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

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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 10, 2017	2017_491647_0015	021144-17	Resident Quality Inspection

Licensee/Titulaire de permis

HUNTSVILLE LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

MUSKOKA LANDING
65 ROGERS COVE DRIVE HUNTSVILLE ON P1H 2L9

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

JENNIFER BROWN (647), VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 6, 7, 8, 12, 13, 14, 15, 18, 19, 20, 21, 25, 2017.

The following critical incidents (CI) were inspected concurrently with this inspection:
028107-16: related to a fall with injury,
034774-16: related to abuse,
002077-17: related to abuse,
003201-17: related to abuse,

003558-17: related to abuse,
011916-17: related to a fall with injury,
013599-17: related to abuse,
016498-17: related to abuse.

The following complaints were inspected concurrently with this inspection:
022953-16: related to laundry service, plan of care, communication and response system, prevention of abuse, food production and Residents' Bill of Rights,
026477-16: related to plan of care and whistle-blowing protection,
003112-17: related to altercations and other interactions between residents and notifications relating to incidents.

The following follow up to an existing compliance order was inspected concurrently with this inspection:
011653-17: related to a compliance order issued to the licensee for c.8, s.5 on June 12, 2017, during inspection 2017_535557_0005.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director of Care (CoDOC), Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Education Coordinator, Residents, Family Members, and Substitute Decision Makers.

During the course of the inspection, the inspectors conducted observation in home and residents' areas, observation of care delivery processes including medication passes and meal delivery services, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **6 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
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2017_535557_0005	647

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse.

The home submitted a Critical Incident Report (CI) on an identified date, indicating that resident #007 reported to direct care staff member that he/she was afraid of resident #006 because he/she kept saying certain phrases to him/her. Resident #006 had also been observed having inappropriate responsive behaviours towards resident #007 and resident #008.

The home subsequently submitted another CI report on an identified date, indicating that resident #006 had been observed having inappropriate responsive behaviours of cognitively impaired resident #007 when he/she had been sitting in a chair. Resident #006 had been observed having inappropriate responsive behaviours to resident #007 prior to being separated by staff.

A record review indicated that resident #006 was admitted, with a previous history of having inappropriate responsive behaviours. The record review further indicated that there had been an incident on an identified date, where by resident #006 had been having inappropriate responsive behaviours.

A record review for resident #007 indicated he/she had been admitted with the diagnosis of cognitive impairment and due to his/her cognition level, would not have been able to consent to the inappropriate responsive behaviours from resident #006.

A review of the progress notes on an identified date, indicated that resident #006 required and had been provided close monitoring for his/her having inappropriate responsive behaviours. The progress notes indicated that resident #006 responded well to the close monitoring and the having inappropriate responsive behaviours had been minimized. The progress notes further indicated that on an identified date, the close monitoring had been discontinued as it had been reviewed and deemed not necessary as the having inappropriate responsive behaviours had lessened. An additional progress note entry on the same identified date, further indicated that the close monitoring is to be restarted if resident #007 shows signs of having inappropriate responsive behaviours.

A review of the progress notes between an identified period of time, indicated 11 additional incidents where resident #006 had displayed having inappropriate responsive behaviours toward co-residents after the close monitoring had been discontinued.

During an interview with Registered staff member #113 and #114 it had been indicated that the purpose of the close monitoring had been implemented after the inappropriate responsive behaviours reported to the Ministry of Health (MOH) on an identified date, to

ensure resident #006 had not been able to re-approach co-resident's with having inappropriate responsive behaviours. The above mentioned Registered staff confirmed that resident #007 was cognitively impaired and would not have been able to consent to resident #006's having inappropriate responsive behaviours.

An interview with the Co-Director of Care (CoDOC) indicated that the close monitoring had been provided to resident #006 after the incident of having inappropriate responsive behaviours on the identified date, to ensure resident #006 had been supervised at all times and to further ensure co-residents were not able to be re-approached.

A further interview with the CoDOC acknowledged that the incidents between the identified period of time, would be considered having inappropriate responsive behaviours by resident #006. The CoDOC further acknowledged that the close monitoring for resident #006 should have been reinstated to ensure that residents were protected from abuse.

It had been confirmed during an interview with the Director of Care (DOC) that the expectation of the home is to protect all residents from abuse. The DOC acknowledged during the above mentioned interview that resident #007 had been abused by resident #006. The DOC confirmed at the time of the interview that resident #007 had been cognitively impaired and would not have been able to provide resident #006 with consent prior to the incident of having inappropriate responsive behaviours. The DOC further acknowledged that there had been no interventions put into place after the first incident to resident #007 and therefore had not protected resident #007 from being abused. [s. 19. (1)]

2. Review of the CI, submitted on an identified date, reported an allegation of resident to resident abuse. The report indicated that resident #026 reported to Registered staff member #121 that resident #022 entered his/her room and when he/she requested to this resident to get out of his/her room, resident #022 then interacted with him/her and he/she sustained an upper body injury.

Review of resident #022 and #026's progress notes indicated that an unwitnessed altercation did occur in resident #026's room as indicated by this resident.

Review of resident #022's plan of care indicated resident was diagnosed with cognitive impairment and directed staff to monitor for signs of responsive behaviour and to administer medications as directed by the physician.

The inspector was not able to reach the direct care staff member #108 as he/she was not available.

Interview with Registered staff member #119 confirmed resident #022 would exhibit responsive behaviours, and was unpredictable and could exhibit these responsive behaviours at any time. He/she further indicated that the home tried several interventions, which included an assessment through the Behavioral Support Team (BSO).

The inspector was not able to interview resident #022 as this resident had been discharged from the home.

Interview with resident #026 revealed he/she is cognitively impaired and could not recall the incident with resident #022.

Interview with the Co-DOC and DOC confirmed there had been an incident of responsive behaviour between resident #022 and #026 and that resident #026 did obtain an upper body injury. The DOC confirmed the home did not protect resident #026 from abuse from resident #022. [s. 19. (1)]

3. Review of the CI, on an identified date, reported an allegation of resident to resident abuse. The report indicated that resident #025 reported to his/her substitute decision maker (SDM) that resident #022 entered his/her bed through the night.

Record review of resident #025's plan of care revealed he/she is cognitively intact however could recall the incident with resident #022. His/her progress notes revealed on the identified date, at the time of the incident resident #022 was found asleep in resident #025's bed. Resident #025 was asleep as well. Resident #022 was awakened and taken to his/her own bed in the same room.

Resident #025 then became frightened repeatedly indicated that he/she was a afraid and would not be able to sleep, reassurance was given, call bell was placed within reach and resident #022 was checked frequently to ensure his/her whereabouts.

Review of resident #022's plan of care identified the resident was admitted to the home with a diagnosis of cognitive impairment and directed staff to monitor for signs of responsive behaviours. The resident was placed on Dementia Observation Scale (DOS)

documentation on admission. His/her CPS score was three and he/she was identified as being cognitively impaired.

Interview with resident #025 confirmed he/she had good recall of the incident on the above mentioned time. The resident confirmed resident #022 by name and that the resident was not invited into his/her room.

Interview with Registered staff member #122 confirmed he/she had found resident #022 sound asleep in resident #025's bed. At the time resident #025 had not indicated that he/she was inappropriately touched by resident #022, but indicated he/she was afraid and because of this he/she would not sleep. The staff implemented more frequent checks to ensure resident #022's whereabouts.

The inspector was not able to interview resident #022 as this resident had been discharged from the home.

Interview with the Co-DOC and DOC confirmed the incident had been investigated between resident #022 and #025. Both the Co-DOC and DOC indicated resident #025 had confirmed the incident with resident #025. Further discussion with the Co-DOC and DOC revealed the resident was frightened after the incident and upon completion of the home's investigation deemed the incident as abuse as resident #025 had not consented to being inappropriately touched by resident #022.

The DOC confirmed the home did not protect resident #025 from abuse from resident #022. Resident #025 was the recipient of non-consensual touching from resident #022.

A compliance order will be served to the home based on the scope, which is a pattern, the severity of the non-compliance was actual harm to residents, and the home had previously been issued a VPC as part of inspection 2015_299559_0010 on May 4, 2015 for this legislation. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The home submitted a CI on an identified date, indicating that resident #004 had been transferred to hospital and later diagnosed with a lower body injury.

A further review of the CI mentioned above indicated that on the identified date, resident #004 had been observed ambulating independently in the hallway and leaned against a closed door, and began to slide down the door onto the floor, landing on his/her right side. A review of the clinical records further indicated that resident #004 had a change in mood for days following the above mentioned incident and had been ordered to receive a further assessment.

A review of the progress notes of the incident and the current care plan, indicated that as a result of the many falls resident #004 had experienced, the home had initiated a bed and chair sensor alarm to be in place at all times.

Observation of resident #004 on an identified date and time revealed that resident #004 had been observed to be in the hallway with no chair sensor in place and with no staff

present.

Interviews with Registered staff member's #100, #101, and #104, indicated that resident #004 required the chair sensor alarm at all times while up due to multiple previous falls and due to the resident's cognitive ability that does not allow resident #004 to have insight into the risks of self-transferring.

An interview with direct care staff member #105, indicated that he/she had been responsible for the care of resident #004 and confirmed that resident #004 had been at high risk for falls and had required a chair sensor alarm in place at all times when up in his/her chair. Inspector #647 asked direct care staff member, as to the reason for the chair alarm not being in place at the above mentioned time and direct care staff member #105 stated that he/she forgot.

Direct care staff member #105 acknowledged during the interview that as a result of the chair alarm not being in place, the resident had been placed at risk as resident will attempt to self-transfer. Direct care staff member #105 further acknowledged that if resident had tried to self-transfer, staff would not have been alerted by the sensor alarm as it had not been used.

An interview with the DOC confirmed that the chair sensor alarm continues to be a current intervention in the plan of care for resident #004 and is required to be in use at all times when resident #004 is up in his/her chair to ensure staff are alerted if resident #004 attempts to self-transfer. [s. 6. (7)]

2. Review of a CI report, on an identified date and time reported that resident #022 interacted with resident #021's walker and then interacted with resident #021 resulting in the resident falling to the floor. Resident #021 obtained an upper body injury. Resident #021 declined being transferred to the hospital for further assessment.

On an identified date, resident #021 fell to the floor as a result of an interaction with resident #022. Resident #021 was placed on head injury routine (HIR).

Record review for resident #021 revealed that on an identified date, HIR charting was initiated. Review of the HIR record revealed that the charting was incomplete on two identified days.

Interview with Registered staff #112 confirmed he/she did not want to wake resident #021

up as he/she was sleeping, therefore did not complete the HIR at the identified times.

Interview with Co-DOC and DOC confirmed that the HIR documentation was incomplete for the above identified time frames for resident #021. The DOC further indicated even if a resident is sleeping staff are expected to follow the plan of care and assess the resident. [s. 6. (7)]

3. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six month and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

A record review of the physician's order indicated resident #011 had been prescribed a transdermal medication to be applied at bedtime and to be removed the following morning.

Record review of a medication incident form on an identified date, indicated that two applications of the transdermal medication had been found on resident #011 in the morning of an identified date.

An interview with Registered staff member #111 indicated that the Registered staff that administer the transdermal medication are to document in the electronic medication administration record (eMAR).

A record review of the progress notes for resident #011 from the time of admission to the home, to the time of the incident report, there had been six prior occasions where the transdermal medication had been documented as "not found".

An interview with Registered staff #111 indicated that resident #011's health status would not allow him/her to remove his/her transdermal medication on his/her own. Registered staff #111 further indicated that it has been observed on several occasions that the transdermal medication had been found on resident's clothing and bedding due to the adhesive backing on them.

A further review of the progress notes dated after the identified incident, indicated that the prescribed transdermal medication had been documented as "not found" on 23 additional occasions.

An interview with the DOC confirmed that the plan of care had not been updated or

revised to include strategies on how to ensure the transdermal medication stays in place as prescribed. The DOC further confirmed that the staff are expected to review and revise the plan of care if the current care set out in the plan has not been effective. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with.

Under O.Reg 79/10, s. 114 (1) (2), written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Record review of the contracted service providers pharmacy policy, titled: "Documentation and Storage of Medications, Controlled Substances Documentation",

policy number 5.3, last review date of June 2016, identified 1) counts must be done at every shift change with two staff members present, complete and document the count together on the Controlled Substance Shift Count Record (CSSCR), and 2) to document on the individual controlled substance administration record (ICSAR) the following: date and time, administered quantity, remaining quantity and signature of person administering the medication.

Record review of home's resident care manual, title: "Resident Rights, Care and Services – Medication Management – Narcotics and Controlled Substances", Section: Medication Management System, revised date October 7, 2013, identified 1) to complete a running inventory or count of each narcotic in the home, and 2) to complete the count sheet and to include the amount on hand, dispensed and the amount remaining at the time of narcotic administration.

On an identified date and time, on an identified home area (HA), the inspector and Registered staff member #111 reviewed the Controlled Substance Shift Count record to ensure that two staff signed this record at the change of shift and that the individual narcotic/controlled substance count record were accurate with the individual resident's blister packs.

The inspector observed Registered staff member #111 did not sign the CSSCR, and resident #024's ICSAR for an identified medication there were three tablets remaining. Resident #024's identified medication pack contained two tablets.

Record review of the electronic medication administration record (eMAR) confirmed that Registered staff member #111 administered the identified medication at an identified time to resident #024.

Interview with Registered staff member #111 confirmed he/she did count with the out going shift nurse and forgot to sign the CSSCR at the time. Registered staff member #111 further confirmed that he/she had administered the identified medication and he/she further confirmed that they had neglected to sign the ICSAR at the time of administration. Registered staff member #111 confirmed he/she had not followed the home's medication policy for counting narcotics/controlled substances at shift change and for documenting medication administration at the time of administration.

Interview with the Co-DOC and DOC stated that it is the home's expectation that 1) the off-going and on-coming registered staff do the shift count of narcotics and controlled

substances together and document, and 2) all registered staff document the administration of any medication at the time of the administration on all records as per the home's policy. The Co-DOC and DOC acknowledged that the home's policy on medication documentation was not complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #4: 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 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.

Review of an identified CI report, on an identified date and time, reported that resident #022 interacted with resident #021 resulting in resident #021 falling to the floor. Resident #021 obtained an upper extremity injury. Resident #021 declined being transferred to the hospital for further assessment. The Ministry of Health and Long Term Care after hours pager was not contacted. The CI was not submitted until the following day.

Interview with Registered staff member #112 confirmed he/she did contact the DOC after the incident but did not contact the Ministry of Health and Long Term Care after hours pager. He/she further indicated that they felt the resident did not meet the criteria of abuse.

Interview with the DOC confirmed he/she had been notified of the incident and had sent an email to the Co-DOC to follow up the next day.

An interview with the Co-DOC confirmed he/she submitted the report to the Director on the following day, the DOC confirmed the report was not submitted immediately. [s. 24. (1) 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 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The home submitted a CI on an identified date, indicating that resident #004 had been transferred to hospital and later diagnosed with a lower extremity injury.

A further review of the CI mentioned above indicated that on an identified date, resident #004 had been ambulating independently and had been witnessed standing in front of a door in the hallway and then sliding down the door to the floor, landing on his/her right side. A review of the clinical records further indicated that resident #004 had a change in mood for days following the above mentioned incident and had been ordered to receive a further assessment.

A review of the clinical records for resident #004 indicated that resident had a history of falls and unsteady gait. A further review indicated that due to cognitive impairment, he/she had been dependent on staff for all activities of daily living (ADL's) which included being transferred by two staff and a mechanical lift.

A review of the progress notes of the incident indicated that as a result of the many falls resident #004 had experienced, the home had initiated a DOS to monitor for fall trends and nursing and safety measures, however this had not been implemented until after his/her fall on the above mentioned identified date.

A review of the above mentioned DOS record indicated there had been no documentation on the DOS record for three identified dates.

Interviews with Registered staff member's #100, #101, #104, and direct care staff member all indicated that the DOS record is part of the plan of care for resident #004 and

was used to trend times and dates for resident falls. The above mentioned staff further indicated that once the tool is complete the information collected is used to trend times and dates of resident falls to allow for new interventions to be put into place to mitigate falls for resident #004. The above mentioned staff further confirmed during the interview that without the DOS record being completed the staff would not have been able to trend the data, revise interventions or mitigate falls for resident #004.

An interview with the DOC confirmed that the implementation of the DOS record for resident #004 was an intervention of the fall's program for which the resident was under to collect data to establish if there had been a pattern for resident #004’s falls. The DOC further confirmed that the staff are expected to document the resident's response to the intervention of being monitored while under the falls prevention program. [s. 30. (2)]

2. The home submitted a CI on an identified date, indicating that resident #004 had been transferred to hospital and later diagnosed with a lower extremity injury.

A further review of the CI mentioned above indicated that on an identified date, resident #004 had been witnessed sliding to the floor, landing on his/her right side. A review of the clinical records further indicated that resident #004 had a change in mood for days following the above mentioned incident and had been ordered to receive a further assessment.

A review of the progress notes of the incident indicated that as a result of the fall on the above mentioned date, the home had initiated a HIR to monitor resident #004's vital signs, orientation, response to stimuli, limb movement, pupil size, and reaction to light and movement.

A review of the above mentioned HIR record indicated there had been no documentation on the HIR record for two identified date and times. It had further been documented on the HIR record on two identified dates that resident had been sleeping.

Interviews with Registered staff member’s #100, #101, #104, all indicated that the head injury routine is part of an intervention as part of the home's fall prevention program and was used for resident #004 to monitor the vital signs, orientation, response to stimuli, limb movement, pupil size, and reaction to light and movement for resident #004. The above mentioned staff further indicated that the head injury routine is expected to be completed if a resident had been sleeping at the time to ensure the resident responds to the above mentioned assessment. The above mentioned staff further confirmed during

the interview that without the completion of the head injury routine, the staff would not have been able to assess the resident's vital signs, orientation, response to stimuli, limb movement, pupil size, and reaction to light and movement trend the data, revise interventions or mitigate falls for resident #004.

An interview with the DOC confirmed that the completion of the head injury routine for resident #004 had been a part of his/her plan of care to ensure resident #004 responds appropriately to the above mentioned indicators. The DOC further confirmed that the staff are expected to document the resident's response to the HIR intervention at all times the HIR schedule indicated. [s. 30. (2)]

3. This inspection was initiated as resident #001 triggered in Stage 1 for having a fall in the last 30 days as indicated in a staff interview.

A review of the progress notes for resident #001 indicated that resident had been found in the activity room on the floor between two chairs on an identified date. A further review of the progress notes indicated that it had been unknown what resident had been doing prior to the incident however it was believed that resident attempted to sit down and misjudged the distance of the chair. The resident received a head to toe assessment with no documented injuries however a HIR had been initiated to monitor resident #001’s vital signs, orientation, response to stimuli, limb movement, pupil size, and reaction to light and movement, as the incident had been unwitnessed.

A review of the above mentioned HIR record indicated there had been no assessment completed on the identified date as resident had been documented as eating, and no documentation on two other identified days as resident has been documented as sleeping.

Interviews with Registered staff member’s #100, #101, and #104, all indicated that the head injury routine is part of the home's fall prevention program and was used to monitor the vital signs, orientation, response to stimuli, limb movement, pupil size, and reaction to light and movement for resident #001. The above mentioned staff further indicated that the head injury routine is expected to be completed if a resident had been eating or sleeping at the time to ensure the resident responds to the above mentioned assessment. The above mentioned staff further confirmed during the interview that without the completion of the head injury routine, the staff would not have been able to assess the resident’s vital signs, orientation, response to stimuli, limb movement, pupil size, or reaction to light and movement trend the data for resident #001.

An interview with the DOC confirmed that the completion of the head injury routine for resident #001 was an intervention directed for use by the home's falls prevention program to ensure resident #001 responds appropriately to the above mentioned indicators. The DOC further confirmed that the staff are expected to document the resident's response to the interventions at all times the HIR schedule indicated. [s. 30. (2)]

4. The home submitted a CI on an identified date, indicating that resident #007 reported to a direct care staff member that he/she was afraid of resident #006 because he/she kept repeating a certain phase. Resident #006 also had exhibited inappropriate responsive behaviours to resident #007 and resident #008.The residents had been immediately separated and assessed for injury which determined there had not been any.

A review of the progress notes of the incident indicated that as a result of the incident indicated above, the home had initiated a DOS to monitor for the inappropriate responsive behaviours or any other responsive behaviour trends.

It had been indicated during an interview with Registered staff member's #100, #101, #104, #113, #114, and #115, that the expectation is for all staff to document the resident's behaviour at all indicated times. The above mentioned RPN's further indicated that once the DOS record is completed the data is then analyzed to identify trends of resident #006's responsive behaviour and put interventions in place to minimize the risk to others.

A review of the DOS record from the time of the incident indicated above to the following month, indicated there had been no documentation on the DOS record on 22 occasions.

Interviews with Registered staff member's #100, #101, #104, #113, #114, #115, and direct care staff member's #105 and #116, all indicated that the DOS record is part of the home's responsive behaviour program and is used to trend times and dates for the inappropriate responsive behaviours. The above mentioned staff further indicated that once to tool is complete the information collected is used to trend times and dates of the inappropriate responsive behaviours to allow for new interventions to be put into place to mitigate the inappropriate responsive behaviours for resident #006. The above mentioned staff further confirmed during the interview that without the DOS record being completed the staff would not have been able to trend the data, revise interventions or mitigate the inappropriate responsive behaviours for resident #006.

An interview with the DOC confirmed that the implementation of the DOS record for resident #006 had been an intervention to collect data to establish if there had been a pattern for resident #006's inappropriate responsive behaviours. The DOC further confirmed that the staff are expected to document the residents response to the interventions on the DOS record as part of resident #006's responsive behaviour plan of care. [s. 30. (2)]

5. This inspection had been initiated to inspect intakes #034774-16, #013599-17, and #016498-17, for the following critical incidents related to prevention of abuse and neglect.

The home submitted a CI on an identified date, indicating that resident #007 reported to a direct care staff member that he/she was afraid of resident #006 because he/she kept repeating certain phrases. Resident #006 had also been observed exhibiting inappropriate responsive behaviours to resident #007 and resident #008.

The home subsequently submitted another CI on an identified date, indicating that resident #006 had been observed exhibiting inappropriate responsive behaviours towards cognitively impaired resident #007 when he/she had been sitting in a chair. Resident #006 had been observed to be exhibiting inappropriate responsive behaviours to resident #007 prior to being separated by staff.

The home submitted a further CI report on an identified date, indicating that resident #007 had been sitting in a compromising position and resident #009 had been observed exhibiting inappropriate responsive behaviours.

A review of the progress notes of the incidents, indicated that as a result of the incidents indicated above, the home had initiated a DOS for a period of two weeks to monitor for inappropriate responsive behaviours or any other responsive behaviour trends.

A further review of the progress notes indicated that there had been two other occasions, where the home had instituted a DOS to monitor for inappropriate responsive behaviours or any other responsive behaviour trends.

A review of the DOS record from the periods of time indicated above, indicated there had been no documentation on the DOS record on 23 identified occasions.

Interviews with Registered staff member's #100, #101, #104, #113, #114, #115, and direct care staff member's #105 and #116, all indicated that the DOS record is part of the home's responsive behaviour program and is used to trend times and dates for the inappropriate responsive behaviours. The above mentioned staff further indicated that once to tool is complete the information collected is used to trend times and dates of the inappropriate responsive behaviours to allow for new interventions to be put into place to mitigate the inappropriate responsive behaviours for resident #007. The above mentioned staff further confirmed during the interview that without the DOS record being completed the staff would not have been able to trend the data, revise interventions or mitigate the inappropriate responsive behaviours for resident #007.

An interview with the DOC confirmed that the implementation of the DOS record for resident #007 had been an intervention to collect data to establish if there had been a pattern for resident #007's inappropriate responsive behaviours. The DOC further confirmed that the staff are expected to document the residents response to the interventions on the DOS record as part of resident #007's responsive behaviour plan of care. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

During the RQI and the inspection of handling of medication incidents and adverse drug reactions, inspector #557 reviewed the following two incident reports for resident #030.

(a) On an identified date, a medication incident report was completed identifying the administration of an identified medication. Review of the LTC Controlled Substance Administration Record for the above mentioned identified date, revealed the identified medication had been administered on two occasions. The administration time between doses was two hours and fifteen minutes. Review of the eMAR revealed there was no documentation on the EMAR for the administration of one of the identified time of the identified medication.

(b) On an identified date, a medication incident report was completed identifying the administration of an identified medication. Review of the LTC Controlled Substance Administration Record for the same identified date, revealed the medication was administered at four identified times however the legibility of administration time was not readable. The administration time between doses was one hour and thirty minutes. Review of the eMAR on the identified date, revealed there was no documentation on the eMAR for the administration of the one dose of identified medication.

Review of the eMAR on an identified date, revealed there was no documentation on the eMAR for the administration of the identified medication. Review of the eMAR on an identified date, revealed there was documentation on the eMAR for the administration of the identified medication, however, the Registered staff member documented on the wrong prescription order, he/she should have documented on the other identified medication.

During the course of the inspection the inspector was unable to reach the identified registered staff member, #129, who was involved in the two above identified incidents.

Interviews with Registered staff member #113 who discovered the medication errors confirmed the homes process on the administration of resident #030's identified medication was not followed and resident #030 received too much of the identified medications on both occasions, as identified above.

Interview with the Co-DOC confirmed he/she met with the identified Registered staff member and reviewed the medication errors with him/her and provided education. The Co-DOC confirmed it is the home's expectation that medications are administered as prescribed to all residents with in the home. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Record review of quarter two incident reports from an identified three month period of time, revealed there were 33 Medication Incident (MI) forms completed. These MI forms were incomplete as follows:
-On four occasions the DOC had not been notified,
-On ten occasions the Pharmacy was had not been notified,
-On twenty-one occasions the Medical Director, attending physician or the registered nurse in the extended class attending the resident had not been notified, and
-On fifteen occasions the Resident or SDM had not been notified.

An interview with the DOC confirmed that the above identified persons were not notified at the time of the medication incidents. He/she further confirmed it is an expectation that every medication incident involving a resident and every adverse drug reaction is reported to the resident or the resident's substitute decision-maker, the DOC, the MD, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

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 every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Record review of the quarter two Professional Advisory Committee-Pharmacy and Therapeutics committee meeting held on an identified date, revealed the Administrator, DOC, and medical director did not attend the meeting.

Interview with the DOC confirmed that the above identified staff did not participate in the quarterly meeting held on the above mentioned identified date, to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. [s. 115. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The home uses the Institute for Safe Medication Practice (ISMP), Medication Safety Self-Assessment Audit to complete the home's annual medication management system.

Record review of the annual evaluation of the medication management system revealed the Administrator, MD, pharmacist and registered dietitian did not participate in the annual review of the homes medication management system. Review of the ISMP self-assessment audit does not identify whom participates in the audit.

An interview with the DOC confirmed the Administrator, MD, pharmacist and registered dietitian did not participate in the annual review. He/she revealed the review of the self-assessment audit is completed by nursing and that there are no documented recommendation of changes to improve the medication management system. [s. 116. (1)]

Issued on this 10th day of November, 2017

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

Original report signed by the inspector.

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

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) :	JENNIFER BROWN (647), VALERIE PIMENTEL (557)
Inspection No. / No de l'inspection :	2017_491647_0015
Log No. / No de registre :	021144-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 10, 2017
Licensee / Titulaire de permis :	HUNTSVILLE LONG TERM CARE CENTRE INC. 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	MUSKOKA LANDING 65 ROGERS COVE DRIVE, HUNTSVILLE, ON, P1H-2L9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carrie Acton

To HUNTSVILLE LONG TERM CARE CENTRE 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) (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 :

Within one week of receipt of this order, the licensee shall prepare and submit a plan to include the following tasks:

1. Develop strategies and interventions to ensure that all residents are not subjected to further actions of the identified abuse by resident #006.
2. Conduct a review of resident #006's plan of care with all direct care staff to ensure that the team collaborates on establishing interventions.
3. Educate staff on the home's abuse policy with a focus on recognizing sexual abuse and the process of determining capacity and consent related to resident to resident identified interaction.

The licensee shall develop, implement and submit a plan, that includes all the above requirements, the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to jennifer.brown6@ontario.ca.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are protected from abuse.

The home submitted a Critical Incident Report (CI) on an identified date, indicating that resident #007 reported to direct care staff member that he/she was afraid of resident #006 because he/she kept saying certain phrases to him/her. Resident #006 had also been observed having inappropriate responsive behaviours towards resident #007 and resident #008.

The home subsequently submitted another CI report on an identified date, indicating that resident #006 had been observed having inappropriate

responsive behaviours of cognitively impaired resident #007 when he/she had been sitting in a chair. Resident #006 had been observed having inappropriate responsive behaviours to resident #007 prior to being separated by staff.

A record review indicated that resident #006 was admitted, with a previous history of having inappropriate responsive behaviours. The record review further indicated that there had been an incident on an identified date, where by resident #006 had been having inappropriate responsive behaviours.

A record review for resident #007 indicated he/she had been admitted with the diagnosis of cognitive impairment and due to his/her cognition level, would not have been able to consent to the inappropriate responsive behaviours from resident #006.

A review of the progress notes on an identified date, indicated that resident #006 required and had been provided close monitoring for his/her having inappropriate responsive behaviours. The progress notes indicated that resident #006 responded well to the close monitoring and the having inappropriate responsive behaviours had been minimized. The progress notes further indicated that on an identified date, the close monitoring had been discontinued as it had been reviewed and deemed not necessary as the having inappropriate responsive behaviours had lessened. An additional progress note entry on the same identified date, further indicated that the close monitoring is to be restarted if resident #007 shows signs of having inappropriate responsive behaviours.

A review of the progress notes between an identified period of time, indicated 11 additional incidents where resident #006 had displayed having inappropriate responsive behaviours toward co-residents after the close monitoring had been discontinued.

During an interview with Registered staff member #113 and #114 it had been indicated that the purpose of the close monitoring had been implemented after the inappropriate responsive behaviours reported to the Ministry of Health (MOH) on an identified date, to ensure resident #006 had not been able to re-approach co-resident's with having inappropriate responsive behaviours. The above mentioned Registered staff confirmed that resident #007 was cognitively impaired and would not have been able to consent to resident #006's having inappropriate responsive behaviours.

An interview with the Co-Director of Care (CoDOC) indicated that the close monitoring had been provided to resident #006 after the incident of having inappropriate responsive behaviours on the identified date, to ensure resident #006 had been supervised at all times and to further ensure co-residents were not able to be re-approached.

A further interview with the CoDOC acknowledged that the incidents between the identified period of time, would be considered having inappropriate responsive behaviours by resident #006. The CoDOC further acknowledged that the close monitoring for resident #006 should have been reinstated to ensure that residents were protected from abuse.

It had been confirmed during an interview with the Director of Care (DOC) that the expectation of the home is to protect all residents from abuse. The DOC acknowledged during the above mentioned interview that resident #007 had been abused by resident #006. The DOC confirmed at the time of the interview that resident #007 had been cognitively impaired and would not have been able to provide resident #006 with consent prior to the incident of having inappropriate responsive behaviours. The DOC further acknowledged that there had been no interventions put into place after the first incident to resident #007 and therefore had not protected resident #007 from being abused. [s. 19. (1)] (647)

2. Review of the CI, on an identified date, reported an allegation of resident to resident abuse. The report indicated that resident #025 reported to his/her substitute decision maker (SDM) that resident #022 entered his/her bed through the night.

Record review of resident #025's plan of care revealed he/she is cognitively intact however could recall the incident with resident #022. His/her progress notes revealed on the identified date, at the time of the incident resident #022 was found asleep in resident #025's bed. Resident #025 was asleep as well. Resident #022 was awakened and taken to his/her own bed in the same room.

Resident #025 then became frightened repeatedly indicated that he/she was a afraid and would not be able to sleep, reassurance was given, call bell was placed within reach and resident #022 was checked frequently to ensure his/her whereabouts.

Review of resident #022's plan of care identified the resident was admitted to the home with a diagnosis of cognitive impairment and directed staff to monitor for signs of responsive behaviours. The resident was placed on Dementia Observation Scale (DOS) documentation on admission. His/her CPS score was three and he/she was identified as being cognitively impaired.

Interview with resident #025 confirmed he/she had good recall of the incident on the above mentioned time. The resident confirmed resident #022 by name and that the resident was not invited into his/her room.

Interview with Registered staff member #122 confirmed he/she had found resident #022 sound asleep in resident #025's bed. At the time resident #025 had not indicated that he/she was inappropriately touched by resident #022, but indicated he/she was afraid and because of this he/she would not sleep. The staff implemented more frequent checks to ensure resident #022's whereabouts.

The inspector was not able to interview resident #022 as this resident had been discharged from the home.

Interview with the Co-DOC and DOC confirmed the incident had been investigated between resident #022 and #025. Both the Co-DOC and DOC indicated resident #025 had confirmed the incident with resident #025. Further discussion with the Co-DOC and DOC revealed the resident was frightened after the incident and upon completion of the home's investigation deemed the incident as abuse as resident #025 had not consented to being inappropriately touched by resident #022.

The DOC confirmed the home did not protect resident #025 from abuse from resident #022. Resident #025 was the recipient of non-consensual touching from resident #022. (557)

3. Review of the CI, submitted on an identified date, reported an allegation of resident to resident abuse. The report indicated that resident #026 reported to Registered staff member #121 that resident #022 entered his/her room and when he/she requested to this resident to get out of his/her room, resident #022 then interacted with him/her and he/she sustained an upper body injury.

Review of resident #022 and #026's progress notes indicated that an unwitnessed altercation did occur in resident #026's room as indicated by this

resident.

Review of resident #022's plan of care indicated resident was diagnosed with cognitive impairment and directed staff to monitor for signs of responsive behaviour and to administer medications as directed by the physician.

The inspector was not able to reach the direct care staff member #108 as he/she was not available.

Interview with Registered staff member #119 confirmed resident #022 would exhibit responsive behaviours, and was unpredictable and could exhibit these responsive behaviours at any time. He/she further indicated that the home tried several interventions, which included an assessment through the Behavioral Support Team (BSO).

The inspector was not able to interview resident #022 as this resident had been discharged from the home.

Interview with resident #026 revealed he/she is cognitively impaired and could not recall the incident with resident #022.

Interview with the Co-DOC and DOC confirmed there had been an incident of responsive behaviour between resident #022 and #026 and that resident #026 did obtain an upper body injury. The DOC confirmed the home did not protect resident #026 from abuse from resident #022.

A compliance order will be served to the home based on the scope, which is a pattern, the severity of the non-compliance was actual harm to residents, and the home had previously been issued a VPC as part of inspection 2015_299559_0010 on May 4, 2015 for this legislation. [s. 19. (1)] (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Jennifer Brown

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