Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 18, 2021	2020_866585_0002 (A1)	005393-20, 013285-20, 014896-20, 021916-20, 022535-20, 022899-20, 022989-20	Critical Incident System

Licensee/Titulaire de permis

St. Peter's Care Centres
125 Redfern Avenue Hamilton ON L9C 7W9

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

St. Peter's Residence at Chedoke
125 Redfern Avenue Hamilton ON L9C 7W9

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

Amended by LEAH CURLE (585) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

This public inspection report has been revised to reflect an adjustment to the compliance due date (CDD) for compliance order (CO) #001 pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 6. (7).

The Critical Incident System Inspection #2020_866585_0002 was completed on December 11, 22, 23, 29, 30, 2020 and January 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 2021.

A copy of the revised report is attached.

Issued on this 18th day of February, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
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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
Feb 18, 2021	2020_866585_0002 (A1)	005393-20, 013285-20, 014896-20, 021916-20, 022535-20, 022899-20, 022989-20	Critical Incident System

Licensee/Titulaire de permis

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

St. Peter's Residence at Chedoke
125 Redfern Avenue Hamilton ON L9C 7W9

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

Amended by LEAH CURLE (585) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 11, 22, 23, 29,

30, 2020 and January 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 2021.

The following Critical Incident System (CIS) inspections were conducted during this inspection:

Log # 005393-20 / CIS report #2927-000005-20 related to falls;

Log # 013285-20 / CIS report #2927-000013-20 related to abuse;

Log # 014896-20 / CIS report #2927-000014-20 related to personal supports;

Log # 021916-20 / CIS report #2927-000020-20 related to personal supports;

Log # 022535-20 / CIS report #2927-000023-20 related to alleged abuse;

Log # 022899-20 / CIS report #2927-000026-20 related to abuse; and,

Log # 022989-20 / CIS report #2927-000027-20 related to falls.

Complaint inspection #2020_866585_0001 was also conducted concurrent to this CIS inspection.

During the course of the inspection, the inspector(s) spoke with residents, family members, essential care-givers, Personal Care Workers (PCWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Resident Care Supervisors (RCSs), the Physiotherapist (PT), Physiotherapist Assistants (PTAs), a Financial Analyst, the Nurse Practitioner (NP), Registered Dietitian (RD), Manager of Resident Services (MRS), Assistant Director of Care (ADOC), Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed

residents and the provision of care, reviewed relevant records and documents that included, but were not limited to: clinical health records, policies and procedures, program evaluations, training records, staff schedules and investigation records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- **8 WN(s)**
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in two residents plan of care on how staff were to provide care, was provided to the resident as specified in the plan.

A) A Personal Care Worker (PCW) confirmed they did not follow a resident's plan of care during a shift in 2020. The Assistant Director of Care (ADOC) confirmed the resident required a different level of care than what the PCW provided.

The PCW's failure to follow the plan of care resulted in actual harm to the resident as they sustained injury and pain as a result of the improper care.

B) A PCW was interviewed and confirmed they did not follow a resident's plan of care during a shift in 2020. The Director of Care (DOC) confirmed the resident required a different level of care than what the PCW provided.

Failure to follow the plan of care put the resident at risk as the intervention was in place for their safety.

Sources: investigation notes, two resident health records, interviews with PCWs, the ADOC and DOC. [s. 6. (7)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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:

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 has failed to ensure that an allegation of financial abuse of a resident and an allegation of emotional abuse of a resident were immediately investigated.

A) In 2020, the home received information of alleged financial abuse of a resident. The Manager of Resident Services (MRS) confirmed action was not taken to investigate until 10 days after the home was first made aware of the allegations.

Failure to immediately investigate the allegation increased risk to the resident.

Sources: internal investigation notes, interview with the MRS.

B) In 2020, a registered nurse (RN) was notified by another staff regarding an allegation of emotional abuse of a resident. The home's investigation notes showed the incident was not investigated immediately, which was confirmed by the RN.

Failure to immediately investigate increased risk to the resident as there was a delay in the assessment of the resident's status.

Sources: investigation notes, the resident's health record, interview with a RN and other staff. [s. 23. (1) (a)]

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques to assist a resident.

The home's Lift and Transfer Policy stated to not attempt to lift any resident from the floor without a mechanical lift. A staff failed to follow the home's policy in October 2020 when attempting to assist one resident from the floor, which was confirmed by a RN.

Failure to use safe transferring techniques put the resident at risk of harm for discomfort and injury.

Sources: investigation reports, the resident's health record, Lift and Transfer Policy, interview with a RN. [s. 36.]

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 and ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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 failed to ensure that when a resident experienced a fall, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

In October 2020, a resident experienced a fall. A Registered Practical Nurse (RPN) confirmed the fall was reported to registered nursing staff. A RN stated a post-fall assessment should have been completed; however, confirmed it was not done.

Failure to complete a post-fall assessment resulted in a lack of assessment and monitoring of the resident's status after experiencing a fall.

Sources: resident health record, interviews with staff. [s. 49. (2)]

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 and 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when two residents exhibited altered skin integrity, they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Skin assessments were not completed for two residents when registered nursing staff were aware both residents had new areas of altered skin.

The DOC confirmed registered nursing staff were expected to use the home's skin assessment tool when new areas of altered skin integrity were identified.

Sources: two resident's clinical health records, interviews with staff and the DOC. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that when two residents exhibited altered skin integrity, they were assessed by a registered dietitian (RD) who was a member of the staff of the home.

Two residents had new areas of altered skin integrity noted in their clinical record. Neither resident had been assessed by the RD specifically in relation to the identified areas of altered skin, which was confirmed by the RD.

Sources: two resident health records, interview with the RD. [s. 50. (2) (b) (iii)]

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 and ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment; and, (iii) is assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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. The licensee has failed to ensure that actions taken to meet the needs of three residents with responsive behaviours included assessments and documentation of the resident's responses to the interventions.

Three residents had been demonstrating responsive behaviours. Specified interventions were put in place for the residents which included increased monitoring and documentation of their behaviours. The documentation was not completed on all shifts as required. The MRS confirmed the expectation was for staff to document on all shifts, and that it was incomplete.

One resident had an additional intervention to be completed in response to their behaviours; however, staff failed to document the outcome of the intervention. This was confirmed by a Resident Care Supervisor (RCS).

Sources: three residents clinical records, interview with the MRS and a RCS. [s. 53. (4) (c)]. [s. 53. (4) (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 and ensure that for each resident demonstrating responsive behaviours, 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. 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 a resident was protected from physical abuse by a co-resident.

The following is further evidence to support the order issued on November 27, 2020, during inspection 2020_848748_0002 to be complied by February 18, 2021.

Section 2. (1) of the Ontario Long-Term Care Homes Act, 2008, defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

An incident occurred in 2020 where a resident sustained an injury and pain as a result of force used against them by a co-resident. This was confirmed by a RN.

Sources: resident's health record, interview with a RN and other staff. [s. 19. (1)]

WN #8: 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 has failed to ensure that they immediately reported the suspicion of the misuse or misappropriation of a resident's money to the Director when they had reasonable grounds to do so.

The following is further evidence to support the order issued on November 27, 2020, during inspection 2020_848748_0002 to be complied by February 18, 2021.

The home had been investigating an allegation of financial abuse of a resident. When the home received information that was reasonable grounds to suspect the misuse or misappropriation of the resident's money, they did not immediately report the suspicion to the Director. This was confirmed by the MRS and ADOC.

Sources: CIS report #2927-000013-20, the home's investigation notes, interview with the MRS and the ADOC. [s. 24. (1)]

Issued on this 18th day of February, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by LEAH CURLE (585) - (A1)
Inspection No. / No de l'inspection :	2020_866585_0002 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	005393-20, 013285-20, 014896-20, 021916-20, 022535-20, 022899-20, 022989-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 18, 2021(A1)
Licensee / Titulaire de permis :	St. Peter's Care Centres 125 Redfern Avenue, Hamilton, ON, L9C-7W9
LTC Home / Foyer de SLD :	St. Peter's Residence at Chedoke 125 Redfern Avenue, Hamilton, ON, L9C-7W9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jennifer Banks

Ontario

Ministry of Long-Term Care

Ministère 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 St. Peter's Care Centres, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre: 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. 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).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

Specifically, the licensee must ensure:

1. A resident is provided care as per the plan of care; and,

2. Specified personal care workers (PCW) are provided re-education on the importance of following a resident's plan of care and the requirement to provide care based on the assessed need of the resident. A documented record must be maintained of the education provided, including the names of staff who received the education, date the education was provided and content and format of the education.

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

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in a resident's plan of care on how staff were to provide care, was provided to the resident as specified in the plan.

A Personal Care Worker (PCW) confirmed they did not follow a resident's plan of care during a shift in 2020. The Assistant Director of Care (ADOC) confirmed the resident required a different level of care than what the PCW provided.

The PCW's failure to follow the plan of care resulted in actual harm to the resident as they sustained injury and pain as a result of the improper care.

Sources: investigation notes, the resident's health record, interviews with a PCWs and the ADOC. [s. 6. (7)].

An order was made by taking the following factors into account:

Severity: Failing to follow the plan of care resulted in actual injury and harm to the resident.

Scope: This was an isolated case as no other incidents of improper care were identified during this inspection.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 6 (7) whereby one Written Notification (WN) and two Voluntary Plans of Correction (VPCs) were issued to the home. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 15, 2021(A1)

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre: 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 must be compliant with s. 23 (1) of the LTCHA.

Specifically, the licensee must ensure:

1. Any allegation of financial or emotional abuse of any resident are immediately investigated.

2. An identified registered nurse is re-educated on their requirement, as set out in the home's Non-Abuse of Residents policy, to immediately report to a member of the leadership team upon becoming aware of an allegation of resident abuse and to immediately assess the resident for emotional distress. A record of this re-education will be maintained.

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

Grounds / Motifs :

1. The licensee has failed to ensure that an allegation of financial abuse of a resident and an allegation of emotional abuse of a resident were immediately investigated.

A) In 2020, the home received information of alleged financial abuse of a resident. The Manager of Resident Services (MRS) confirmed action was not taken to investigate until 10 days after the home was first made aware of the allegations.

Failure to immediately investigate the allegation increased risk to the resident.

Sources: internal investigation notes, interview with the MRS.

B) In 2020, a registered nurse (RN) was notified by another staff regarding an allegation of emotional abuse of a resident. The home's investigation notes showed the incident was not investigated immediately, which was confirmed by the RN.

Failure to immediately investigate increased risk to the resident as there was a delay in the assessment of the resident's status.

Sources: investigation notes, the resident's health record, interview with a RN and other staff.

An order was made by taking the following factors into account:

Severity: Having staff not immediately investigate allegations of abuse resulted in potential harm to the residents.

Scope: This was a pattern as there were two instances of failing to immediately investigate allegations of abuse.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 23. (1) whereby one Voluntary Plan of Correction (VPC) was issued to the home. (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 15, 2021

Ontario

Ministry of 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 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(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

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 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:

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

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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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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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 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 18th day of February, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by LEAH CURLE (585) - (A1)

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