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 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 # / Registre no	Type of Inspection / Genre d'inspection
May 9, 2016	2016_333577_0005	001645-16	Resident Quality Inspection

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

DEBBIE WARPULA (577), JENNIFER LAURICELLA (542), KATHERINE BARCA (625)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 8, 9, 10, 11, 12, 15, 16, 17, 18, 2016.

Follow up inspection for three previous Compliance Orders, issued on October 23, 2015, with a compliance date of November 23, 2015, was conducted concurrently with this RQI.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Manager of housekeeping, laundry and dietary, Registered Nurses (RN), Registered Practical Nurses (RPN), Staff Educator, Environmental Services Supervisor, Restorative Care Coordinator, housekeeping staff, laundry staff, Personal Support Workers (PSW), Residents and Family Members.

The inspector(s) conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed resident health care records, and reviewed homes policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #003	2015_380593_0024	577
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2015_380593_0024	577
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #002	2015_380593_0024	577

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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 a person who had reasonable grounds to suspect that abuse of a resident by anyone occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A Critical Incident report (CI) was submitted to the Director in March 2015, in relation to staff to resident abuse that occurred in February 2015. The report indicated that resident #002 reported to RN #103 that PSW #117 chastised them when they requested assistance. The report also identified that RN #103 had been required to report the incident immediately but had not done so.

The home's policy titled "Resident Rights, Care and Services-Abuse" last revised March 26, 2015, indicated that suspected and/or confirmed allegations of abuse should be reported immediately, when the Administrator or Director of Care were not in the home, the Charge Nurse would initiate the MOHLTC Critical Incident Report. The policy also stated that, upon receiving a report of suspected or actual abuse, the Administrator or Director of Care would immediately notify the MOHLTC and initiate a MOHLTC Critical Incident Report.

A review of RN #103's employee file included a letter related to the March 2015 incident, signed by the home's previous Administrator #111, which indicated, as Charge Nurse, RN #103 was responsible to report abuse immediately.

During an interview with Inspector #625 in February 16, 2016, the current Administrator confirmed that the incident of staff to resident abuse occurred in February 2015, at a time when the Administrator and Director of Care were not present in the home. The Administrator also stated that RN #103 reported the incident to the home's Director of Care in writing in February 2015, but the Director of Care did not receive the letter until they returned to work. At that time, the Director was notified of the incident by the report being submitted, 64 hours after the incident had been reported to RN #103. [s. 24. (1)]

2. During an interview with Inspector #542 on February 9, 2016, resident #005 stated that a staff member bullied and embarrassed them while taking an object away from them.

A review of the health care records for resident #005 revealed a progress note dated December 2015, for an incident that occurred in December 2015, which indicated that resident #005 reported to RN #116 they were upset because a PSW grabbed an object from the resident’s hand without asking them. The note indicated that the resident stated they were bullied by the PSW and were embarrassed in front of other residents. A progress note dated December 2015, revealed that resident #005 complained to RN #116 about the incident that occurred the previous evening.

During an interview on February 18, 2016, the Administrator stated to Inspectors #542 and #577 that they became aware of the December 2015 incident a few days later, when reviewing shift report progress notes and, in December 2015, they spoke to the resident and recorded their discussion, but did nothing further. The Administrator acknowledged that the alleged incident of abuse should have been reported immediately and was not reported until February 2016, after discussion with inspectors. [s. 24. (1)]

3. During a review of the home’s concern and complaints binder, a Concern/Complaint Form was found dated October 2015, which indicated that resident #009 had reported concerns of events that occurred in October 2015, to the Education Coordinator #111 as follows:

-PSW #109 argued with the resident about a treatment and made the resident feel “small and stupid”;

-PSW #109 brought the resident a beverage during the evening and did not offer the resident a choice;

-PSW #109 had thrown a towel towards the resident that landed on their chest;

-PSW #109 banged the resident's legs on the dresser during the transfer of the resident into bed; and

-the resident wanted to go to bed at 1800hr but PSW #109 did not assist the resident into bed until 1930hr.

The Concern/Complaint Form was signed by the Administrator and indicated that the form had been received by the Administrator in October 2015.

During an interview with Inspector #625 on February 18, 2016, the Administrator confirmed that they had been aware of the allegations of abuse made by resident #009 in October 2015, but had not reported the allegations to the Director.

Non-related non-compliance has been previously identified.

The decision to issue this compliance order was based on the scope which was a pattern as three residents were affected, the severity which indicates potential for actual harm. [s. 24. (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. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM, if payment was required.

During the inspection, numerous residents were identified as having dental care issues, specifically resident #005, #015 and #023.

A review of the health care records for all three residents was completed and Inspector #542 was unable to locate any annual dental assessments or other preventative dental services.

During an interview with Education Coordinator #111 and the Administrator, they confirmed that the home does not offer annual dental assessments and other preventive dental services to the residents. [s. 34. (1) (c)]

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 each resident of the home receives oral care to maintain the integrity of the oral tissue that includes an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident’s substitute decision-maker, if payment is required, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of resident #007's progress notes revealed that the resident had multiple falls from January 2015 to February 2016.

During an interview with the DOC they indicated that the paper post fall assessment tool was the home's clinical instrument which was to be completed after every fall and filed in the paper chart. They indicated that a fall was considered the condition or circumstance where a resident would require a post-fall assessment to be completed using a clinically appropriate assessment instrument.

During an interview with Restorative Care Coordinator #121, the Lead for the falls program, they indicated that the post fall assessment tool was the home's clinical tool and was to be completed after every fall and filed in the paper chart.

A review of the health records for resident #007 revealed 59% of the post fall assessment tool forms were completed. The resident did not have a post fall assessment using a clinical instrument on the following dates:
-a day in July 2015
-a day in August 2015
-a day in September 2015
-a day in October 2015
-a day in November 2015
-two days in December 2015
-a day in January 2016

A review of the home's policy "Falls Prevention and Management Program", last revised November 11, 2014, found that residents would have a reassessment post fall and, where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. Additionally the results of the post fall worksheet were to be included in the falls incident note and a completed falls incident progress note was to be completed.

During an interview with the DOC and Administrator, they confirmed that registered staff are responsible for transcribing the assessment information from the post fall assessment tool into a fall incident note. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, specifically for resident #007, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents’ Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents’ Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents’ Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Residents’ Council advice related to concerns or recommendations.

During an interview on February 16, 2016, with Inspector #625, the Administrator stated the the Life Enrichment Coordinator #122, who was the Residents' Council Assistant, recorded the meetings and completed the meeting minutes for the council. The Administrator provided the Residents' Council Meeting minutes with letters of response signed by the Administrator to each set of minutes to Inspector #625.

A review of the Residents’ Council Meeting Minutes dated November 2015, identified dietary concerns including:

-tea and coffee not always being hot; and

-the residents' request for another jam container to be purchased and to make sure that

the containers were kept full as they would often run out of peanut butter.

The response letter from the Administrator to the concerns brought forward in the November 2015, Residents' Council Meeting minutes was dated December 2015, and did not address the Residents' Council concerns related to the tea and coffee not always being hot, jam containers not being kept full and running out of peanut butter.

A review of the Residents' Council Meeting Minutes dated December 2015, identified the following resident concerns:

-continued and new concerns about tea and coffee not always being hot;

-residents requested more choices of fresh fruits;

-residents requested jam containers to be full before sending them into the dining room as they often ran out of peanut butter; and

-new clothing protectors were defective and many had snaps that did not work.

The response letter from the Administrator to the concerns brought forward in the December 2015, Residents' Council Meeting minutes was dated December 2015, and did not address the Residents' Council concerns or recommendations regarding dietary items, but wrote that the Food Services Manager would respond to the concerns about food choice through the Food Committee Meeting minutes. The letter did not include a reply specific to the concerns that the Residents' Council Committee had identified in the December 2015, meeting minutes.

During an interview on February 17, 2016, with Inspector #625, the Administrator confirmed that not all items identified as concerns or recommendations by residents during the November 30 and December 21, 2015, Residents' Council Meeting minutes had been responded to in writing, including concerns specific to cold coffee and tea, the availability of peanut butter and the defective clothing protectors. [s. 57. (2)]

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 if the Residents' Council has advised the licensee of concerns or recommendations, the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Inspector #625 reviewed the Family Council Meeting Minutes and written response letters from the Administrator to the concerns and recommendations identified in the meeting minutes.

The Family Council Meeting Minutes dated November 2015, identified concerns including the noise level of the TV in the small lounge area being too loud during the evenings and staff speaking loudly during report.

The response letter from the Administrator regarding the concerns brought forward in the Family Council Meeting Minutes was dated November 2015, and did not address the concerns related to the noise of the TV and noise during staff report, in writing.

A review of the Family Council Meeting Minutes dated December 2015, identified

concerns including:

-a strong odour that was embarrassing for residents and suggested cleaning the couch and chair cushions regularly to address the odour and remove food stains;

-providing a place to set dishes during snack times;

-checking the functionality of the charcoal deodorizers and focusing more attention on bathroom cleanliness; and

-some rooms being too hot when room doors were closed.

The response letter from the Administrator regarding the concerns brought forward in the December 2015, Family Council Meeting Minutes was dated December 2015. It did not address the specific concerns or recommendations made by the Family Council about the strong odour and food stains, where the recommendation to clean the couches regularly to address these items was made. Rather the response indicated that quarterly cleaning of cushions occurred but did not identify how the concerns that were presented with the current quarterly cleaning schedule would be addressed. In addition, the council's request for the provision of a place to set dishes during snack times, the recommendation to check to ensure charcoal air deodorizers were functional and the temperature of rooms when doors were closed were also not addressed.

During an interview the Administrator, they confirmed that the response letter to Family Council dated November 2015, did not address the noise concerns identified in the Family Council Meeting Minutes. The Administrator also confirmed that the response letter to Family Council dated December 2015, did not address all of the concerns and suggestions including a place to put snacks when sitting on couches to avoid spills, checking the operation of charcoal air fresheners in bathrooms, or the hot temperature experienced in rooms with closed doors. [s. 60. (2)]

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 if the Family Council has advised the licensee of concerns or recommendations, the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the rights of residents were fully respected and promoted, specifically that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity.

During an interview with resident #002 they revealed that in February 2015, they had needed to use the washroom urgently and asked a staff member for assistance. The staff member responded by berating the resident.

A Critical Incident report was submitted for an incident of staff to resident abuse that occurred in February 2015, which indicated that PSW #117 chastised resident #002 by speaking to the resident inappropriately, when they requested assistance.

A review of interview notes made by the previous Administrator #111 of the incident that occurred in February 2015, confirmed the information provided by resident #002 to Inspector #625 during the February 10, 2016, interview. The interview notes also indicated that Administrator #111 discussed with PSW #117 that they had spoken to resident #002 inappropriately and that actions had been taken to address the incident. [s. 3. (1) 1.]

Issued on this 9th day of June, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére 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) : DEBBIE WARPULA (577), JENNIFER LAURICELLA (542), KATHERINE BARCA (625)

Inspection No. / No de l'inspection : 2016_333577_0005

Log No. / Registre no: 001645-16

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : May 9, 2016

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 : Lee Turley

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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)

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 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. c. 8, s. 24 (1), 195 (2).

Grounds / Motifs :

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

A Critical Incident report (CI) was submitted to the Director in March 2015, in relation to staff to resident abuse that occurred in February 2015. The report indicated that resident #002 reported to RN #103 that PSW #117 chastised them when they requested assistance. The report also identified that RN #103 had been required to report the incident immediately but had not done so.

The home's policy titled "Resident Rights, Care and Services-Abuse" last

revised March 26, 2015, indicated that suspected and/or confirmed allegations of abuse should be reported immediately, when the Administrator or Director of Care were not in the home, the Charge Nurse would initiate the MOHLTC Critical Incident Report. The policy also stated that, upon receiving a report of suspected or actual abuse, the Administrator or Director of Care would immediately notify the MOHLTC and initiate a MOHLTC Critical Incident Report.

A review of RN #103's employee file included a letter related to the March 2015 incident, signed by the home's previous Administrator #111, which indicated, as Charge Nurse, RN #103 was responsible to report abuse immediately.

During an interview with Inspector #625 in February 16, 2016, the current Administrator confirmed that the incident of staff to resident abuse occurred in February 2015, at a time when the Administrator and Director of Care were not present in the home. The Administrator also stated that RN #103 reported the incident to the home's Director of Care in writing in February 2015, but the Director of Care did not receive the letter until they returned to work. At that time, the Director was notified of the incident by the report being submitted, 64 hours after the incident had been reported to RN #103. [s. 24. (1)] (625)

2. During an interview with Inspector #542 on February 9, 2016, resident #005 stated that a staff member bullied and embarrassed them while taking an object away from them.

A review of the health care records for resident #005 revealed a progress note dated December 2015, for an incident that occurred in December 2015, which indicated that resident #005 reported to RN #116 they were upset because a PSW grabbed an object from the resident's hand without asking them. The note indicated that the resident stated they were bullied by the PSW and were embarrassed in front of other residents. A progress note dated December 2015, revealed that resident #005 complained to RN #116 about the incident that occurred the previous evening.

During an interview on February 18, 2016, the Administrator stated to Inspectors #542 and #577 that they became aware of the December 2015 incident a few days later, when reviewing shift report progress notes and, in December 2015, they spoke to the resident and recorded their discussion, but did nothing further. The Administrator acknowledged that the alleged incident of abuse should have been reported immediately and was not reported until

February 2016, after discussion with inspectors. [s. 24. (1)]
(625)

3. During a review of the home's concern and complaints binder, a Concern/Complaint Form was found dated October 2015, which indicated that resident #009 had reported concerns of events that occurred in October 2015, to the Education Coordinator #111 as follows:

-PSW #109 argued with the resident about a treatment and made the resident feel "small and stupid";

-PSW #109 brought the resident a beverage during the evening and did not offer the resident a choice;

-PSW #109 had thrown a towel towards the resident that landed on their chest;

-PSW #109 banged the resident's legs on the dresser during the transfer of the resident into bed; and

-the resident wanted to go to bed at 1800hr but PSW #109 did not assist the resident into bed until 1930hr.

The Concern/Complaint Form was signed by the Administrator and indicated that the form had been received by the Administrator in October 2015.

During an interview with Inspector #625 on February 18, 2016, the Administrator confirmed that they had been aware of the allegations of abuse made by resident #009 in October 2015, but had not reported the allegations to the Director.

Non-related non-compliance has been previously identified.

The decision to issue this compliance order was based on the scope which was a pattern as three residents were affected, the severity which indicates potential for actual harm. [s. 24. (1)] (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 16, 2016

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
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 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 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 9th day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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