Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MONIQUE BERGER (151)
Inspection No. / No de l'inspection :	2013_138151_0030
Log No. / Registre no:	S-000419-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 4, 6, 2013
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 :	TONY PARMAR

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # /
Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that resident #001 has a written plan of care that addresses resident's responsive behaviours and that gives clear direction to staff providing care.

This plan is to be submitted to Inspector Monique Berger (151), Health System Accountablity and Performance Division, Sudbury Service Area Office, 159 Cedar Street, Suite 403, Sudbury, ON P3E 6A5 by November 12, 2013

Grounds / Motifs :

1. Inspectors 151, 543 and 544 reviewed the resident's health care records and noted that resident #001 had a serious incident related to responsive behaviours. Though the incident was recorded in the progress notes, internal reporting protocol or incident reporting procedure was not initiated, or the family notified of the incident, or the care plan altered in light of the incident, or was the Director advised as per O.Reg.79/10,s.107 (3). Manager of Resident Care confirmed the incident did not result in changes to the resident's plan of care.

According to the resident's health care records, forty two days later, the resident experienced a similar serious incident of responsive behaviour. Inspectors 151, 543 and 544 reviewed a letter and attached documents from the home's Manager of Resident Care to the ministry's Central Intake Assessment Triage Team (CIATT). It is noted in these attachments that a review of Resident #001's care plans prior to the second incident had "no focus/intervention with respect to [the behaviours]". Review of Resident #001's health care records by Inspectors 151, 543 and 544 confirmed the Manager of Resident Care's statement. . Inspectors reviewed the most recent Kardexes used by front line staff to direct the resident's care. The most recent Kardex for Resident #001 was printed for staff's use 6 days post second incident and makes no mention of the behaviours related to the incidents.

The home did not assess and communicate the resident's responsive behaviour risks to staff providing care to the resident and did not plan and implement interventions in prevention of a second incident.

The plan of care does not set out clear directions to staff and others who provide direct care to the residents.

(151)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 12, 2013

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that information critical to the care needs of resident #001 and any other residents is communicated to all staff and documented in the plan of care to ensure the safety and well-being of all residents, and to ensure residents are not neglected

This plan is to be submitted to Inspector Monique Berger (151), Health System Accountablity and Performance Division, Sudbury Service Area Office, 159 Cedar Street, Suite 403, Sudbury, ON P3E 6A5 by November 12, 2013

Grounds / Motifs :

1. Inspectors 151, 543 and 544 reviewed the resident's health care records and noted that resident #001 had a serious incident related to responsive behaviours. Though the incident was recorded in the progress notes, internal reporting protocol or incident reporting procedure was not initiated, or the family notified of the incident, or the care plan altered in light of the incident, or was the Director advised as per O.Reg.79/10,s.107 (3). Manager of Resident Care confirmed the incident did not result in changes to the resident's plan of care.

According to the resident's health care records, forty two days later, the resident experienced a similar serious incident of responsive behaviour. Inspectors 151, 543 and 544 reviewed a letter and attached documents from the home's Manager of Resident Care to the ministry's Central Intake Assessment Triage Team (CIATT). It is noted in these attachments that a review of Resident #001's care plans prior to the second incident had "no focus/intervention with respect to [the behaviours]". Review of Resident #001's health care records by Inspectors 151, 543 and 544 confirmed the Manager of Resident Care's statement. Inspectors reviewed the most recent Kardexes used by front line staff to direct the resident's care. The most recent Kardex for Resident #001 was printed for staff's use 6 days post second incident and makes no mention of the behaviours related to the incidents.

The home did not assess and communicate the resident's responsive behaviour risks to staff providing care to the resident and did not plan and implement interventions in prevention of a second incident.

Inaction and lack of communication on the part of the staff jeopardized the safety and well-being of Resident #001: hence the licensee did not ensure that Resident #001 was protected from neglect.

(151)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 12, 2013

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

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
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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 6th day of November, 2013

Signature of Inspector / Signature de l'inspecteur : Monique S. Berger (157)

Name of Inspector / Nom de l'inspecteur : MONIQUE BERGER

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

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 4, 6, 2013	2013_138151_0030	S-000419-13	Complaint

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

MONIQUE BERGER (151)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 30,31, 2013

inspection relates to:
S-000419-13 and related IL: 29935-SU

During the course of the inspection, the inspector(s) spoke with Administrator, Manager of Resident Care (MORC), Unit Managers, Registered Staff (RN and RPN), Personal Support Workers (PSW), Activity Co-ordinator, Residents, Families

During the course of the inspection, the inspector(s) - direct observations of the delivery of care and services to residents,
- walk-through the home daily
- reviewed policies, procedures, protocols and programs in relation to responsive behaviours
- reviewed policies, procedures, protocols in relation to provision of safe and secure home
- reviewed home's staffing patterns
- reviewed home's staff education initiatives for the last year
- reviewed resident health care records
- reviewed the home's emergency response program for code yellow
- reviewed Activation Program goals, objectives, calendar of activities
- reviewed activation attendance records,

- reviewed home's complaint process
- reviewed required posting of information

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Reporting and Complaints

Responsive Behaviours

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. Inspectors 151, 543 and 544 reviewed the resident's health care records and noted that resident #001 had a serious incident related to responsive behaviours. Though the incident was recorded in the progress notes, internal reporting protocol or incident reporting procedure was not initiated, or the family notified of the incident, or the care plan altered in light of the incident, or was the Director advised as per O.Reg.79/10,s.107 (3). Manager of Resident Care confirmed the incident did not result in changes to the resident's plan of care.

According to the resident's health care records, forty two days later, the resident experienced a similar serious incident of responsive behaviour. Inspectors 151, 543 and 544 reviewed a letter and attached documents from the home's Manager of Resident Care to the ministry's Central Intake Assessment Triage Team (CIATT). It is noted in these attachments that a review of Resident #001's care plans prior to the second incident had "no focus/intervention with respect to [the behaviours]". Review of Resident #001's health care records by Inspectors 151, 543 and 544 confirmed the Manager of Resident Care's statement. Inspectors reviewed the most recent Kardexes used by front line staff to direct the resident's care. The most recent Kardex for Resident #001 was printed for staff's use 6 days post second incident and makes no mention of the behaviours related to the incidents.

The home did not assess and communicate the resident's responsive behaviour risks to staff providing care to the resident and did not plan and implement interventions in prevention of a second incident.

The plan of care does not set out clear directions to staff and others who provide direct care to the residents.
[s. 6. (1) (c)]

2. Inspectors 151, 543 and 544 reviewed the resident's health care records and noted that resident #001 had a serious incident related to responsive behaviours. Though the incident was recorded in the progress notes, internal reporting protocol or incident reporting procedure was not initiated, or the family notified of the incident, or the care plan altered in light of the incident, or was the Director advised as per O.Reg.79/10,s.107 (3). Manager of Resident Care confirmed the incident did not result in changes to the resident's plan of care.

According to the resident's health care records, forty two days later, the resident

experienced a similar serious incident of responsive behaviour. Inspectors 151, 543 and 544 reviewed a letter and attached documents from the home's Manager of Resident Care to the ministry's Central Intake Assessment Triage Team (CIATT). It is noted in these attachments that a review of Resident #001's care plans prior to the second incident had "no focus/intervention with respect to [the behaviours]". Review of Resident #001's health care records by Inspectors 151, 543 and 544 confirmed the Manager of Resident Care's statement. Inspectors reviewed the most recent Kardexes used by front line staff to direct the resident's care. The most recent Kardex for Resident #001 was printed for staff's use 6 days post second incident and makes no mention of the behaviours related to the incidents.

The home did not assess and communicate the resident's responsive behaviour risks to staff providing care to the resident and did not plan and implement interventions in prevention of a second incident.

Staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. [s. 6. (4) (a)]

3. Inspectors 151, 543 and 544 reviewed the resident's health care records and noted that resident #001 had a serious incident related to responsive behaviours. Though the incident was recorded in the progress notes, internal reporting protocol or incident reporting procedure was not initiated, or the family notified of the incident until a second incident 42 days later. As the family was not apprised of the incident, they were not afforded the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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. Inspectors 151, 543 and 544 reviewed the resident's health care records and noted that resident #001 had a serious incident related to responsive behaviours. Though the incident was recorded in the progress notes, internal reporting protocol or incident reporting procedure was not initiated, or the family notified of the incident, or the care plan altered in light of the incident, or was the Director advised as per O.Reg.79/10,s.107 (3). Manager of Resident Care confirmed the incident did not result in changes to the resident's plan of care.

According to the resident's health care records, forty two days later, the resident experienced a similar serious incident of responsive behaviour. Inspectors 151, 543 and 544 reviewed a letter and attached documents from the home's Manager of Resident Care to the ministry's Central Intake Assessment Triage Team (CIATT). It is noted in these attachments that a review of Resident #001's care plans prior to the second incident had "no focus/intervention with respect to [the behaviours]". Review of Resident #001's health care records by Inspectors 151, 543 and 544 confirmed the Manager of Resident Care's statement. Inspectors reviewed the most recent Kardexes used by front line staff to direct the resident's care. The most recent Kardex for Resident #001 was printed for staff's use 6 days post second incident and makes no mention of the behaviours related to the incidents.

The home did not assess and communicate the resident's responsive behaviour risks to staff providing care to the resident and did not plan and implement interventions in prevention of a second incident

Inaction and lack of communication on the part of the staff jeopardized the safety and well-being of Resident #001: hence the licensee did not ensure that Resident #001 was protected from neglect.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. Inspectors 151, 543 and 544 reviewed the resident's health care records and noted that resident #001 had a serious incident related to responsive behaviours. Though the incident was recorded in the progress notes, internal reporting protocol or incident reporting procedure was not initiated, or the family notified of the incident, or the care plan altered in light of the incident, or was the Director advised as per O.Reg.79/10,s.107 (3). Manager of Resident Care confirmed the incident did not result in changes to the resident's plan of care.

According to the resident's health care records, forty two days later, the resident experienced a similar serious incident of responsive behaviour. Inspectors 151, 543 and 544 reviewed a letter and attached documents from the home's Manager of Resident Care to the ministry's Central Intake Assessment Triage Team (CIATT). It is noted in these attachments that a review of Resident #001's care plans prior to the second incident had "no focus/intervention with respect to [the behaviours]". Review of Resident #001's health care records by Inspectors 151, 543 and 544 confirmed the Manager of Resident Care's statement. Inspectors reviewed the most recent Kardexes used by front line staff to direct the resident's care. The most recent Kardex for Resident #001 was printed for staff's use 6 days post second incident and makes no mention of the behaviours related to the incidents. The resident had no plan of care to address the behaviours.

The responsive behaviour plan of care was not based on an interdisciplinary assessment of the resident that included wandering behaviours. [s. 26. (3) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that resident #001's behaviour plan of care is based on an interdisciplinary assessment of the resident that includes the serious behaviours demonstrated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Inspectors 151, 543, 544 reviewed the resident's health care record which indicated that on August 31, 2013, resident #001 was found outside the home by a visitor who brought the resident back into the home. Staff were unaware the resident was outside the home until the resident was returned by the visitor. Though the incident was recorded in the progress note, the home did not initiate any internal reporting protocol or incident reporting procedure, did not notify the family of the incident, did not alter the care plan in light of the incident ,nor did they advise the ministry as per r.107.(3)

On October 12, 2013, the resident was again found outside the home and according to his health care records, was nearly struck by 2 motor vehicles while the resident wandered on Notre Dame Avenue in his wheelchair. Staff were unaware the resident was outside the home until the resident was returned to the home by one of the motorists. Inspector could find no record that the home advised the Director of the incident of missing resident as per o.Reg. 79/10, s.107 (3)1. In an interview, the Manager of Resident Care confirmed that no report had been sent.

The licensee did not informed the Director no later than one business day after the occurrence of the incident of a resident who went missing for less than three hours and who was returned to the home with no injury or adverse change in condition. [s. 107. (3) 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 all incidents of serious resident incidents are reported to the ministry as per the requirements of O.Reg.79/10, s.107 (3), to be implemented voluntarily.

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 6th day of November, 2013

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

Monique G. Berger (151)