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 le Loi de 2007 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Dec 22, 2016;	2016_405189_0014 (A3)	024960-16	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

HUMBER VALLEY TERRACE
95 Humber College Blvd. Rexdale ON M9V 5B5

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

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 le Loi de 2007 les foyers de soins de longue durée

NICOLE RANGER (189) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

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Issued on this 22 day of December 2016 (A3)

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

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

Ministère de la Santé et des Soins de longue durée

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

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HUMBER VALLEY TERRACE
95 Humber College Blvd. Rexdale ON M9V 5B5

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

NICOLE RANGER (189) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 29, 30, 31, Sept 1, 2, 6, 2016

This Critical Incident Inspection is related to an allegation of abuse.

During the course of the inspection, the inspector(s) spoke with the Interim Executive Director, Assistant Director of Care (ADOC), Physician, Staff Educator, Office Manager, registered staff, personal support workers, Substitute Decision Maker (SDM), police force.

During the course of the inspection, the inspector conducted a tour of the unit, observed resident and staff interactions, reviewed clinical health records, reviewed video surveillance, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 was protected from abuse by anyone and not neglected by the licensee or staff.

On an identified date, the home submitted a Critical Incident System Report (CIS) , reporting an allegation of abuse.

During the interview with staff members who worked the evening and night shifts of the alleged incidents, the inspector confirmed that the home did not protect resident #002 from abuse. The inspector found that the home did not take appropriate action to protect resident #002 from abuse.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.
The home failed to take appropriate actions to ensure the safety and protect resident #002 from abuse.

The scope of the non-compliance is isolated to Resident #001 and Resident #002.

A review of the Compliance History revealed the following non-compliances related to LTCHA, 2007. s. 19
In June 2016, the home was issued a Compliance Order related to LTCHA, 2007. s. 19, related to failure to protect three residents from abuse within report 2016_431527_0007.
In April 2015, the home was issued a Voluntary Plan of Correction for failing to comply with LTCHA 2007, s. 19 in that the home did not protect a resident from abuse within report 2015_405189_0006. [s. 19. (1)]

Additional Required Actions:

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

(A3)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #002's substitute decision-maker was notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

On an identified date, the home submitted a Critical Incident System Report (CIS)

reporting an allegation of abuse.

Interview with resident #002's Substitute Decision Maker (SDM) revealed that he/she received a call from RPN #102 on an identified date, informing him/her that he/she is to speak to the nurse upon arrival to the home. The SDM reported that he/she asked the nurse if anything was wrong, and the nurse reported that he/she would speak to him/her once he/she arrived to the home. The SDM told the inspector that he/she was concerned as the nurse did not identify what the issue was. The SDM reported that he/she arrived at the home and was informed by RPN #102 of the alleged abuse. The SDM told the inspector that he/she became distressed about receiving the information and was taken into the Administration office, where he/she was informed by the Interim Executive Director #100 and the ADOC #101 that nothing had happened. The SDM reported that he/she was assured that nothing had seriously happened to resident #002, until he/she was contacted by the Police who informed him/her that an incident of abuse did occur.

The inspector determined that the SDM was not informed in full details of the allegations of abuse as he/she received inconsistent information from the licensee about the incident. The licensee failed to ensure that resident #002's SDM was immediately notified upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

The content of information related to the alleged/witnessed incident of abuse was not fully communicated to resident #002's SDM.

The scope of the non-compliance is isolated to Resident #001 and Resident #002. [s. 97. (1) (a)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

On an identified date, the home submitted a Critical Incident System Report (CIS) reporting an allegation of abuse.

Interview with RN #112 and RPN #113 revealed that they did not contact the police to report the alleged/witnessed abuse.

Interview with the Interim Executive Director #100 confirmed that the police were not notified of the alleged/witnessed incident until the following day.

The inspector spoke with Lead Detective Police Constable #116 who told the inspector that the police were not notified about the two incidents of abuse until the following day which was greater than 12 hours after the first incident.

Given what was witnessed by the staff, the licensee should have suspected this was a criminal offence and contacted the police after the first incident.The inspector confirmed that the licensee failed to immediately notify the appropriate

police force of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

The home failed to immediately notify the appropriate police force of any alleged, suspected or witnessed incident of abuse of resident #002.

The scope of the non-compliance is isolated to Resident #001 and Resident #002.

A review of the Compliance History revealed the following non-compliances related to LTCHA, 2007. s. 98
In June 2016, the home was issued a Voluntary Plan of Correction related to O.Reg 79/10. r. 98, related to failure to immediately notify the appropriate police force of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence within report 2016_431527_0007. [s. 98.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

The home submitted a Critical Incident System Report (CIS) to the Director on an identified date, related to an incident of alleged abuse of resident #002 .

The home's abuse policy "Resident Non-Abuse – Ontario", LP-C-20-ON revised September 2014, indicates that in the case of physical and/or sexual abuse, it is imperative to preserve potential evidence as the complaint may result in criminal charges. Staff are to ensure that measures are taken to preserve evidence.

The inspector spoke with Lead Detective Police Constable #116 who told the inspector upon examining resident #002 on an identified date, the home did not ensure measures were taken to preserve evidence.

Interview with PSW #105 who assigned to care for resident #002 on an identified date told the inspector that he/she did not alter his/her care for the resident in order to preserve evidence as he/she had not been given any directions to do anything differently.
Interview with the ADOC revealed that he/she spoken with PSW #105 and confirmed the PSW did not take measures to preserve evidence. The ADOC acknowledge that the PSW did not follow the home's abuse policy for abuse to preserve evidence. [s. 20. (1)]

2. The home's abuse policy "Resident Non-Abuse – Ontario", LP-C-20-ON revised September 2014, titled " Immediate Interventions Following Allegations of Resident Abuse" identified that:
- the first priority is to ensure the safety and comfort of the abuse victim, first taking all reasonable steps to provide for their immediate safety and well being, then

through completion of full assessments, a determination of the resident's need and a documented plan to meet those needs
- In case of resident to resident abuse, staff shall ensure the residents are separated and tended to separately.

During an interview with RN #112, when asked what support the staff provided resident #002 after the incident, the RN told the inspector that the resident did not respond when questioned and did not appear distressed.

During an interview with RPN #113, when asked what support the staff provided resident #002 after the incident, the RPN told the inspector that the resident was sleeping in bed when he/she assessed the resident.

Through interviews, the inspector determined that the staff did not offer resident #002 any support or assistance to determine the well-being of resident #002 after the incidents. There was no protection put into place after the first incident to prevent the second incident from occurring. The staff did not take reasonable actions or interventions to ensure the safety and well-being for resident #002, and there was not a documented plan to meet the needs of resident #002. The staff did not follow the home's abuse policy related to immediate care and safety of resident following allegations of resident abuse. [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 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had 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 reported the suspicion and the information upon which it was based to the Director.

Critical Incident Systems (CIS) report was submitted to the Director on an identified date, an allegation of abuse.

The home initiated the CIS report on an identified date at 1735 hours. This is the first time the Ministry (Director, LTCHA) was notified of either of the incidents. Two incidents of abuse occurred between the evening and night prior to the submission of the the report to the MOHLTC Director. The Office Manager was in charge of the home at the time of the incidents, told the inspector that he/she received a call about both incidents, however there was no immediate reporting to the Ministry after both incidents.

Interview with the ADOC confirmed the home did not call the Ministry's after-hours line (after 1630 hrs Monday to Friday and all other times including statutory holidays) to inform the Director immediately upon becoming aware of the incident of alleged abuse of resident #002, and the Ministry was notified of the incident as reported on the CIS. [s. 24. (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 a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

Issued on this 22 day of December 2016 (A3)

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

Ministère de la Santé et des Soins de longue durée

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : NICOLE RANGER (189) - (A3)

Inspection No. / No de l'inspection : 2016_405189_0014 (A3)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 024960-16 (A3)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Dec 22, 2016;(A3)

Licensee / Titulaire de permis :
REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR,
MISSISSAUGA, ON, L5R-4B2

LTC Home / Foyer de SLD :
HUMBER VALLEY TERRACE
95 Humber College Blvd., Rexdale, ON, M9V-5B5

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Heather Reuber

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 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 :

(A3)
The licensee shall prepare, submit, and implement a plan to ensure that the home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. The plan will include but not limited to the following:
- Develop a plan on how the home will educate staff and on-call managers to identify and respond when they witness high risk situations for residents who are roommates and have different levels of cognitive impairment.
- Develop a plan to educate nursing staff to assess residents with cognitive impairments who have been abused. To further identify the type of assessments that need to be completed for residents with compromised communication skills. Including how to complete assessments to determine if the resident has suffered harm.
- Develop a plan to educate all staff of their obligation to act, and how to identify and avoid situations where a resident may have the potential to repeatedly abuse a co-resident within a short period.

The licensee shall maintain a record of re-training provided including dates, times, attendees, trainers and material taught.

The plan to be submitted via email to nicole.ranger@ontario.ca by November 28, 2016

Grounds / Motifs :

1. The licensee has failed to ensure that resident #002 was protected from abuse by anyone and not neglected by the licensee or staff.

On an identified date, the home submitted a Critical Incident System Report (CIS) , reporting an allegation of abuse.

During the interview with staff members who worked the evening and night shifts of the alleged incidents, the inspector confirmed that the home did not protect resident #002 from abuse. The inspector found that the home did not take appropriate action to protect resident #002 from abuse.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.
The home failed to take appropriate actions to ensure the safety and protect resident #002 from abuse.

The scope of the non-compliance is isolated to Resident #001 and Resident #002.

A review of the Compliance History revealed the following non-compliances related to LTCHA, 2007. s. 19
In June 2016, the home was issued a Compliance Order related to LTCHA, 2007. s. 19, related to failure to protect three residents from abuse within report 2016_431527_0007.
In April 2015, the home was issued a Voluntary Plan of Correction for failing to comply with LTCHA 2007, s. 19 in that the home did not protect a resident from abuse within report 2015_405189_0006. [s. 19. (1)] (189)

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

Jan 27, 2017(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being. The plan will include but not limited to the following:
- Develop communication strategies for managers and registered staff to ensure that full and accurate information is provided immediately to the resident or substitute decision maker.
- Provide education on reporting incidents such as any alleged, suspected, or witnessed incidents of neglect to SDM under the requirements of the legislation.
- Maintain a record of re-training provided including dates, times, attendees, trainers and material taught.

Plan to be submitted via email to nicole.ranger@ontario.ca by November 28, 2016.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that Resident #002's substitute decision-maker was notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

On an identified date, the home submitted a Critical Incident System Report (CIS) reporting an allegation of abuse.

Interview with resident #002's Substitute Decision Maker (SDM) revealed that he/she received a call from RPN #102 on an identified date, informing him/her that he/she is to speak to the nurse upon arrival to the home. The SDM reported that he/she asked the nurse if anything was wrong, and the nurse reported that he/she would speak to him/her once he/she arrived to the home. The SDM told the inspector that he/she was concerned as the nurse did not identify what the issue was. The SDM reported that he/she arrived at the home and was informed by RPN #102 of the alleged

abuse. The SDM told the inspector that he/she became distressed about receiving the information and was taken into the Administration office, where he/she was informed by the Interim Executive Director #100 and the ADOC #101 that nothing had happened. The SDM reported that he/she was assured that nothing had seriously happened to resident #002, until he/she was contacted by the Police who informed him/her that an incident of abuse did occur.

The inspector determined that the SDM was not informed in full details of the allegations of abuse as he/she received inconsistent information from the licensee about the incident. The licensee failed to ensure that resident #002's SDM was immediately notified upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

The content of information related to the alleged/witnessed incident of abuse was not fully communicated to resident #002's SDM.

The scope of the non-compliance is isolated to Resident #001 and Resident #002. [s. 97. (1) (a)] (189)

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

Jan 27, 2017(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The plan shall include, but not limited to the following:

-develop an education plan that addresses when to contact the police,steps to take prior to and after notification of the police
- provide the education identified in the plan to all staff
- Education to be provided by a person experienced in law enforcement and investigation.

The plan to be submitted via email to nicole.ranger@ontario.ca by November 28, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

On an identified date, the home submitted a Critical Incident System Report (CIS) reporting an allegation of abuse.

Interview with RN #112 and RPN #113 revealed that they did not contact the police to report the alleged/witnessed abuse.

Interview with the Interim Executive Director #100 confirmed that the police were not notified of the alleged/witnessed incident until the following day.

The inspector spoke with Lead Detective Police Constable #116 who told the inspector that the police were not notified about the two incidents abuse until the following day which was greater than 12 hours after the first incident.

Given what was witnessed by the staff, the licensee should have suspected this was a criminal offence and contacted the police after the first incident.The inspector confirmed that the licensee failed to immediately notify the appropriate police force of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. (189)

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

Jan 27, 2017(A1)

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
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 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

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

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

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

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

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

RENSEIGNEMENTS 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
Inspection 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

Ontario

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

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

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

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

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

Directeur
a/s Coordinateur des appels
Inspection 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

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 22 day of December 2016 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : NICOLE RANGER - (A3)

Service Area Office /
Bureau régional de services : Toronto