers ordre existant: 2014_376594_0005, CO #001;

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 ensure a criminal reference check is completed and provided to the home prior to the licensee hiring a staff member or accepting a volunteer, and shall ensure that education on the homes abuse policy is provided to all staff.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was protected from abuse by anyone in the home in that on June 10, 2014 a critical incident reported to the Director stated that resident #001 was heard shouting "get out of here" by staff #S-103. Staff #S-103 entered resident #001's room and found staff #S-100 and #S-102, and heard resident #001 shout "I hate you" and staff #S-100 reply "I hate you too".

The inspector reviewed staff #S-100 employee record which identified a previous alleged abuse incident in 2013 by staff #S-100 toward resident #001, where staff #S-100 was alleged to have hit resident #001. This critical incident was reported to the Director in 2013 and stated action taken to prevent recurrence, 'staff #S-100 to work with their assigned co-worker and have the assigned co-worker provide care to resident #001 to avoid any further issues.' Further review of staff #S-100 employee record by the inspector, identified a positive Vulnerable Sector Screening search which was obtained after staff #S-100 was hired.

Given a positive criminal reference check, a previous alleged abuse incident toward resident #001 in August 2013 and a witnessed abuse incident toward resident #001 on June 10, 2014, the licensee did not ensure resident #001 was protected from abuse by staff #S-100. (594)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 17, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 10th day of September, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Monika Gray

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