Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 26, 2013	2013_199161_0016	O-000307-13	Critical Incident System

Licensee/Titulaire de permis

ROYAL OTTAWA HEALTH CARE GROUP
1141 Carling Avenue, OTTAWA, ON, K1Z-7K4

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

ROYAL OTTAWA PLACE
1145 CARLING AVENUE, OTTAWA, ON, K1Z-7K4

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

KATHLEEN SMID (161)

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): May 29, 30, 31, June 4, 2013 on-site

During the course of this inspection, the inspector(s) also conducted a complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Practical Nurse, several Personal Care Assistants and a Corporate Policy Co-ordinator.

During the course of the inspection, the inspector(s) observed the identified Resident and reviewed their health record, the home's policies "Use of Physical Restraints (Policy # 306.01) revised May 2005; "Assessment for Physical Restraint" (Policy # 306.02) revised May 2005; "Consent for Restraint" (Policy # 306.07) revised May 2005; "Guide to Restraints Meeting the Standards"; "Abuse of a Resident by an Employee" (Policy # 309.04) revised May 2005; Position Description of Personal Care Attendant dated May 20, 2009; Abuse and Neglect Inservice content dated July 2011; the home's fact finding notes on a date in April 2013.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

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. 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 :

The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c. 8, s. 19 (1) in that the licensee did not protect Resident #1 from neglect by a staff(s) member.

The applicable definition of neglect in O. Reg. 79/10, s. 5 of the LTCHA is "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

A review of the health record indicated Resident #1 was admitted to the Royal Ottawa Place in 2007 with a progressive medical condition.

Due to the progression of Resident #1's medical condition, in March 2013 the attending physician ordered that for safety reasons, Resident #1 was to have a thigh belt on at all times while up in a specific type of chair. In April 2013 the attending physician also ordered for safety reasons, a front closure seat belt to be applied at all times while Resident #1 was up in the specific type of chair.

On a date in April 2013, Resident #1's progress notes indicate that Personal Care Assistant (PCA) #S103 found Resident #1 in his/her room, having slid down in the specific type of chair and the secured seat belt was pressing against Resident #1's neck. The Resident was cyanotic and gasping for air. The PCA #S103 immediately released the seat belt and called for assistance. A Registered Staff member assessed Resident #1 and noted that the Resident was cyanotic, diaphoretic and had red marks on his/her neck due to the seat belt. According to PCA #S103 and the clinical record, Resident #1 did not have a thigh belt in place at the time of the incident.

On a date in June 2013 discussion held with PCA #S103 who was responsible for the provision of care to Resident #1 on the date in April 2013 when the incident occurred. The PCA #S103 indicated to the inspector that she was not aware that the Resident required a thigh belt when up in the specific type of chair.

On a date in May 2013 discussion with Registered staff member #S100 who indicated she had updated the Resident #1's care plan in March 2013 to reflect the attending physician's order for the usage of a thigh belt. She indicated that she forgot to print a copy of Resident #1's updated care plan to place in the PCA binder kept at the nursing station for the PCA's to refer to. The care plan that was in the PCA binder on the date of the incident in April 2013 was reviewed. It had been completed on a date

in February 2013 and indicated that the thigh belt was on "hold" when Resident #1 was in the specific type of chair.

The home immediately initiated an investigation into this incident. The PCA #S103, responsible for the provision of care to Resident #1 remains off work pending outcome of the home's on-going investigation.

On a date in June 2013 the inspector discussed with the home's Administrator, the definition of neglect as per O. Reg. 79/10, s. 5 of the LTCHA. The Administrator agreed that this inaction by PCA #S103 constituted neglect of Resident #1. [s. 19. (1)]

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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c. 8, s. 6 (1) (c) in that the licensee did not ensure that there is a written plan of care for Resident #1 that sets out clear directions to staff and others who provide direct care to the resident.

On a date in March 2013 the attending physician ordered that for safety reasons, Resident #1 was to have a thigh belt on at all times while up in a specific type of chair.

On a date in April 2013, Resident #1's progress notes indicate that Personal Care Assistant (PCA) #S103 found Resident #1 in his/her room, having slid down in the specific type of chair and the secured seat belt was pressing against Resident #1's neck. The Resident was cyanotic and gasping for air. The PCA #S103 immediately released the seat belt and called for assistance. A Registered Staff member assessed Resident #1 and noted that the Resident was cyanotic, diaphoretic and had red marks on his/her neck due to the seat belt. According to PCA #S103 and the clinical record, Resident #1 did not have a thigh belt in place at the time of the incident.

On a date in May 2013 discussion with Registered staff member #S100 who indicated she had updated the Resident #1's care plan in March 2013 to reflect the attending physician's order for the usage of a thigh belt. She indicated that she forgot to print a copy of Resident #1's updated care plan to place in the PCA binder kept at the nursing station for the PCA's to refer to. The care plan that was in the PCA binder on the date of the incident in April 2013 was reviewed. It had been completed on a date in February 2013 and indicated that the thigh belt was on "hold" when Resident #1 was in the specific type of chair.

On a date in May 2013 discussion with Personal Care Assistants #S101 and #S102 who confirmed that all Resident's care plans are kept in a PCA binder at the nursing station for them to refer to.

On a date in June 2013 discussion held with PCA #S103 who was responsible for the provision of care to Resident #1 on a date in April 2013 when the incident occurred. The PCA #S103 indicated to the inspector that she was not aware that the Resident required a thigh belt when up in the specific type of chair.

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 a written plan of care for Residents who are physically restrained, that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.29. (1) (a) in that the licensee did not ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations.

On May 29, 2013 the inspector requested a copy of the home's written policy to minimize the restraining of residents. The Administrator provided the inspector with the following written policies:

- Use of Physical Restraints Policy #306.01 revised May 2005
- Assessment for Physical Restraint Policy #306.02 revised May 2005
- Magnetic Restraints Policy #306.03 revised May 2005
-Chemical Restraints Policy #306.04 revised May 2005
- Posture Pals Policy #306.06 revised May 2005
- Consent for Restraint Policy #306.07 revised May 2005

On May 31, 2013 the home's Administrator and the licensee's Corporate Policy Co-ordinator indicated to the inspector that the home's written policy to minimize the restraining of residents was currently in the process of being updated to reflect the Long-Term Care Homes Act 2007 and the Ontario Regulation 79/10 made under the Long-Term Care homes Act 2007. [s. 29. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 r. 96 (b) (c) (e) in that the licensee failed to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents contains the following,

(b) clearly set out what constitutes abuse and neglect
(c) identifies measures and strategies to prevent abuse and neglect;
(e) identifies the training and retraining requirements for all staff, including,
(i)training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii)situations that may lead to abuse and neglect and how to avoid such situations.

2. On June 4, 2013 the inspector requested a copy of the home's written policy to promote zero tolerance of abuse and neglect of residents. The Director of Care provided the inspector with a written policy titled "Abuse of a Resident by an Employee", Policy #309-04 Revised May 2005.

The policy was reviewed and does not clearly set out what constitutes abuse and neglect. [O. Reg 79/10 r. 96 (b)] including the following applicable definitions in O. Reg. 79/10, s. 5 of the LTCHA 2007

"emotional abuse" means,
(a)any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or
(b)any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences;

"financial abuse" means any misappropriation or misuse of a resident's money or property;

"physical abuse" means,
(a)the use of physical force by anyone other than a resident that causes physical injury or pain,

(b)administering or withholding a drug for an inappropriate purpose, or
(c)the use of physical force by a resident that causes physical injury to another resident;

"sexual abuse" means,
(a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or
(b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member;
"verbal abuse" means,
(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or
(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences. ("mauvais traitement d'ordre verbal") O. Reg. 79/10, s. 2 (1).

"neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. [O. Reg. 79/10, s. 5.]

3. The policy does not identify measures and strategies to prevent abuse and neglect. [O. Reg 79/10 r. 96 (c)]

4. The Policy does not identify the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. [O. Reg 79/10 r. 96 (e)] [s. 96.]

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 licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents contains the following,
(b) clearly set out what constitutes abuse and neglect
(c) identifies measures and strategies to prevent abuse and neglect;
(e) identifies the training and retraining requirements for all staff, including,
(i)training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii)situations that may lead to abuse and neglect and how to avoid such situations., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 r.110 (7)1, 2, 4, in that the licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that (1) the circumstances precipitating the application of the physical device; (2) alternatives were considered and why those alternatives were inappropriate, (4) consent.

The home's Administrator provided a copy of a document titled "Guide to Restraints, Meeting the Standards", the purpose of which is to ensure that nursing staff meet the "MOHLTC standards and criteria" related to the use of restraints. The document includes the following forms:

- "Assessment for Restraint" which includes the reason for assessment, alternatives considered, resident responses to the alternatives, the type of restraint to be used, the involvement of the resident/family in the decision making.
- Consent/Refusal for Physical Restraint

On a date in March 2013 Resident #1 was ordered a thigh belt on at all times when up in a specific type of chair for safety.

Resident #1's health record was reviewed. There was not a "Guide to Restraints, Meeting the Standards" completed for the thigh belt ordered on a date in March 2013 nor were there any other sources of documentation found regarding the circumstances precipitating the application of the thigh belt; alternatives that were considered and why those alternatives were inappropriate, nor consent. [s. 110. (7) 1.]

2. The licensee failed to comply with O. Reg 79/10 r.110 (7) 6, in that the licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that all monitoring, including the resident's responses are documented.

On a date in February 2013 Resident #1 was ordered a front closure seat belt on at all times when up in a specific type of chair for safety and to refer to the Resident's restraint monitoring sheet.

Resident #1's restraint monitoring sheet for the front closure seat belt was reviewed

for the evening of a date in April 2013. It is documented on the restraint monitoring sheet that the front closure seat belt was applied at 16:00 hours on the date in April 2013. The monitoring of Resident #1 while using the front closure seat belt, including the resident's response were not documented on that date in April 2013 from 17:00 hours – 20:30 hours. No other sources of documentation were found for staff monitoring and documentation of the use of physical restraints. Discussion with the home's Director of Care who indicated that staff use the restraint monitoring sheets to document the use of physical restraints including the time of application, all monitoring including the resident's response, times for release and repositioning. [s. 110. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that all components of O. Reg 79/10 (7) are documented., to be implemented voluntarily.

WN #6: 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, ss. 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, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 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, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.24. (2) in that the licensee did not immediately report the neglect of a resident by a staff member that resulted in harm or the risk of harm, including the information upon which it was based, to the Director.

On a date in April 2013 at approximately 16:00 hours, the home's Director of Care telephoned the MOHLTC Director to report that on the previous day, Resident #1 had slid down in his/her specific type of chair and was found with his/her secured seat belt pressed against his/her neck. The resident was cyanotic and breathing. The staff member had neglected to apply a thigh belt as ordered by the attending physician. The staff member responsible for the provision of care to the resident was currently off work pending outcome of the home's investigation. [s. 24. (1)]

Issued on this 4th day of July, 2013

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

Kathleen Smid

Ministry of Health and Long-Term Care

Ministére 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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHLEEN SMID (161)
Inspection No. / No de l'inspection :	2013_199161_0016
Log No. / Registre no:	O-000307-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 26, 2013
Licensee / Titulaire de permis :	ROYAL OTTAWA HEALTH CARE GROUP 1141 Carling Avenue, OTTAWA, ON, K1Z-7K4
LTC Home / Foyer de SLD :	ROYAL OTTAWA PLACE 1145 CARLING AVENUE, OTTAWA, ON, K1Z-7K4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	KAREN DALEY

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure all residents who are physically restrained are provided with the treatment, care, services, or assistance as per the requirements under O. Reg. 79/10, s. 5 of the LTCHA 2007.

This plan shall be submitted in writing by July 10, 2013 to Inspector: Kathleen Smid, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 347 Preston Street, 4th floor, Ottawa, Ontario. K1S 3J4 or by fax at 613.569.9670

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c. 8, s. 19 (1) in that the licensee did not protect Resident #1 from neglect by a staff(s) member.

The applicable definition of neglect in O. Reg. 79/10, s. 5 of the LTCHA is "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

A review of the health record indicated Resident #1 was admitted to the Royal Ottawa Place in 2007 with a progressive medical condition.

Due to the progression of Resident #1's medical condition, in March 2013 the attending physician ordered that for safety reasons, Resident #1 was to have a

thigh belt on at all times while up in a specific type of chair. In April 2013 the attending physician also ordered for safety reasons, a front closure seat belt to be applied at all times while Resident #1 was up in the specific type of chair.

On a date in April 2013, Resident #1's progress notes indicate that Personal Care Assistant (PCA) #S103 found Resident #1 in his/her room, having slid down in the specific type of chair and the secured seat belt was pressing against Resident #1's neck. The Resident was cyanotic and gasping for air. The PCA #S103 immediately released the seat belt and called for assistance. A Registered Staff member assessed Resident #1 and noted that the Resident was cyanotic, diaphoretic and had red marks on his/her neck due to the seat belt. According to PCA #S103 and the clinical record, Resident #1 did not have a thigh belt in place at the time of the incident.

On a date in June 2013 discussion held with PCA #S103 who was responsible for the provision of care to Resident #1 on the date in April 2013 when the incident occurred. The PCA #S103 indicated to the inspector that she was not aware that the Resident required a thigh belt when up in the specific type of chair.

On a date in May 2013 discussion with Registered staff member #S100 who indicated she had updated the Resident #1's care plan in March 2013 to reflect the attending physician's order for the usage of a thigh belt. She indicated that she forgot to print a copy of Resident #1's updated care plan to place in the PCA binder kept at the nursing station for the PCA's to refer to. The care plan that was in the PCA binder on the date of the incident in April 2013 was reviewed. It had been completed on a date in February 2013 and indicated that the thigh belt was on "hold" when Resident #1 was in the specific type of chair.

The home immediately initiated an investigation into this incident. The PCA #S103, responsible for the provision of care to Resident #1 remains off work pending outcome of the home's on-going investigation.

On a date in June 2013 the inspector discussed with the home's Administrator, the definition of neglect as per O. Reg. 79/10, s. 5 of the LTCHA. The Administrator agreed that this inaction by PCA #S103 constituted neglect of Resident #1. [s. 19. (1)]
(161)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 10, 2013

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

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

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

Issued on this 26th day of June, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : KATHLEEN SMID

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