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
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 # / Registre no	Type of Inspection / Genre d'inspection
Jul 2, 2014	2014_376594_0005	S-000212-14	Critical Incident System

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

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

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 16, 17, 18, 2014.

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

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 employee education training related to 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

Findings of Non-Compliance were found during this inspection.

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. 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. According to a critical incident report submitted to the Director in May 2014, resident #001 reported they no longer wanted staff #S-100 providing care to them as this staff member was leaving bruises on their hands, pushed them onto the bed telling them to stay there and stating the staff member was domineering.

On June 17, 2014 resident #001 told the inspector that staff #S-100 was very forceful and wouldn't leave when asked by resident #001.

The inspector reviewed staff #S-100 employee record and found three previous resident or family complaints/concerns, relating to staff #S-100 verbal and physical approach with residents dated from 2001, 2012 and 2013.

Staff #S-100 has received a counselling session in 2013, an oral reminder (Step 1) in 2012 and a written reminder (Step 2) in 2012 all related to their approach with residents and performance. Staff #S-100 has reviewed DVD "One is One too Many" about abuse, reviewed and signed Abuse Policy and Residents' Bill of Rights after the counselling session in 2013. Staff #S-100 attended "Gentle Persuasion Approach" staff training in 2014 and "Abuse & Neglect in LTC Setting" staff training in 2014.

Staff #S-100 was issued a letter after the incident in May 2014 identified as 'Decision Making Leave - 3 day Suspension Re: Job Performance'. This letter stated "it is evident that you have had incidents in the past where your verbal and non-verbal communications could be considered verbally abusive."

Documented meeting minutes from June 2014, between staff #S-100 and DOC identified that when staff #S-100 was asked what they learned from incident in May 2014, staff #S-100 stated there was no bad approach with resident #001 and can't think of anything they would have changed about the situation.

A review of resident #001 care plan was completed by inspector. It indicated "If resident #001 refuses care, leave and return 5-10 minutes, allow for flexibility in ADL routine to accommodate resident #001 mood".

Despite, staff #S-100 receiving counselling, an oral reminder, a written reminder related to their approach with residents and performance, and education regarding Residents' Bill of Rights, the home's Abuse Policy and Gentle Persuasion Approach, prior to the incident in May 2014, it failed to alter the approach staff #S-100 used with resident #001.

The licensee did not ensure that resident #001 was protected from abuse by staff member #S-100. [s. 19. (1)]

Additional Required Actions:

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

Issued on this 7th day of July, 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_0005
Log No. / Registre no:	S-000212-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 2, 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:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that residents are protected from abuse by staff.
This plan is to be submitted to:
Attention: Monika Gray (594), Inspector - Nursing
Sudbury Service Area Office
Ministry of Health and Long-Term Care Performance Improvement and Compliance Branch
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Fax 705.564.3133 by Thursday July 17, 2014

Grounds / Motifs :

1. According to a critical incident report submitted to the Director in May 2014, resident #001 reported they no longer wanted staff #S-100 providing care to them as this staff member was leaving bruises on their hands, pushed them onto the bed telling them to stay there and stating the staff member was domineering.

On June 17, 2014 resident #001 told the inspector that staff #S-100 was very forceful and wouldn't leave when asked by resident #001.

The inspector reviewed staff #S-100 employee record and found three resident or family complaints/concerns, relating to staff #S-100 verbal and physical approach with residents from 2001, 2012, and 2013.

Staff #S-100 has received a counselling session in 2013, an oral reminder in 2012 and a written reminder in 2012 all related to their approach with residents and performance. Staff #S-100 has reviewed DVD "One is One too Many"

about abuse, reviewed and signed Abuse Policy and Residents' Bill of Rights after the counselling session in 2013. Staff #S-100 attended "Gentle Persuasion Approach" staff training and "Abuse & Neglect in LTC Setting" staff training in 2014.

Staff #S-100 was issued a letter after the incident in May 2014 identified as 'Decision Making Leave - 3 day Suspension Re: Job Performance'. This letter stated "it is evident that you have had incidents in the past where your verbal and non-verbal communications could be considered verbally abusive."

Documented meeting minutes, from June 2014 between #S-100 and DOC identified that when #S-100 was asked what they learned from incident in May 2014, staff #S-100 stated there was no bad approach with resident #001 and can't think of anything they would have changed about the situation.

A review of resident #001 care plan was completed by inspector. It indicated "If resident #001 refuses care, leave and return 5-10 minutes, allow for flexibility in ADL routine to accommodate resident #001 mood".

Despite staff #S-100 receiving counselling, an oral reminder, a written reminder related to their approach with residents and performance, and education regarding Resident's Bill of Rights, the home's Abuse Policy and Gentle Persuasion Approach, prior to the incident in May 2014, it failed to alter the approach staff #S-100 used with resident #001. (594)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 25, 2014

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

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.

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

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 2nd day of July, 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