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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 16, 2019	2019_556168_0007	002858-19, 005188-19	Complaint

Licensee/Titulaire de permis

Liuna Local 837 Nursing Home (Hamilton) Corporation
44 Hughson Street South HAMILTON ON L8N 2A7

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

Queen's Garden
80 Queen Street North HAMILTON ON L8R 3P6

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

LISA VINK (168)

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): March 6, 7, 8, 19, 20, 21 and 22, 2019 (onsite) and telephone interviews were conducted on March 25, 27, 28, 2019 and April 3, 2019 (offsite).

This inspection was conducted concurrently with Critical Incident Inspection #2019 -556168-0008.

Log #002858-18, related to IL-64010-HA was inspected related to: whistle-blowing protections, continence care and bowel management and infection prevention and control.
Log #005188-19 was inspected related to: duty to protect, reporting certain matters to the Director and licensee must investigate, respond and act.

During the course of the inspection, the inspector(s) spoke with current and former staff including the Administrator, Director of Care (DOC), Environmental Services Supervisor (ESS), Personal Support Workers (PSW), housekeeping staff, laundry staff, dietary staff, the restorative care aid, Registered Nurses (RN), Registered Practical Nurses (RPN), Program Manager, human resources staff, Social Worker, Business/Office Manager, family members and residents.

During the course of the inspection, the inspector observed the provision of care and services, reviewed relevant records including but not limited to: investigative notes, training records, clinical health records, polices and procedures, logs and staff files.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

10 WN(s)
7 VPC(s)
2 CO(s)
0 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	Légende 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 O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: the complaint was investigated and resolved where possible, and a response that complied with paragraph 3 was provided within 10 business days of the receipt of

the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation was commenced immediately and a response was provided to the person who made the complaint, which indicated, what the licensee did to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for the belief.

i. An email was sent to the DOC, dated in December 2018, regarding PSW #103. The email was brief regarding the concern and did not clearly specify the concern with the staff member, for example did it impact residents or staff, nor did it describe the actions displayed.
Written documentation by the DOC identified that they spoke with PSW #103 the following day about workload and a specific resident; however, there was no mention of the specific concern.
There was no other information available related to an investigation into the concern, as confirmed by the DOC during an interview.
There was no Investigation Form completed related to this concern, as confirmed by the DOC.
The DOC identified that the email was "vague" and did not provide sufficient details into the complainant's concern(s).
Interview with the complainant verified that the DOC acknowledged receipt of the email; however, that they had no additional discussions regarding their concern, nor was a response provided related to actions taken to resolve the concern.
Interview with the Administrator confirmed that it was not the practice in the home to notify specific individuals of the outcome or response to their concerns for reasons of confidentiality.

ii. According to an Investigation Form a complaint was received regarding care provided to resident #003 by PSW #103 on a specified date in December 2018.
The resident was interviewed regarding the allegation, which according to the written interview notes, did not substantiate the concern.
The DOC did, speak with PSW #103, on a specified date in January 2019, at which time they mentioned comments made by the resident during the discussion on a specified date in December 2018.
The DOC could not recall a response to the complainant regarding the concern.
The Investigation Form for the concern did not include documentation of a response to the complainant.
Interview with the Administrator confirmed that it was not the practice in the home to notify specific individuals of the outcome or response to their concerns for reasons of

confidentiality.

iii. A concern was received regarding the care provided to resident #005 by PSW #103, according to hand written notes, by the DOC, attached to an Investigation Form, for resident #004, dated on a specified date in January 2019.
The DOC could not recall a concern regarding the care provided to resident #005 when interviewed in March 2019.
Interview with the Administrator, in March 2019, identified that they were not aware of a previous concern regarding the care provided to resident #005, and confirmed on review of the notes that there was a concern voiced and that it was not investigated.
There was no Investigation Form completed related to this concern as confirmed by the DOC.
On a specified date in March 2019, the Administrator identified that they had spoke with the resident the day prior, as part of the investigation process, who denied any concerns with care.
Interview with the Administrator confirmed that it was not the practice in the home to notify specific individuals of the outcome or response to their concerns for reasons of confidentiality.

iv. A concern was received regarding the care provided to resident #004 by PSW #103, according to hand written notes, by the DOC, attached to an Investigation Form, dated on a specified date in January 2019.
The DOC provided documentation of their meeting with PSW #103, on a specified date in January 2019, regarding resident #004.
As a result of the discussion with the complainant and PSW #103, resident #004 was reassessed for their care needs, according to the DOC and restorative care staff #138 and RN #139.
The Investigation Form for the concern did not include documentation of a response to the complainant.
PSW #103, when interviewed on a specified date in March 2019, identified that they were not aware of the outcome of their discussion with the DOC, in January 2019, and were awaiting possible changes to the plan of care based on concerns they identified related to the provision of care and planned assessments to be conducted.
Interview with the initial complainant, in March 2019, confirmed that following their discussion with the DOC, on a specified date in January 2019, they had no additional discussions regarding their specific concern, nor was a response provided related to actions taken to resolve the specific concern.
During an Interview with the DOC, on a specified date in March 2019, they could not

recall a response to PSW #103 related to the concern. A second interview, on a specified date in April 2019, confirmed that a response was not provided; however, was planned to be completed.
Interview with restorative care staff #138 and RN #139, both in March 2019, confirmed that they did not provide a response to PSW #103 following the assessment of the resident.
Interview with the Administrator confirmed that it was not the practice in the home to notify specific individuals of the outcome or response to their concerns for reasons of confidentiality.

v. A concern was received regarding the care provided to resident#003 by PSW #103, according to hand written notes, by the DOC, attached to an Investigation Form, for resident #004, dated on a specified date in January 2019.
The DOC confirmed, on a specified date in April 2019, that they had followed up with the resident earlier that day and that the resident reported no concerns.
The DOC did however, speak with PSW #103 on a specified date in January 2019, regarding a previous discussion with the resident where comments were made regarding staffing and care in December 2018.
There was no Investigation Form provided related to this concern.
Interview with the complainant, on a specified date in March 2019, confirmed that following their discussion with the DOC, in January 2019, they have had no additional discussion with staff at the home regarding the concern, or a response related to actions taken to resolve the concern.
Interview with the Administrator confirmed that it was not the practice in the home to notify specific individuals of the outcome or response to their concerns for reasons of confidentiality.

Not every complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: that the complaint was investigated and resolved where possible, and a response that complied with paragraph 3 was provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation was commenced immediately and a response was provided to the person who made the complaint, which indicated, what the licensee did to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for the belief. [s. 101. (1)]

2. The licensee failed to ensure that the documented record (of complaints received) was

reviewed and analyzed for trends, at least quarterly.

On request the Administrator provided a copy of the 2018 and 2019 Complaint Logs.
A review of the logs did not include the complaints, that the home received, on two specified date in December 2018, or one from January 2019.
The three complaints included a trend regarding PSW #103.
The Administrator confirmed that complaints received from specific individuals were not included on the log, regardless of the concern identified and that they were managed as "investigations"; however, that "investigations" were not logged or tracked.
A review of the Quarter Four Complaint Action Plan, for October to December 2018, noted one complaint only.
The Complaint Action Plan was created based on information recorded in the Complaint Log.
The Quarter Four Complaint Action Plan, for October to December 2018, did not include a review and analysis of all complaints received during the time period, did not identify any trends, nor did it include any improvements required in the home related to complaints received.
The home had not completed a Complaint Action Plan for 2019, at the time of this inspection, as the quarter had not yet been completed.

The documented record (of complaints received) was not reviewed and analyzed for trends, at least quarterly. [s. 101. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 documented record (of complaints received) are reviewed and analyzed for trends, at least quarterly, to be implemented voluntarily.

WN #2: 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 failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may have occurred, immediately reported the suspicion and the information upon which it was 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 risk of harm.

i. An Investigation Form dated on a specific date in December 2018, identified that there was an allegation of abuse, towards resident #003 by PSW #103.
The Administrator confirmed that the allegation was investigated by the DOC, on a specified date in December 2018, who interviewed the resident, at which time the allegation could not be substantiated.
The allegation of abuse was not reported to the Director as required, as the management of the home, was not able to support the allegation and suspected that the concerns were related to another issue.
The Administrator confirmed the requirements for immediate reporting and confirmed that this was not completed.

ii. Hand written notes, by the DOC, attached to an Investigation Form, for resident #004, for a specific date in January 2019, identified a concern with care provided by PSW #103 to resident #005, who had known issues with pain.
Interview with the Administrator, on a specified date in March 2019, following a review of

the notes confirmed that an allegation was made and that the allegation of abuse was not reported to the Director as required.

iii. Hand written notes, attached to an Investigation Form, dated on a specified date in January 2019, identified a concern was voiced with the care provided by PSW #103 to resident #004.
The DOC investigated the allegation by interviewing PSW #103, on a specified date in January 2019, who identified challenges during the provision of care with the resident.
The DOC initiated assessments of the resident to determine if changes in the plan of care were required.
The home could not confirm the allegation of abuse, according to the DOC based on the internal investigation which did not include an interview of the resident nor the observation of the provision of care by PSW #103.
The home did not report the allegation of abuse to the Director as required, as confirmed during an interview with the Administrator.

The person who had reasonable grounds to suspect that any of the following had occurred or may have occurred, failed to immediately reported the suspicion and the information upon which it was 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 risk of harm. [s. 24. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

Resident #002 resided in a room.
According to the current plan of care, with a review date of December 2018, resident #002 demonstrated responsive behaviours related to an activity of daily living and was identified at a specified risk for falls.
Observation of the resident's environment on three dates in March 2019, identified items secured to a location, extending out and around a piece of equipment/furnishing, which was confirmed by RN #112, the Administrator, housekeeper #126 and PSW #115.
The environment was observed following use, independently by the resident, on a specified date in March 2019 and it was noted that one of the items, previously secured had been moved to another location.
The items, in the location, presented a hazard for falls.
Interview with the Administrator confirmed the use of the items to assist in the management of the behaviour; however, that they were considering other options to meet this care need.

The home was not a safe and secure environment. [s. 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 to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A. Resident #002 had a known responsive behaviour related to the activity of daily living.
The home involved additional care partners in revisions of the plan of care with the support of the substitute decision makers (SDM).
The current plan of care had a review date of December 2018.
i. Interview with the DOC and Administrator identified an intervention to manage this behaviour included staff to provide care ever two hours when awake.
The plan of care identified the behaviour and that staff were to provide extensive assistance with one staff to provide the care in the morning; however, no other care routine or schedule was developed.
ii. The plan of care included that a specific piece of equipment was in use, which was initiated in June 2018.
A review of the clinical record including Behavioural Supports Ontario (BSO) Summary of Successful Recommendations document and the progress identified the use of another piece of equipment, which was not effective and removed in February 2019.
Observation of the environment on four dates in March 2019, did not include the presence of either piece of equipment.
Following a review of the plan of care the DOC confirmed that the plan was not revised to reflect the current care needs of the resident.

B. According to PSW #113 and resident interviews, on a specified date in March 2019, resident #004 was dependent on staff for activities of daily living and utilized a device for a specific activity of daily living.
This was a change from the previous device used.

A review of the current plan of care, with a review date of January 2019, noted the use of one type of device for the activity of daily living.
PSW #113 and the DOC each identified communication interventions during the provision of care to meet a care need.
The plan of care also identified, under the focus statement of another specific activity daily of living, that the resident was to be provided care with a third device, an intervention initiated in October 2017, as well as, two staff to provide care utilizing a different device, an intervention initiated in January 2019.
Interview with the DOC following a review of the plan of care confirmed that the plan of care was not reviewed and revised following a change in care needs.

The plan of care was not revised to reflect changes in the resident's care needs. [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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

i. Resident #002 demonstrated responsive behaviours related to an activity of daily living.
Observation of the resident's environment on four dates in March 2019, identified that there was a seat missing from a specific piece of furnishings/equipment in the room, which was confirmed during interviews with RN #112, the ESS, the Administrator and PSW #115.
Interview with the Administrator confirmed that the previous seat, which was used to assist in the management of the behaviour, had been removed as it was not effective.

ii. Resident #008 resided in a private room.
Observations of the resident's environment on three dates in March 2019, identified that there was no lid on a specific piece of furnishings/equipment in the room.
Interview with the ESS confirmed that the absence of the lid and that this was due to previous actions of the resident. It was identified that the home had explored other options to a traditional lid; however, no decisions had been made at the time of the inspection.
Observation of the environment on a specific date in March 2019, identified the lid in place.
Interview with PSW #115 could not identify why previously, the lid was not in place, but confirmed it was recently replaced.

Not all furnishings/equipment were maintained in a safe condition and a good state of repair. [s. 15. (2) (c)]

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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #6: 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 failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's policy and procedure Abuse Allegations and Follow Up, LTC-CA-WQ-100-05 -02, revised July 2016, provided direction in the event of allegations of abuse.
This procedure identified "allegation of abuse immediate action, when a staff member receives a report of abuse or observed anyone (another staff member, volunteer, family member, visitor, or residents) abusing a resident in an manner, staff will: stop the abuse, separate resident and the alleged abuser, ensure safety, get help and assess" and provided direction to "Speak privately with the alleged abuser indicating the inappropriate actions. Document the details of this discussion. In addition to the steps outlined above, additional steps must be taken depending on the role/identify of the alleged abuser, as outlined in "Appendix C - Actions to be taken if the Alleged Abuser is....".
Appendix C - Actions to take if alleged abuser is an employee identified that "the employee is to be removed to an alternative area and/or may be sent home pending completion of the investigation based on the situation and immediately report to police all allegations of an Employee abuse of a resident - physical abuse, with or without resident

injury and/or transport to hospital".

i. Hand written notes, attached to an Investigation Form, dated on a specific date in January 2019, identified a concern was voiced with the care provided by PSW #103 to resident #004.
The DOC investigated the allegation by interviewing PSW #103, on a specified date in January 2019, who identified challenges during the provision of care with the resident.
Interview with the DOC identified that the resident was not immediately assessed, as directed in the policy; however, that they organized assessments to be completed, for a review of the resident's care needs/approaches. These assessments were completed on or after a specific date in January 2019.
During discussions the DOC identified that, based on a number of factors, during the time frame of the allegation they had frequent contact with PSW #103. The DOC noted that there was some consideration to reassigning the PSW to another care area, based on a number of factors; however, this did not occur, other than for one shift, in December 2018. The DOC confirmed that as a result of the allegation they did not remove PSW #103 to an alternative area or send them home pending the completion of the investigation.
There was no information provided that the police were notified of the allegation.

ii. Hand written notes, by the DOC, attached to an Investigation Form, for resident #004, dated on a specific date in January 2019, identified an allegation of concerns with PSW #103 and resident #005, who had known issues with a symptom.
The DOC and Administrator were not able to recall a concern regarding the care provided to resident #005 when interviewed in March 2019; however, on review of the notes confirmed the allegation and lack of investigation or actions taken as a result.
There were no immediate actions taken as a result of the allegation of abuse nor were steps taken regarding the alleged abuser as per the policy and procedure.
On a specific date in March 2019, the Administrator, identified that they had spoken with the resident the day prior, who denied any concerns with care.

The policy and procedure was not complied with. [s. 20. (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 the written policy that promoted zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated, specifically, abuse of a resident by anyone.

Hand written notes, by the DOC, attached to an Investigation Form, regarding resident #004, dated on a specific date in January 2019, identified a concern with specific care provided by PSW #103 to resident #005.
The DOC could not recall a concern regarding resident #005, when interviewed in March 2019.
Interview with the Administrator, in March 2019, identified that they were not aware of a previous concern regarding the care provided to resident #005, and confirmed on review of the notes that there was an allegation and that it was not investigated.
On a specific date in March 2019, the Administrator, identified that they had spoke with the resident the day prior as part of the investigation process who denied any concerns with care.

Every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated, specifically, abuse of a resident by anyone. [s. 23. (1) (a)]

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 alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated, specifically, abuse of a resident by anyone, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1)

performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff received training as required by the section.

The licensee failed to ensure that that no person mentioned in subsection (1) performed their responsibilities before receiving training in the areas of the home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26; infection prevention and control; all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that were relevant to the person's responsibilities and any other areas provided for in the regulations.

The licensee failed to ensure that persons who received training under subsection (2) received retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee failed to ensure that staff who provided direct care to residents received, as a condition of continued contact, training in the areas set out, in the times and or at intervals provided for in the regulation; specifically, related to abuse recognition and prevention and any other areas provided for in the regulations.

Ontario Reg. 79/10 s. 221 identified that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training was to be provided to all staff who provided direct care to residents: skin and wound care; and continence care and bowel management.

Ontario Reg. 79/10 s. 221(2) identified that all staff who provided direct care to residents received the training provided for in subsection 76 (7) of the Act based on the following, subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

A. A request was made for confirmation of annual staff retraining for 2018, specifically to be reviewed for the areas of the home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; abuse recognition and prevention, infection prevention and control; skin and wound; and continence care and bowel management.
The Administrator provided a copy of the Annual LTC (long-term care) Specific Mandatory Education Module, as well as 2018 Annual LTC Specific Mandatory Education Attendance Tracker.
The Administrator identified the expectation that the 2018 retraining of current staff was

completed by December 31, 2018.
A review of the updated Attendance Tracker, identified that housekeeper #129 and dietary aid #135 did not complete the required training until a specified date in March 2019.
The Administrator confirmed that the two identified staff did not submit their completed retraining records, for 2018, until a request was made by the Inspector.
Interview with housekeeper #129 and dietary aid #135, each confirmed that their annual mandatory staff retraining was not completed for 2018 until specified dates in 2019.
The retraining was not completed as required.

B. The home had a policy and procedure, in the Infection Control Manual, Cleaning of Blood and Bodily Substances, LTC-CA-WQ-205-02-02, revised November 2017, which identified the expectation that "spills of body substances on floors (laminate or carpet) must be cleaned and the area disinfected as soon as the spill is detected due to risk of microbial growth and spread as well as the risk of slips and falls for staff and residents. Nursing staff and Housekeeping staff are to clean the spill".

Interviews with housekeeping staff #110, #125, and #126, and PSW staff #103, and RPN #106 each verified that they were not aware of the expectations in this policy and procedure related to nursing and housekeeping staff were responsible to clean the area; however, some of the staff identified that they had recently been re-educated on the expectations.
Interview with the Administrator confirmed that there was no documentation or evidence to support that staff were previously trained on the policy and procedure until March 2019.
Training was not provided as required.

C. The licensee failed to ensure that staff received training in the area of whistle-blowing protections afforded under section 26, prior to performing their responsibilities.

A review of the Whistleblower Policy, CCHR-A-13, with a revision date of October 2018, and the Annual LTC Specific Mandatory Education Modules, did not include the protections afforded under section 26, related to no person shall retaliate against another person, whether by action or omission, to threaten to do so because of anything that had been disclosed to an Inspector, the Director, or in an inquest under the Coroners Act.
Interview with the Administrator confirmed that the home did not have any additional training or information related to education provided to staff on whistle-blowing protections and more specifically protections afforded under section 26, of the LTCHA.

Interview with multiple front line staff during the course of the inspection identified awareness of the term whistle-blowing protections and the internal processes established by Chartwell related to the protections; however, were not familiar with the protections afforded under section 26 of the LTCHA, related to disclosure to the Ministry.

The staff did not receive the training as required. [s. 76. (2) 9.]

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 staff receive training as required, to be implemented voluntarily.

WN #9: 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 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 were documented.

On a specified date in January 2019, concerns were voiced regarding the care and services provided to resident #004.
In an effort to investigate the concerns, the DOC spoke with PSW #103, at which time it was identified that there were challenges during the provision of care for the resident.
As a result of the staff concerns a decision was made to reassess the resident for specific care needs.
According to an email, dated in January 2019, the DOC requested that the resident be assessed by restorative care staff #138 and RN #139.
A email from restorative care staff #138, on a specified date in January 2019, confirmed that the resident had been assessed and no changes were made to the plan of care as a result.
Interview with the DOC confirmed that RN #139 also assessed the resident in response to their request.
A review of the clinical record did not include the assessments of the resident related to the specific care needs, which was confirmed by the DOC, following a review of the clinical record.
Interview with restorative care staff #138 and RN #139 confirmed that the assessments had been completed however, were not documented in the clinical record.

Not every action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. [s. 30. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee failed to ensure that equipment was readily available at the home to meet the nursing and personal care needs of residents.

According to the progress notes, on a specified date in November 2018, resident #006 was provided a piece of equipment to assist with toileting and toilet transfers. The equipment was located on another resident home area and provided for use.
A progress note, on a specific date in November 2018, identified the need for the equipment to assist with toileting and toileting transfers. The equipment was again located on the other resident home area and provided for use.
A subsequent note later in the shift by RPN #106 identified the need for the resident to use the equipment and that one was borrowed from the home until the substitute decision maker (SDM) was able to purchase one for the resident. The note identified that the SDM was encouraged to bring in the equipment so that the resident could be assessed with it.
A note, on a specified date in November 2018, identified that the SDM brought in a new piece of equipment for the resident which they had purchased.
Interview with the DOC confirmed knowledge that the SDM provided the equipment for the resident; however, was not aware that it was specifically purchased for their use while in the home.
The DOC communicated plans to approach the SDM regarding reimbursement.
Interview with the Administrator confirmed that it was not their practice to request SDM's to purchase or provide equipment, which was to be provided by the home.
Interview with the SDM, in March 2019, confirmed that the home had reimbursed the family, for the purchase of the equipment.
Interview with RPN #106, confirmed that the equipment was provided by the SDM when the home did not have one to provide to the resident.
The specified piece of equipment was an allowable expense under the Nursing and Personal Care envelope.

The equipment was not readily available. [s. 44.]

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 29th day of April, 2019

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

Ministère 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) :	LISA VINK (168)
Inspection No. / No de l'inspection :	2019_556168_0007
Log No. / No de registre :	002858-19, 005188-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 16, 2019
Licensee / Titulaire de permis :	Liuna Local 837 Nursing Home (Hamilton) Corporation 44 Hughson Street South, HAMILTON, ON, L8N-2A7
LTC Home / Foyer de SLD :	Queen's Garden 80 Queen Street North, HAMILTON, ON, L8R-3P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kate MacDonald

To Liuna Local 837 Nursing Home (Hamilton) Corporation, 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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

3. A response shall be made to the person who made the complaint, indicating,

i. what the licensee has done to resolve the complaint, or

ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Order / Ordre :

The licensee shall be compliant with s. 101(1) of Ontario Regulation 79/10.

Specifically the licensee must:
a. Ensure that every complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with according to the regulations, specifically:
the complaint is investigated and resolved where possible, and a response that complies with paragraph 3 is provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation is commenced immediately and a response provided to the person who made the complaint, which indicates, what the licensee did to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the belief.
b. The licensee shall comply with the regulations regardless of who made the complaint.
c. The licensee shall ensure that there is a written record maintained for all actions taken in response to complaints concerning the care of a resident or operation of the home.

Grounds / Motifs :

1. The licensee failed to ensure that every complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: the complaint was investigated and resolved where possible, and a response that complied with paragraph 3 was provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation was commenced immediately and a response was provided to the person who made the complaint, which indicated, what the licensee did to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for the belief.

i. An email was sent to the DOC, dated in December 2018, regarding PSW #103. The email was brief regarding the concern and did not clearly specify the concern with the staff member, for example did it impact residents or staff, nor did it describe the actions displayed.
Written documentation by the DOC identified that they spoke with PSW #103 the following day about workload and a specific resident; however, there was no

mention of the specific concern.
There was no other information available related to an investigation into the concern, as confirmed by the DOC during an interview.
There was no Investigation Form completed related to this concern, as confirmed by the DOC.
The DOC identified that the email was "vague" and did not provide sufficient details into the complainant's concern(s).
Interview with the complainant verified that the DOC acknowledged receipt of the email; however, that they had no additional discussions regarding their concern, nor was a response provided related to actions taken to resolve the concern.
Interview with the Administrator confirmed that it was not the practice in the home to notify specific individuals of the outcome or response to their concerns for reasons of confidentiality.

ii. According to an Investigation Form a complaint was received regarding care provided to resident #003 by PSW #103 on a specified date in December 2018.
The resident was interviewed regarding the allegation, which according to the written interview notes, did not substantiate the concern.
The DOC did, speak with PSW #103, on a specified date in January 2019, at which time they mentioned comments made by the resident during the discussion on a specified date in December 2018.
The DOC could not recall a response to the complainant regarding the concern.
The Investigation Form for the concern did not include documentation of a response to the complainant.
Interview with the Administrator confirmed that it was not the practice in the home to notify specific individuals of the outcome or response to their concerns for reasons of confidentiality.

iii. A concern was received regarding the care provided to resident #005 by PSW #103, according to hand written notes, by the DOC, attached to an Investigation Form, for resident #004, dated on a specified date in January 2019.
The DOC could not recall a concern regarding the care provided to resident #005 when interviewed in March 2019.
Interview with the Administrator, in March 2019, identified that they were not aware of a previous concern regarding the care provided to resident #005, and

confirmed on review of the notes that there was a concern voiced and that it was not investigated.
There was no Investigation Form completed related to this concern as confirmed by the DOC.
On a specified date in March 2019, the Administrator identified that they had spoke with the resident the day prior, as part of the investigation process, who denied any concerns with care.
Interview with the Administrator confirmed that it was not the practice in the home to notify specific individuals of the outcome or response to their concerns for reasons of confidentiality.

iv. A concern was received regarding the care provided to resident #004 by PSW #103, according to hand written notes, by the DOC, attached to an Investigation Form, dated on a specified date in January 2019.
The DOC provided documentation of their meeting with PSW #103, on a specified date in January 2019, regarding resident #004.
As a result of the discussion with the complainant and PSW #103, resident #004 was reassessed for their care needs, according to the DOC and restorative care staff #138 and RN #139.
The Investigation Form for the concern did not include documentation of a response to the complainant.
PSW #103, when interviewed on a specified date in March 2019, identified that they were not aware of the outcome of their discussion with the DOC, in January 2019, and were awaiting possible changes to the plan of care based on concerns they identified related to the provision of care and planned assessments to be conducted.
Interview with the initial complainant, in March 2019, confirmed that following their discussion with the DOC, on a specified date in January 2019, they had no additional discussions regarding their specific concern, nor was a response provided related to actions taken to resolve the specific concern.
During an Interview with the DOC, on a specified date in March 2019, they could not recall a response to PSW #103 related to the concern. A second interview, on a specified date in April 2019, confirmed that a response was not provided; however, was planned to be completed.
Interview with restorative care staff #138 and RN #139, both in March 2019, confirmed that they did not provide a response to PSW #103 following the assessment of the resident.

Interview with the Administrator confirmed that it was not the practice in the home to notify specific individuals of the outcome or response to their concerns for reasons of confidentiality.

v. A concern was received regarding the care provided to resident#003 by PSW #103, according to hand written notes, by the DOC, attached to an Investigation Form, for resident #004, dated on a specified date in January 2019.
The DOC confirmed, on a specified date in April 2019, that they had followed up with the resident earlier that day and that the resident reported no concerns.
The DOC did however, speak with PSW #103 on a specified date in January 2019, regarding a previous discussion with the resident where comments were made regarding staffing and care in December 2018.
There was no Investigation Form provided related to this concern.
Interview with the complainant, on a specified date in March 2019, confirmed that following their discussion with the DOC, in January 2019, they have had no additional discussion with staff at the home regarding the concern, or a response related to actions taken to resolve the concern.
Interview with the Administrator confirmed that it was not the practice in the home to notify specific individuals of the outcome or response to their concerns for reasons of confidentiality.

Not every complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: that the complaint was investigated and resolved where possible, and a response that complied with paragraph 3 was provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation was commenced immediately and a response was provided to the person who made the complaint, which indicated, what the licensee did to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for the belief.

The severity of this issue was determined to be a level 2, minimum harm or potential for actual harm.
The scope of this issue was determine to be a level 3, widespread, involving three complaints inspected.
The home had a compliance history of a level 2, one or more unrelated non

compliance in the last three years. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 09, 2019

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be compliant with s. 24(1) of the LTCHA.

Specifically the licensee must:
a. Ensure that the person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reports the suspicion and the information upon which it is based to the Director.
b. Consider information provided, by any source including staff, as potential grounds to suspect abuse or neglect of residents.
c. Follow their policy Abuse Allegations and Follow-Up, LTC-CA-WQ-100-05-02, revised July 2016, which notes that "abuse reporting is immediate and mandatory. If there is any doubt or question as to whether or not the incident is to be reported to regulatory bodies always make the report. The report is to be amended and updated as more information becomes available during the investigation".

Grounds / Motifs :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may have occurred, immediately reported the suspicion and the information upon which it was 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 risk of harm.

i. An Investigation Form dated on a specific date in December 2018, identified that there was an allegation of abuse, towards resident #003 by PSW #103.
The Administrator confirmed that the allegation was investigated by the DOC, on a specified date in December 2018, who interviewed the resident, at which time the allegation could not be substantiated.
The allegation of abuse was not reported to the Director as required, as the management of the home, was not able to support the allegation and suspected that the concerns were related to another issue.
The Administrator confirmed the requirements for immediate reporting and confirmed that this was not completed.

ii. Hand written notes, by the DOC, attached to an Investigation Form, for resident #004, for a specific date in January 2019, identified a concern with care provided by PSW #103 to resident #005, who had known issues with pain.
Interview with the Administrator, on a specified date in March 2019, following a review of the notes confirmed that an allegation was made and that the allegation of abuse was not reported to the Director as required.

iii. Hand written notes, attached to an Investigation Form, dated on a specified date in January 2019, identified a concern was voiced with the care provided by PSW #103 to resident #004.
The DOC investigated the allegation by interviewing PSW #103, on a specified date in January 2019, who identified challenges during the provision of care with the resident.
The DOC initiated assessments of the resident to determine if changes in the plan of care were required.
The home could not confirm the allegation of abuse, according to the DOC based on the internal investigation which did not include an interview of the resident nor the observation of the provision of care by PSW #103.
The home did not report the allegation of abuse to the Director as required, as confirmed during an interview with the Administrator.

The person who had reasonable grounds to suspect that any of the following had occurred or may have occurred, failed to immediately reported the suspicion

and the information upon which it was 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 risk of harm.

The severity of this issue was determined to be a level 1, minimum risk.
The scope of this issue was determined to be widespread, which was relevant to three residents inspected.
The home had a level 3 compliance history, of one or more related non compliance in the last three years that included:
-voluntary plan of correction (VPC), dated April 21, 2016, Inspection Report 2016-215123-0004, for LTCHA s 19;
-non compliance, including a Compliance Order (CO) and VPC's dated November 8, 2017, Inspection Report 2017-546585-0018, for LTCHA s. 19, s. 20, s. 23, and a Written Notification (WN) for O Reg. 79.10 s. 97; and
-WN, dated August 8, 2018, Inspection Report 2018-661683-0013, for LTCHA s. 19. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 09, 2019

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 16th day of April, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

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