Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 31, Nov 1, 2, 3, 7, 8, 9, 10, 14, 15, 16, 18, 2011	2011_034117_0034	Complaint

Licensee/Titulaire de permis

DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5

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

WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0

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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the RAI Coodinator, to several Registered Nurses (RN), to several Registered Practical Nurses (RPN), to several Personal Support Workers (PSW), to several residents, to several resident family members and to the President of the Family Council.

During the course of the inspection, the inspector(s) reviewed several residents health care records, reviewed a Critical Incident report, reviewed the home's policy on Abuse (Policy # 02-06-01), reviewed the home's policy on Resident Safety/Emergency Procedures (Policy # 08-09-03), reviewed the residents bath schedule, observed resident care, observed grooming status of several residents, observed cleanliness of clothing for several residents, reviewed the home's nursing staffing schedule, reviewed the home's education plan and inservices given between July 1 to November 1 2011, reviewed the home's complaint process and reviewed the newly hired staff qualifications.

The following complaint inspections were done during this inspection log # O-001307-11, log # O-001456-11, log # O-001466-11 and log # O-002390-11.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Falls Prevention

Minimizing of Restraining

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. An identified resident has cognitive impairments and requires assistance with personal care and bathing needs. Since late June 2011, the resident refused to have a bath. Responsive behaviour interventions were ineffective in redirecting the resident to have a bath.

On an identified day in July 2011, there was an incident of staff to resident abuse that occurred during the provision of evening care for an identified resident. This was witnessed by another PSW.

The incident was reported by PSW-witness to the night RN. The night RN reported the incident to day RN at shift change. It is noted that the resident was not assessed by either RN. The RNs did not report the incident of abuse to the home's Administrator or DOC.

Two days later, the PSW-witness reported the incident of staff to resident abuse to the home's Administrator and DOC. The Administrator and DOC immediately started an investigation into the incident of staff to resident abuse.

The Administrator called local OPP offices to report the incident of staff to resident abuse.

Two days after the incident, the day RN assessed the identified resident. Bruises were noted to be present.

Disciplinary measures for involved staff were implemented as per the home's Human Resources Policies (log # 001456-11) [LTCHA 2007, c.8, section 3 (1)(2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

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;
(b) appropriate action is taken in response to every such incident; and
(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. On an identified day in July 2011, there was an incident of staff to resident abuse that occurred during the provision of evening care for an identified resident. This was witnessed by another PSW.

The incident was reported by PSW-witness to the night RN. The night RN reported the incident to day RN at shift change. It is noted that the resident was not assessed by either RN. The RNs did not report the incident of abuse to the home's Administrator or DOC.

Two days later, the PSW-witness reported the incident of staff to resident abuse to the home's Administrator and DOC. The Administrator and DOC immediately started an investigation into the incident of staff to resident abuse.

The Administrator called local OPP offices to report the incident of staff to resident abuse.

The Administrator confirmed that the night RN did not notify either herself the Administrator or the DOC on the morning after the incident of staff to resident abuse. The Administrator states that this was confirmed with RN during Admin/ DOC investigation into incident

The Administrator confirmed that the day RN did not notify either the Administrator or the DOC at anytime during the day after the incident and of being made aware of the incident of staff to resident abuse by the night RN at the start of the day shift. The Administrator states that this was confirmed with RN during Admin/ DOC investigation into incident. (log # O-001456-11)

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. As per the LTCHA 2007, S.O. 2007, c.8, section 20 (1), 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.

The Licensee policy regarding Resident Abuse (Policy # 02-06-01) identifies that "all staff members are to report any allegation, witnessed or suspected abuse immediately to the Administrator, Director of Care / designate or their Supervisor".

On an identified day in July 2011, there was an incident of staff to resident abuse that occurred during the provision of evening care for an identified resident. This was witnessed by another PSW.

The incident was reported by PSW-witness to the night RN. The night RN reported the incident to day RN at shift change. It is noted that the resident was not assessed by either RN. The RNs did not report the incident of abuse to the home's Administrator or DOC.

Two days later, the PSW-witness reported the incident of staff to resident abuse to the home's Administrator and DOC. The Administrator and DOC immediately started an investigation into the incident of staff to resident abuse.

The Administrator called local OPP offices to report the incident of staff to resident abuse.

The Administrator confirmed that the night RN did not notify either herself the Administrator or the DOC on the morning after the incident of staff to resident abuse. The Administrator states that this was confirmed with RN during Admin/ DOC investigation into incident

The Administrator confirmed that the day RN did not notify either the Administrator or the DOC at anytime during the day after the incident and of being made aware of the incident of staff to resident abuse by the night RN at the start of the day shift. The Administrator states that this was confirmed with RN during Admin/ DOC investigation into incident

2. As per the O.Reg 79/10 under the LTCHA 2007, S.O. 2007, c.8, section 48 (1)(1), the Licensee is to have a Falls Prevention and Management Program to reduce the incident of falls and the risk of injury.

The Licensee has a Fall Prevention and Management program that includes a policy regarding Resident safety / Emergency Procedures : Neurological Signs / Head Injury Routine (Policy # 08-09-03) identifies that " the HIR (head injury routine) is to be implemented whenever a resident experiences a head injury, or is suspected of having experienced a head injury e.g. from a fall".

An identified resident who suffers from cognitive impairments is identified as being at risk for falls.

In May 2011, the identified resident fell while mobilizing to the bathroom. The resident sustained an injury. The resident was transferred to hospital for further assessment. The resident was returned to the home later that day. The resident was not assessed as per the home's Head Injury Routine

Interviewed RN and DOC confirmed that the home's head injury protocols were not initiated as per the home's policy. (log # O-001307-11)

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 long-term care home's policies, protocols and procedures regarding the reporting and investigation of abuse and head injury routine are complied with,, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. On November 1 2011 at 12:05 an RPN was observed to leave his/her medication unlocked and unattended for several minutes, outside of the dining room to give medication to two residents.
2. Several staff members, who were on a day long training session as well as one resident were observed to walk past the unattended and unlocked medication cart.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The Licensee has a Fall Prevention and Management program that includes a policy regarding Resident safety / Emergency Procedures : Neurological Signs / Head Injury Routine (Policy # 08-09-03) identifies that " the HIR (head injury routine) is to be implemented whenever a resident experiences a head injury, or is suspected of having experienced a head injury e.g. from a fall".

An identified resident who suffers from cognitive impairments, is identified as being at risk for falls.

In May 2011, the identified resident fell while mobilizing to the bathroom. The resident sustained an injury. The resident was transferred to hospital for further assessment. The resident was returned to the home later that day. The resident was not assessed as per the home's Head Injury Routine

Interviewed RN and DOC confirmed that the home's head injury protocols were not initiated as per the home's policy. (log # O-001307-11)

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. A resident has responsive behaviours. Psychogeriatric outreach services are working with the home regarding the resident's responsive behaviour management interventions.

In July and August 2011 the resident had increased responsive behaviours.

In early August 2011, the resident was assessed by psychogeriatric outreach services. The resident's prescribed medication was increased and a prn (as needed) medication was ordered. The medication's effectiveness on resident behaviours was not assessed or documented in the resident's health care record until the end of August 2011.

The resident continued to have frequent periods of active responsive behaviours, from early September to the end of October 2011. The resident does have medication order for prn medication for acute agitation. A review of the resident's health care record notes that the prn medication was not administered as per medication orders when other plan of care interventions were not effective. (log # O-001307-11)

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 actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: 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 subsections:

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

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

Findings/Faits saillants :

1. An identified resident has cognitive impairments and requires assistance with personal care and bathing needs. The resident's plan of care identifies that the resident is to have an anxiolitic medication 1hr prior to his/her bath/shower.

Since late June 2011, the identified resident had refused to have a bath even with the administration of the anxiolitic medication 1h prior to his/her scheduled bath/shower. Responsive behaviour interventions were ineffective in redirecting the resident to have a bath.

On an identified day in July 2011, there was an incident of staff to resident abuse that occurred during the provision of evening care for the identified resident. This was witnessed by another PSW.

The resident's Medication Administration Record (MAR) for July 2011 indicated that the identified resident did not receive the anxiolitic medication 1hr prior to his/her bath. (log # O-001456-11)

2. An identified resident's plan of care indicates that the resident is to have two showers per week. Daily care flow sheets for July, August, September and October 2011 were reviewed.

It is noted that the resident received only one shower on the following weeks: June 28, July 12, August 9, September 6-13-20 and October 4 and 25 2011 (log # O-001456-11)

There is no documentation for resident shower refusal or alternative provision of care noted in the resident's health care record.

3. An identified resident's plan of care indicates that the resident is to have two showers per week. Daily care flow sheets for July, August, September and October 2011 were reviewed.

It is noted that the resident received no shower or only one shower on the following weeks: June 28; July 5,12,19,26; August 2,16; September 20, 27; and October 4,11 and 18 2011. (log # O-001456-11)

There is no documentation for resident shower refusal or alternative provision of care noted in the resident's health care record.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

CORRECTED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 8.	CO #001, #002	2011_044161_0011	117
LTCHA, 2007 S.O. 2007, c.8 s. 8.	CO #001, #002	2011_044161_0011	117
LTCHA, 2007 S.O. 2007, c.8 s. 8.	CO #001	2011_044161_0017	117
O.Reg 79/10 r. 75.	CO #001	2011_042148_0023	117

Issued on this 29th day of November, 2011

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNE DUCHESNE (117)
Inspection No. / No de l'inspection :	2011_034117_0034
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Oct 31, Nov 1, 2, 3, 7, 8, 9, 10, 14, 15, 16, 18, 2011
Licensee / Titulaire de permis :	DEEM MANAGEMENT LIMITED 2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5
LTC Home / Foyer de SLD :	WELLINGTON HOUSE NURSING HOME 990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARYLIN BENN

To DEEM MANAGEMENT LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The Licensee to ensure that Resident Rights are respected, that every resident is protected from abuse .

Grounds / Motifs :

1. 1. An identified resident has cognitive impairments and requires assistance with personal care and bathing needs. Since late June 2011, the resident refused to have a bath. Responsive behaviour interventions were ineffective in redirecting the resident to have a bath.

On an identified day in July 2011, there was an incident of staff to resident abuse that occurred during the provision of evening care for the identified resident. . This was witnessed by another PSW.

The incident was reported by PSW-witness to the night RN. The night RN reported the incident to day RN at shift change. It is noted that the resident was not assessed by either RN. The RNs did not report the incident of abuse to the home's Administrator or DOC.

Two days later, the PSW-witness reported the incident of staff to resident abuse to the home's Administrator and DOC. The Administrator and DOC immediately started an investigation into the incident of staff to resident abuse.

The Administrator called local OPP offices to report the incident of staff to resident abuse.

Two days after the incident, the day RN assessed the identified resident. Bruises were noted to be present.

Disciplinary measures for involved staff were implemented as per the home's Human Resources Policies. (log # 001456-11) [LTCHA 2007, c.8, section 3 (1)(2)] (117)
2. (117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 25, 2011

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 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. 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;
(b) appropriate action is taken in response to every such incident; and
(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).

Order / Ordre :

The Licensee shall ensure that any staff that are made aware of any alleged, suspected or witnessed incident of abuse is immediately report the incident to the home's Administrator, Director of Care or immediate supervisor to ensure that the incident is immediately investigated.

Grounds / Motifs :

1. On an identified day in July 2011, there was an incident of staff to resident abuse that occurred during the provision of evening care for an identified resident. This was witnessed by another PSW.

The incident was reported by PSW-witness to the night RN. The night RN reported the incident to day RN at shift change. It is noted that the resident was not assessed by either RN. The RNs did not report the incident of abuse to the home's Administrator or DOC.

Two days later, the PSW-witness reported the incident of staff to resident abuse to the home's Administrator and DOC. The Administrator and DOC immediately started an investigation into the incident of staff to resident abuse.

The Administrator called local OPP offices to report the incident of staff to resident abuse.

The Administrator confirmed that the night RN did not notify either herself the Administrator or the DOC on the morning after the incident of staff to resident abuse. The Administrator states that this was confirmed with RN during Admin/ DOC investigation into incident

The Administrator confirmed that the day RN did not notify either the Administrator or the DOC at anytime during the day after the incident and of being made aware of the incident of staff to resident abuse by the night RN at the start of the day shift. The Administrator states that this was confirmed with RN during Admin/ DOC investigation into incident. (log # O-001456-11) [LTCHA 2007, c.8, section 23 (1) (a)(i)] (117)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 25, 2011

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
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 18th day of November, 2011

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNE DUCHESNE

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