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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 28, 2017	2017_657681_0015	007089-17, 021070-17	Follow up

Licensee/Titulaire de permis

THE CITY OF GREATER SUDBURY
200 Brady Street PO Box 5000 Stn A SUDBURY ON P3A 5P3

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

PIONEER MANOR
960 NOTRE DAME AVENUE SUDBURY ON P3A 2T4

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

STEPHANIE DONI (681), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 14-17, 2017, and November 20-24, 2017.

The following intakes were completed during this Follow Up inspection:

- One intake related to CO #001 from inspection report #2017_616542_0010, s. 20 (1) of the Long-Term Care Homes Act (LTCHA),2007, related to ensuring that the home's policy to promote zero tolerance of abuse and neglect was complied with.

- One intake related to CO #001 from inspection report #2017_613609_0001, r. 90 (2) (g-i) of the Ontario Regulation (O. Reg.) 79/10, related to hot water temperatures not being below 40 degrees Celsius or above 49 degrees Celsius.

A Critical Incident System (CIS) inspection #2017_657681_0013 and a Complaint inspection #2017_657681_0014 were conducted concurrently with this Follow Up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care, Manager of Physical Services, Coordinator of Education and Special Services, Program Coordinators, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Health Care Aides (HCAs), Nutritional Aides (NAs), family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed resident care records, home investigation notes, home policies, relevant personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy for zero tolerance of abuse and neglect was complied with.

Ontario Regulation 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

During Inspection #2017_616542_0010, CO #001 was issued to the home, which ordered the licensee to, "ensure that all staff of the home comply with the home's written policy to promote zero tolerance of abuse and neglect of residents specifically but not limited to,
a) ensure that all employees who witness or suspect that a resident was being abused or neglected immediately report the allegations as per the home's policy;
b) ensure that the resident's Substitute Decision Maker is notified immediately regarding any alleged, suspected or witnessed abuse or neglect of a resident;
c) ensure the police are notified when an incident that may constitute a criminal offence occurs;
d) develop and implement a process to ensure that staff are aware and understand what constitutes a suspicion of sexual abuse and that they reported it immediately and,
e) develop and implement a plan to monitor PSW #104, PSW #105 and PSW #106's overall performance towards all residents of the home". The compliance due date of this order was August 18, 2017.

While the licensee complied sections "b", "c", and "e", non-compliance continued to be identified with section "a" and "d", where the licensee was ordered to ensure that staff

who witnessed or suspected abuse report the allegation immediately as per the home's policy.

A Critical Incident System (CIS) report was submitted to the Director, related to staff to resident neglect. The CIS report indicated that resident #003 was found on the toilet at a specified date and time; however, staff from the current shift had not transferred resident #003 to the toilet.

During an interview with Inspector #681, Program Coordinator #106 stated that during the home's investigation, it was determined that HCA #105 assisted resident #003 to the toilet and went back to check on the resident, but resident #003 indicated that they required more time. HCA #105 stated to the home that they verbally reported to staff from the next shift that resident #003 was on the toilet and that they required more time.

During an interview with the Inspector, HCA #109 stated that they were responsible for resident #003 on a specified day. HCA #109 stated that they were never told by staff from the prior shift that resident #003 was on the toilet. HCA #109 stated that if they were aware, they would have immediately assisted resident #003 off the toilet.

Inspector #681 reviewed the home's investigation notes related to the incident, which indicated that HCA #109 was issued disciplinary action for not completing a daily census check on resident #003.

In an interview with Inspector #681, Program Coordinator #106 stated that HCA #109 should have completed a daily census check on resident #003 at the beginning of their shift before starting any resident care; however, this daily census check was not completed. Program Coordinator #106 stated that because this check was not completed, resident #003 was not assisted off the toilet until they were found by HCA #109.

Inspector #681 reviewed the home's policy titled "Resident Daily Census" last updated April 19, 2014, which indicated that daily at 2330, 0530, 0730, 1430, 1530, and 2230, the assigned HCA was to check and verify the location of all residents in their assignment and that these checks were to be documented on the "Resident Daily Census" sheet.

During separate interviews with Inspector #681, Program Coordinator #106 and Program Coordinator #107 both stated that it was determined by the home that resident neglect had occurred because the home failed to meet the needs of resident #003. [s. 20. (1)]

2. A Critical Incident System (CIS) report was submitted to the Director, related to an allegation of staff to resident sexual abuse. The CIS report indicated that resident #004 reported to HCA #118 that HCA #125 spoke and acted inappropriately towards resident #004.

Ontario Regulation 79/10 defines sexual abuse as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that was directed towards a resident by a licensee or staff member.

In an interview with Inspector #681, HCA #118 stated that resident #004 advised them that HCA #125 acted inappropriately while assisting resident #004 with care. HCA #118 stated that they charted the incident, advised RPN #124 about the incident, and told resident #004 to go down and speak with Program Coordinator #123 immediately.

In an interview with Inspector #681, RPN #126 stated that they read shift report, which indicated that resident #004 had made inappropriate comments. RPN #126 stated that after shift report was completed, RPN #124 went on to explain that resident #004 had said that HCA #125 not only made inappropriate comments, but also acted inappropriately. RPN #126 stated that they asked RPN #124 if they had reported the incident to Program Coordinator #123. RPN #124 stated that they had not reported the incident because it was not true and it did not occur. RPN #126 stated that they advised RPN #124 that the incident needed to be reported to Program Coordinator #123 and that if RPN #124 would not report the incident to Program Coordinator #123, then RPN #126 would report it themself.

Inspector #681 reviewed the home's policy titled "Abuse: Resident Abuse/Neglect", which indicated that anyone who witnessed or became aware of or suspected resident abuse must report the incident immediately to Registered Staff who will then report it to the appropriate Manager for further investigation.

During an interview with Inspector #681, Program Coordinator #123 stated that if RPN #124 understood that what HCA #118 was telling them was an allegation of sexual abuse, then this should have been reported to management immediately. [s. 20. (1)]

3. A Critical Incident System (CIS) report was submitted to the Director, related to an allegation of staff to resident physical abuse. The CIS report indicated that HCA #139 was rough while assisting resident #005 and resident #006 with care.

Ontario Regulation 79/10 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

Inspector #681 reviewed the home's investigation notes related to the incident which included written statements from HCA #140 and NA #130. The written statement from HCA #140 and NA #130 indicated that HCA #139 acted roughly while providing care to resident #005 and resident #006.

During an interview with Inspector #681, HCA #140 stated that HCA #139 was visibly flustered and that they were quite rough with residents #005 and #006. HCA #140 stated that HCA #139 did not need to use such force and that resident #006 expressed pain and discomfort when HCA #139 was assisting them with care.

During an interview with Inspector #681, NA #130 stated that they witnessed HCA #139 be rough with resident #006 and that resident #006 verbally expressed pain and discomfort.

Inspector #681 reviewed HCA #139's employee file, which indicated that HCA #139 had their employment with the home terminated, as a result of the allegation of resident abuse being substantiated.

In an interview with Inspector #681, Program Coordinator #107 stated that the allegation of abuse was substantiated and that HCA #139's employment was terminated as a result of the incident. [s. 20. (1)]

4. A Critical Incident System (CIS) report was submitted to the Director related to an allegation of staff to resident physical abuse. The CIS report indicated that HCA #142 acted carelessly and quickly while assisting resident #018 and that HCA #142 was also rough while providing care to resident #017.

Inspector #681 reviewed the home's investigation notes related to the incident, which included a written statement from a student who was working with HCA #142. The written statement indicated that HCA #142 used such force while assisting resident #017 that resident #017 fell forward and injured themself. The written statement also indicated that HCA #142 acted carelessly while assisting resident #018 and that this caused resident #018 to roll over and almost injured themself. Resident #018 requested that HCA #142 stop providing care because they were in pain, however, HCA #142 did not pay attention

to this comment and continued to provide care to resident #018.

During an interview with Inspector #681, the Coordinator of Education and Special Services, stated that during the home's investigation, resident #017 and resident #018 were able to confirm what had been reported by the student.

The home's investigation notes indicated that HCA #142's employment was terminated because the home determined that the allegation of physical abuse was substantiated.

During an interview with Inspector #681, Program Coordinator #107 stated that the allegation of abuse was substantiated and HCA #142 was terminated as a result of the incident. [s. 20. (1)]

5. A Critical Incident System (CIS) report was submitted to the Director, related to an allegation of staff to resident physical and emotional abuse. The CIS report indicated that HCA #141 made inappropriate statements while assisting resident #019 with their meal.

Ontario Regulation 79/10 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

During an interview with Inspector #681, resident #023's family member stated that they observed HCA #141 assist resident #019 with their meal and that HCA #141 made inappropriate and belittling comments toward resident #019, which caused resident #019 to cry.

Inspector #681 reviewed the home's policy titled "Abuse: Resident Abuse/Neglect", which indicated that residents will be free from abuse by employees, students, volunteers, service providers, visitors, and other residents.

Inspector #681 reviewed HCA #141's employee file which indicated that HCA #141's employment at the home was terminated related to this incident because the home determined that the allegation of abuse was substantiated.

During an interview with Inspector #681, Program Coordinator #123 stated that the allegation of abuse was substantiated and that HCA #141's employment was terminated as a result of the incident.

A Director's Order was issued to the licensee on September 14, 2017, to address failure to comply with s. 20. (1) of the LTCHA, 2007. The compliance due date of this Director's Order is January 1, 2018. [s. 20. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service; O. Reg. 79/10, s. 90 (2).
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and O. Reg. 79/10, s. 90 (2).
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that:

(g) the temperature of the water serving all bathtubs, showers and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature, and

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius.

During inspection #2017_613609_0001, CO #001 was issued to the home, which ordered the licensee to:
" a) Ensure the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, regardless of time of day, unit or circumstances.
b) Review, revise, and implement the home's policy titled "Water Temperature Monitoring" to ensure that the policy contains procedures to ensure that immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.
c) Ensure the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius, regardless of time of day, unit or circumstances". The compliance due date of this order was August 31, 2017.

Inspector #543 sampled the water temperature from a tub room in the Park Place home area and recorded a temperature of 38.5 degrees Celsius.

Inspector #543 sampled the water temperature from a hand basin in the Park Place home area and recorded a temperature of 49.3 degrees Celsius.

Inspector #543 sampled the water temperature from a hand basin in the Scenic home area. A water temperature of 51.7 degrees Celsius was recorded.

Inspector #543 sampled the water temperature from a bathtub in the York home area and recorded a temperature of 38.7 degrees Celsius.

Inspector #543 sampled the water temperature from a hand basin in the Lilac/Mallard home area. A water temperature of 49.7 degrees Celsius was recorded.

Inspector #543 sampled the water temperature from a bathtub in the Park Place home area. A water temperature of 38.4 degrees Celsius was recorded.

On a specified day, the Inspector, accompanied by the Manager of Physical Services, sampled water temperatures in the Park Place home area. In the Lilac/Mallard home area, a water temperature of 49.6 degrees Celsius was recorded from the hand basin in an unspecified room.

In a subsequent conversation with the Manager of Physical Services, they verified that the increase in water temperatures in the identified home areas was the result of a mixing valve problem, and that the decrease in temperature with the bathtubs was likely a malfunction with the bathtub's temperature gauge.

On November 16, 2017, Inspector #543 interviewed the Manager of Physical Services who identified that the home completed the work related to water temperatures. They indicated that maintenance staff will monitor the water temperatures in various home areas twice daily (between 0700-0730 hours and 1500-1530 hours).

The Inspector reviewed the home's "Physical Services Policies and Procedures-Water Temperature Monitoring" policy, which indicated that the water temperature serving all bathtubs, showers and hand basins used by residents shall be maintained at a range between 40 and 49 degrees Celsius. [s. 90. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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

Issued on this 8th day of January, 2018

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) :	STEPHANIE DONI (681), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2017_657681_0015
Log No. / No de registre :	007089-17, 021070-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 28, 2017
Licensee / Titulaire de permis :	THE CITY OF GREATER SUDBURY 200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3
LTC Home / Foyer de SLD :	PIONEER MANOR 960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Aaron Archibald

To THE CITY OF GREATER SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_616542_0010, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall comply with the Director's Order that was issued to the licensee on September 14, 2017, related to s. 20 (1) of the Long-Term Care Homes Act (LTCHA), 2007.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's policy for zero tolerance of abuse and neglect was complied with.

Ontario Regulation 79/10 defines sexual abuse as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that was directed towards a resident by a licensee or staff member.

During Inspection #2017_616542_0010, CO #001 was issued to the home, which ordered the licensee to, "ensure that all staff of the home comply with the home's written policy to promote zero tolerance of abuse and neglect of residents specifically but not limited to,
a) ensure that all employees who witness or suspect that a resident was being abused or neglected immediately report the allegations as per the home's policy;
b) ensure that the resident's Substitute Decision Maker is notified immediately regarding any alleged, suspected or witnessed abuse or neglect of a resident;
c) ensure the police are notified when an incident that may constitute a criminal offence occurs;
d) develop and implement a process to ensure that staff are aware and

understand what constitutes a suspicion of sexual abuse and that they reported it immediately and,
e) develop and implement a plan to monitor PSW #104, PSW #105 and PSW #106's overall performance towards all residents of the home". The compliance due date of this order was August 18, 2017.

While the licensee complied sections "b", "c", and "e", non-compliance continued to be identified with section "a" and "d", where the licensee was ordered to ensure that staff who witnessed or suspected abuse report the allegation immediately as per the home's policy.

A Critical Incident System (CIS) report was submitted to the Director, related to an allegation of staff to resident sexual abuse. The CIS report indicated that resident #004 reported to HCA #118 that HCA #125 spoke and acted inappropriately towards resident #004.

Ontario Regulation 79/10 defines sexual abuse as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that was directed towards a resident by a licensee or staff member.

In an interview with Inspector #681, HCA #118 stated that resident #004 advised them that HCA #125 acted inappropriately while assisting resident #004 with care. HCA #118 stated that they charted the incident, advised RPN #124 about the incident, and told resident #004 to go down and speak with Program Coordinator #123 immediately.

In an interview with Inspector #681, RPN #126 stated that they read shift report, which indicated that resident #004 had made inappropriate comments. RPN #126 stated that after shift report was completed, RPN #124 went on to explain that resident #004 had said that HCA #125 not only made inappropriate comments, but also acted inappropriately. RPN #126 stated that they asked RPN #124 if they had reported the incident to Program Coordinator #123. RPN #124 stated that they had not reported the incident because it was not true and it did not occur. RPN #126 stated that they advised RPN #124 that the incident needed to be reported to Program Coordinator #123 and that if RPN #124 would not report the incident to Program Coordinator #123, then RPN #126 would report it themself.

Inspector #681 reviewed the home's policy titled "Abuse: Resident

Abuse/Neglect", which indicated that anyone who witnessed or became aware of or suspected resident abuse must report the incident immediately to Registered Staff who will then report it to the appropriate Manager for further investigation.

During an interview with Inspector #681, Program Coordinator #123 stated that if RPN #124 understood that what HCA #118 was telling them was an allegation of sexual abuse, then this should have been reported to management immediately. [s. 20. (1)]

2. A Critical Incident System (CIS) report was submitted to the Director related to an allegation of staff to resident physical abuse. The CIS report indicated that HCA #142 acted carelessly and quickly while assisting resident #018 and that HCA #142 was also rough while providing care to resident #017.

Inspector #681 reviewed the home's investigation notes related to the incident, which included a written statement from a student who was working with HCA #142. The written statement indicated that HCA #142 used such force while assisting resident #017 that resident #017 fell forward and injured themself. The written statement also indicated that HCA #142 acted carelessly while assisting resident #018 and that this caused resident #018 to roll over and almost injured themself. Resident #018 requested that HCA #142 stop providing care because they were in pain, however, HCA #142 did not pay attention to this comment and continued to provide care to resident #018.

During an interview with Inspector #681, the Coordinator of Education and Special Services, stated that during the home's investigation, resident #017 and resident #018 were able to confirm what had been reported by the student.

The home's investigation notes indicated that HCA #142's employment was terminated because the home determined that the allegation of physical abuse was substantiated.

During an interview with Inspector #681, Program Coordinator #107 stated that the allegation of abuse was substantiated and HCA #142 was terminated as a result of the incident. [s. 20. (1)]

3.A Critical Incident System (CIS) report was submitted to the Director, related to an allegation of staff to resident physical and emotional abuse. The CIS report indicated that HCA #141 made inappropriate statements while assisting resident

#019 with their meal.

Ontario Regulation 79/10 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

During an interview with Inspector #681, resident #023's family member stated that they observed HCA #141 assist resident #019 with their meal and that HCA #141 made inappropriate and belittling comments toward resident #019, which caused resident #019 to cry.

Inspector #681 reviewed the home's policy titled "Abuse: Resident Abuse/Neglect", which indicated that residents will be free from abuse by employees, students, volunteers, service providers, visitors, and other residents.

Inspector #681 reviewed HCA #141's employee file which indicated that HCA #141's employment at the home was terminated related to this incident because the home determined that the allegation of abuse was substantiated.

During an interview with Inspector #681, Program Coordinator #123 stated that the allegation of abuse was substantiated and that HCA #141's employment was terminated as a result of the incident.

A Director's Order was issued to the licensee on September 14, 2017, to address failure to comply with s. 20. (1) of the LTCHA, 2007. The compliance due date of this Director's Order is January 1, 2018. (681)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 01, 2018

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_613609_0001, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee shall:

a) Ensure that the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, regardless of time of day, unit or circumstances.

b) Ensure that the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius, regardless of time of day, unit or circumstances.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that:

(g) the temperature of the water serving all bathtubs, showers and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature, and

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius.

During inspection #2017_613609_0001, CO #001 was issued to the home, which ordered the licensee to:
"a) Ensure the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, regardless of time of day, unit or circumstances.
b) Review, revise, and implement the home's policy titled “Water Temperature Monitoring” to ensure that the policy contains procedures to ensure that immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.
c) Ensure the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius, regardless of time of day, unit or circumstances". The compliance due date of this order was August 31, 2017.

Inspector #543 sampled the water temperature from a tub room in the Park Place home area and recorded a temperature of 38.5 degrees Celsius.

Inspector #543 sampled the water temperature from a hand basin in the Park Place home area and recorded a temperature of 49.3 degrees Celsius.

Inspector #543 sampled the water temperature from a hand basin in the Scenic home area. A water temperature of 51.7 degrees Celsius was recorded.

Inspector #543 sampled the water temperature from a bathtub in the York home area and recorded a temperature of 38.7 degrees Celsius.

Inspector #543 sampled the water temperature from a hand basin in the Lilac/Mallard home area. A water temperature of 49.7 degrees Celsius was recorded.

Inspector #543 sampled the water temperature from a bathtub in the Park Place home area. A water temperature of 38.4 degrees Celsius was recorded.

On a specified day, the Inspector, accompanied by the Manager of Physical Services, sampled water temperatures in the Park Place home area. In the Lilac/Mallard home area, a water temperature of 49.6 degrees Celsius was recorded from the hand basin in an unspecified room.

In a subsequent conversation with the Manager of Physical Services, they verified that the increase in water temperatures in the identified home areas was the result of a mixing valve problem, and that the decrease in temperature with the bathtubs was likely a malfunction with the bathtub's temperature gauge.

On November 16, 2017, Inspector #543 interviewed the Manager of Physical Services who identified that the home completed the work related to water temperatures. They indicated that maintenance staff will monitor the water temperatures in various home areas twice daily (between 0700-0730 hours and 1500-1530 hours).

The Inspector reviewed the home's "Physical Services Policies and Procedures-Water Temperature Monitoring" policy, which indicated that the water temperature serving all bathtubs, showers and hand basins used by residents shall be maintained at a range between 40 and 49 degrees Celsius. [s. 90. (2)]

Two previous compliance orders (CO) were issued to the home related to the

home's failure to comply with O. Reg. 79/10, s. 90 (2). During the Resident Quality Inspection (RQI) on May 2, 2016, CO #002 from inspection #2016_269627_011 and during a follow-up inspection on January 9, 2017, CO #001 from inspection #2017_613609_0001.The decision to issue a CO was based on the severity, which indicated minimal harm or potential for actual harm to residents of the home, and the scope, which indicated a pattern within the home. Furthermore, the home's compliance history identified ongoing noncompliance with O.Reg. 79/10, s.90 (2). (543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 14, 2018

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 28th day of December, 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 : Stephanie Doni

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