Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 24, 25, 27, 31, Feb 1, 2, 14, 16, 21, 22, 27, 28, Mar 5, 13, 15, 20, 26, 2012	2012_027192_0001	Complaint

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

COOKSVILLE CARE CENTRE
55 THE QUEENSWAY WEST, MISSISSAUGA, ON, L5B-1B5

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

DEBORA SAVILLE (192), LALEH NEWELL (147)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with family member, residents, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nurse Practitioner, Recreation Manager, Nurse Clinician, Administrator, Director of Nursing (DON) and the Dietitian in relation to H-000157-12.

During the course of the inspection, the inspector(s) reviewed medical records, incident reports, policy and procedure,and observed resident home areas.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Responsive Behaviours

Skin and Wound Care

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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an alleged, and witnessed incident, of abuse of a resident by another resident, that was reported to the licensee, was immediately investigated. [s. 23. (1)(a)]

a) On a specified date in 2011, a specified resident, who was incapable of consenting to a sexual act, was observed by a Personal Support Worker with genitals exposed and being touched by a specified co-resident. The charge nurse informed the management team of the incident before lunch on the same day. The family was notified of the incident on the specified date in 2011 and alleged the incident constituted abuse. The Police were informed of the incident, the same day as requested by the family.
No immediate investigation was initiated by the licensee.

b) Interview with staff and management confirms that no investigation into the incident was conducted by the home until following a complaint from the family received in 2012. The staff member observing the incident had not been interviewed by the licensee as of February 1, 2012.

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 subsections:

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 a resident of the home was protected from abuse by another resident. [s. 19. (1)]

a) On a specified date in 2011, a specified resident who was incapable of consenting to a sexual act, was observed by a Personal Support Worker with genitals exposed and being touched by a specified co-resident. The charge nurse made the management team aware of the incident before lunch on the same day. The police were not notified of the incident until family requested that police be notified of the alleged abuse on the specified date in 2011.

b) A specified resident exhibits responsive behaviours. Re-assessment of the specified resident confirms the ongoing presence of these behaviours; no new interventions were initiated. Intervention in effect on a specified date in 2011 were ineffective in protecting a specified co-resident from having genitals exposed and being touched by the specified resident.

c) A specified resident was known to wander. The resident was to be monitored every 30 minutes and behaviour to be recorded on the Dementia Observation Sheet (DOS). DOS records initiated prior to a specified incident were not consistently completed and monitoring every 30 minutes was not effective in preventing the specified resident from wandering into a co-resident's room where the resident was found with genitals exposed and being touched by the co-resident.

Identified resident's both demonstrated behaviours that the licensee was aware of. Interventions in place were ineffective in protecting a specified resident from abuse.

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. [s. 3. (1) 11. iv]

a) A specified resident did not have Personal Health Information (PHI) kept confidential in accordance with the Personal Health Information Protection Act, 2004. Interview and documentation provided by the family confirmed that information regarding a resident of the home was disclosed to members of the family who do not have authority to have this information. The family identified the resident by name, were aware of the diagnosis and behaviours exhibited by the resident and indicated this information was obtained through discussion with staff of the home. Interviews with staff and management confirmed that PHI for the specified resident was given to the family but the source of that information could not be confirmed.

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 with the requirement to fully respect and promote every resident's right to be protected from abuse and every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act, to be implemented voluntarily.

WN #4: 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 subsections:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective. [s. 6. (10) (c)]

On a specified date in 2011, a specified resident, who was incapable of consenting to a sexual act, was observed by a Personal Support Worker with genitals exposed and being touched by a specified co-resident.

a) A specified resident demonstrated behaviours frequently throughout the day. This behaviour was observed during the period of the inspection and staff interviewed confirm that the specified resident frequently exhibited these behaviours. Resident Assessment Protocol's (RAP) completed on October 19, 2011 and repeated in the RAP completed January 15, 2012 indicate that the behaviour remains a concern. In spite of the incident on a specified date in 2011 and reassessment of the ongoing behaviour, revision of the plan of care was not completed.

b) A specified resident exhibited behaviours of persistent anger 14 of 31 days in December 2011 and socially inappropriate behaviour 19 of 31 days in December 2011. Staff interviewed confirm that the resident frequently exhibits inappropriate behaviour. The Resident Assessment Protocol summary completed June 16, 2011, September 16, 2011 and December 15, 2011 contain the same information, in spite of ongoing behaviours and ineffective interventions. The plan of care for the resident indicates resistance to care and inappropriate behaviours. The plan was not revised, when behaviours that may put other residents at risk continued to be present during the most recent plan of care review completed in 2012.

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 ensuring that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

WN #5: 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 subsections:

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, ss. 24 (1), 195 (2).

Findings/Faits saillants :

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; 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. [s. 24. (1) 2]

a) On a specified date in 2011, a specified resident, who was incapable of consenting to a sexual act, was observed by a Personal Support Worker with genitals exposed and being touched by a specified co-resident. The charge nurse made the management team aware of the incident before lunch on the same day. The family alleged abuse and the Police were notified of the incident by management staff.
The incident was not reported to the Director until a specified date in 2012 when a voice message and critical incident report were received.

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 ensuring that abuse of a resident by anyone is reported immediately to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with. [r. 8. (1) (b)]

a) The home's policy "Abuse or Neglect Policy" P-10 states:

i) "Where resident abuse or neglect is suspected - the home must investigate the incident immediately while witnesses are readily available."

The home failed to immediately initiate an investigation into the incident of witnessed sexual abuse. On a specified date in 2011, a specified resident was observed by a Personal Support Worker with genitals exposed and being touched by a specified co-resident.

ii) "The investigation must include interviewing all witness and obtaining written statements."

Witnesses to the incident between specified residents that occurred on a specified date in 2011 were not interviewed immediately by the home and written statements have not been obtained. The primary witness to the incident had not been interviewed by the home as of February 1, 2012

b) The homes Skin and Wound Program states:

i) "The expectation is that the Personal Support Worker (PSW) will be checking the skin twice daily and signing off the skin assessment form indicating the site that they have identified and to bring it to the registered staff's attention. The Registered Staff will complete their weekly electronic documentation of the skin assessment on the residents who have areas of concern or skin breakdown as identified by the PSW's."

Documentation review and interview confirm that a specified resident had no Twice Daily Skin Checklist completed for a specified month in 2012. The specified resident sustained a skin tear that was brought to the attention of the registered staff by a family member on a specified date in 2012. The Registered staff did not complete weekly assessment of the area of altered skin integrity identified for the specified resident.

In 2011 a specified resident sustained a skin tear and on another date in 2011 sustained two skin tears. No weekly assessment of these areas of altered skin integrity were completed by registered staff.

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 ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The home failed to ensure residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) A specified resident sustained a skin tear measuring 1 cm, which was reported to the registered staff by the family on a specified date in 2012. Interview with staff and review of the resident's clinical chart indicated that the registered staff did not complete a reassessment of the skin tear. The wound was observed to be healed on a specified date in 2012.

b) A specified resident sustained a skin tear, on a specified date in 2011 from an unknown cause, the skin tear is documented to have healed on a specified date in 2011, however there are no weekly skin reassessments documented by the registered staff for specified weeks in 2011.
Interview with registered staff identified that the resident has no open areas at the present time.

Issued on this 20th day of April, 2012

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

Debra Laird (192)

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) :	DEBORA SAVILLE (192), LALEH NEWELL (147)
Inspection No. / No de l'inspection :	2012_027192_0001
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Jan 24, 25, 27, 31, Feb 1, 2, 14, 16, 21, 22, 27, 28, Mar 5, 13, 15, 20, 26, 2012
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6
LTC Home / Foyer de SLD :	COOKSVILLE CARE CENTRE 55 THE QUEENSWAY WEST, MISSISSAUGA, ON, L5B-1B5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~DON PARADINE~~ Nicole Fisher DS

To RYKKA CARE CENTRES LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Note: This Order(s) of the Inspector report has been revised. This report replaces the original Order(s) of the Inspector report issued for this inspection. DS.

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee shall prepare and submit a plan to ensure that every alleged, suspected or witnessed incident of abuse of a resident is immediately investigated.
The plan shall be implemented.
The plan shall be submitted electronically to Laleh Newell, Nursing Inspector of the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office, at laleh.newell@ontario.ca by the end of business on March 30, 2012.

Grounds / Motifs :

1. On a specified date in 2011, a specified resident who was incapable of consenting to a sexual act, was observed by a Personal Support Worker with genitals exposed and being touched by a co-resident.. The charge nurse made the management team aware of the incident before lunch on the same day. The resident's family alleged abuse and the Police were notified of the incident.
No immediate investigation was initiated by the licensee. The staff member observing the incident had not been interviewed by the licensee as of February 1, 2012.

Interview with staff and management confirms that no investigation into the incident was conducted by the home until following a complaint from the family. (192)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : ~~Apr 06, 2012~~ April 13, 2012

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 : 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 and submit a plan ensuring that a specified resident is protected from abuse by anyone including all potential sources of abuse and giving consideration to the specified resident's behaviours. The plan shall be implemented.

The plan shall be submitted electronically to Laleh Newell, Nursing Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office at laleh.newell@ontario.ca by the end of business on March 30, 2012.

Grounds / Motifs :

1. a) On a specified date in 2011, a specified resident who was incapable of consenting to a sexual act, was observed by a Personal Support Worker with genitals exposed and being touched by a specified co-resident. The charge nurse made the management team aware of the incident before lunch on the same day. The police were not notified of the incident until family requested that police be notified of the alleged abuse on the specified date in 2011.

b) A specified resident exhibits responsive behaviours. Re-assessment of the specified resident confirms the ongoing presence of these behaviours; no new interventions were initiated. Interventions in effect on a specified date in 2011 were ineffective in protecting a specified co-resident from having genitals exposed and being touched by the specified resident.

c) A specified resident was known to wander. The resident was to be monitored every 30 minutes and behaviour to be recorded on the Dementia Observation Sheet (DOS). DOS records initiated prior to a specified incident were not consistently completed and monitoring every 30 minutes was not effective in preventing the specified resident from wandering into a co-resident's room where the resident was found with genitals exposed and being touched by the co-resident.

Identified resident's both demonstrated behaviours that the licensee was aware of. Interventions in place were ineffective in protecting a specified resident from abuse. (192)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : ~~Apr 06, 2012~~ April 13, 2012.

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 Clerk
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

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

Director

Director
c/o Appeals Clerk
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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 26th day of March, 2012

Signature of Inspector / Signature de l'inspecteur : Debora Saville

Name of Inspector / Nom de l'inspecteur : DEBORA SAVILLE

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