



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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
Jul 24, 2014	2014_159178_0013	T-626-14	Complaint

Licensee/Titulaire de permis

ADVENT HEALTH CARE CORPORATION
541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3

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

VALLEYVIEW RESIDENCE
541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3

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

SUSAN LUI (178), JOANNE ZAHUR (589)

Inspection Summary/Résumé de l'inspection



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

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

**This inspection was conducted on the following date(s): May 22, 26, 27, 28, 29,
June 2, 3, 4, 5, 2014.**

**This inspection also addressed Log # T-603-14, which involved the same
resident and concerns.**

**During the course of the inspection, the inspector(s) spoke with Administrator,
Director of Care, Nurse Manager, Resident Assessment Instrument Coordinator,
Office Manager, registered staff, personal support workers, recreation assistant,
private caregiver, receptionist, residents, family of a resident.**

**During the course of the inspection, the inspector(s) reviewed resident records,
reviewed home records, observed resident care.**

The following Inspection Protocols were used during this inspection:

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 76. Training



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

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

Findings/Faits saillants :



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

1. The licensee has failed to ensure that no staff members perform their responsibilities before receiving training in the area of the duty under section 24 of the Long Term Care Homes Act (LTCHA) to make mandatory reports.

Interviews with multiple members of the home's front line staff and management confirm that employees are not trained in the area of mandatory reporting under section 24 of the LTCHA, of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities. Staff interviews confirmed that staff are made aware of the need to report abuse of a resident to their supervisor, but most staff, including management staff, are not aware of the requirement for anyone who suspects abuse of a resident to immediately report the suspected abuse to the Director under the LTCHA, and that it is an offense to not do so.

Staff interviews and record review confirm that resident # 1, a cognitively intact resident, told four front line staff members that he/she had been handled roughly by a member of the staff on an identified date. None of these staff members reported the allegation to the Director under the LTCHA. All four staff members stated that they were unaware of the duty under section 24 of the LTCHA, for anyone who suspects abuse of a resident to report the suspected abuse to the Director under the LTCHA, and that it is an offense to not do so. [s. 76. (2) 4.]

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :



**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**

1. The licensee has failed to ensure that resident # 1's right not to be neglected by staff was fully respected.

Record review and staff and family interviews confirm the following:

On an identified date, resident # 1 rang the call bell to obtain assistance to use the toilet. The resident waited an unacceptably long period of time before staff came to assist him/her. The call bell record provided by the home indicates that the bell was answered 43 minutes and 45 seconds after it was activated by the resident. The home's DOC and Nurse Manager both confirm that this is too long for a resident to wait for the call bell to be answered. The record shows that after 20 minutes the call was acknowledged. The Nurse Manager confirms that the call bell would likely have been acknowledged by phone by a registered staff member. However a further 23 minutes elapsed before the call was answered and the bell was shut off at the source, which was the resident's bedside call bell.

When the assigned staff member was interviewed by the inspector, he/she could not remember or provide any reason why it would have taken 43 minutes to answer the call bell on that night. [s. 3. (1) 3.]

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 residents' right to not be neglected by staff is fully respected, to be implemented voluntarily.

**WN #3: 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 :



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident. Record review and staff interview confirm that the plan of care for resident # 1 does not set out clear directions to staff. The plan of care for toileting stated in one intervention that the resident required one staff assistance in toileting, and in the subsequent intervention that the resident needs two persons assist when not able to toilet self in the toilet. The same plan of care stated under the "Transferring" section, that the resident requires two-person physical assist. Interviews with front line staff indicated that the resident was frequently being transferred in and out of bed with the assistance of one staff member. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plans of care set out clear directions to staff and others who provide direct care to residents, to be implemented voluntarily.

WN #4: 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 persons who had reasonable grounds to suspect that abuse of a resident by anyone has occurred, immediately report the suspicion and the information upon which it was based to the Director under the Long Term Care Homes Act (LTCHA).

Staff interviews and record review confirm that resident # 1, a cognitively intact resident, told four front line staff members that he/she had been handled roughly by a member of the staff on an identified date. None of these staff members reported the allegation to the Director under the LTCHA.

Resident # 1's family reported the resident's allegation of rough handling to the home's management staff the following day. Management staff investigated the incident, but did not report the allegation to the Director under the LTCHA until approximately one month later, when a Critical Incident System (CIS) report was submitted by the home, reporting the allegation and that the resident had been transferred to hospital and diagnosed with a fracture two days prior to the CIS report's submission. [s. 24. (1)]



**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**

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 persons who have reasonable grounds to suspect that abuse of a resident by anyone has occurred, immediately report the suspicion and the information upon which it was based to the Director under the Long Term Care Homes Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

1. The licensee has failed to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Staff interviews and record review confirm that when resident # 1's pain was not relieved by initial interventions, the resident was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Staff and family interviews confirm that resident # 1 was experiencing increasing pain which was not relieved by initial or subsequent interventions. Staff took measures to notify the resident's physician who prescribed various different medications, however the resident was not assessed using a clinically appropriate assessment instrument specifically designed to assess pain. Resident # 1 was eventually transferred to hospital where the resident was diagnosed with a fracture.

Interviews with registered staff confirm that when residents' pain is not relieved by initial interventions, their practice is to call the physician, but they do not normally assess the resident using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (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 to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints



**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**

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,

(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).

(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).

(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).

(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).

(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,

(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).

(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).

(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :



1. The licensee has failed to ensure that a documented record of complaints is kept in the home that includes every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

Staff interviews and record review confirms the following:

Resident # 1 informed various staff members and home management that when he/she rang for assistance to use the toilet on an identified date, the resident had to wait 45 minutes for a staff member to answer the bell. The complaint was investigated by a member of the home's management staff who states that the results of the investigation were discussed with the resident, however no record of this response to and from the complainant was documented and kept in the home.

Review of the home's ADMVHIO35vv, titled Concerns and Complaints, states that major and minor resident related complaints must be documented on the "Incident Notes" in the home's electronic documentation system, Mede-care. The policy states that the documentation should include the date the information was received, the service involved, a list of issues reviewed, the details and date of any follow-up action taken, a description of any final resolution and the details and date of the feedback provided to the client. The policy also states that the response made by the complainant will be documented to determine their level of satisfaction with outcome.

Interviews with front line and management staff confirm that this process is not being followed for resident related complaints received by the home. Record review confirms that the resident related complaints reported by resident # 1 and the resident's family, and the actions taken by the home in response, were not documented in this manner. [s. 101. (2)]

2. The licensee has failed to ensure that the documented record of complaints received is reviewed and analyzed for trends, at least quarterly.

Record review and staff interviews confirm that key members of the home's management team discuss complaints as they arise, and identify trends by memory, but no central documented record of complaints is reviewed and analyzed for trends. [s. 101. (3)]



Ministry of Health and
Long-Term Care

Ministère de la Santé et des
Soins de longue durée

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

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

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:

-a documented record of complaints is kept in the home that includes every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant

-the documented record of complaints received is reviewed and analyzed for trends, at least quarterly, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:

1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive training in pain management either annually, or based on the staff's individually assessed training needs.

Record review and staff interviews confirm that not all staff who provide direct care receive training in pain management annually.

The Director of Care confirmed that since personal support workers (PSWs) completed the pain management training in 2012, they have not been re-trained in pain management annually, or according to their individually assessed training needs.

[s. 221. (2) 1.]



Ministry of Health and
Long-Term Care

Ministère de la Santé et des
Soins de longue durée

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

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

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receive training in pain management either annually, or based on the staff's individually assessed training needs, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).

2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).

3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).

4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

1. The licensee has failed to ensure that for the Pain Management Program, there is a written description of the program that includes the following:

- its goals and objectives
- methods to monitor outcomes
- protocols for referral of residents to specialized resources where required.

Review of the home's pain Management Program and staff interviews confirm that the written description of the home's Pain Management Program does not contain the items listed above. [s. 30. (1) 1.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

The home's DOC confirms that after being informed on an identified date by resident # 1's family that the resident had alleged he/she was handled roughly by a staff member, the allegation was investigated, and the home was unable to confirm abuse. The DOC confirms that the findings of that investigation were not communicated to the family or the resident. [s. 97. (2)]



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

Issued on this 25th day of July, 2014

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

Aaron Liu (178)



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et
des Soins de longue durée**

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

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

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Direction de l'amélioration de la performance et de la conformité**

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**Name of Inspector (ID #) /
Nom de l'inspecteur (No) :** SUSAN LUI (178), JOANNE ZAHUR (589)

**Inspection No. /
No de l'inspection :** 2014_159178_0013

**Log No. /
Registre no:** T-626-14

**Type of Inspection /
Genre
d'inspection:** Complaint

**Report Date(s) /
Date(s) du Rapport :** Jul 24, 2014

**Licensee /
Titulaire de permis :** ADVENT HEALTH CARE CORPORATION
541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3

**LTC Home /
Foyer de SLD :** VALLEYVIEW RESIDENCE
541 Finch Avenue West, NORTH YORK, ON, M2R-3Y3

**Name of Administrator /
Nom de l'administratrice
ou de l'administrateur :** MIKE SAVATOVICH

To ADVENT HEALTH CARE CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:



**Ministry of Health and
Long-Term Care**

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

**Ministère de la Santé et
des Soins de longue durée**

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

Order # / Ordre no : 001	Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)
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Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that no staff performs their responsibilities before receiving training in the duty under section 24 of the LTCHA, to make mandatory reports.

The plan shall be submitted via email to susan.lui@ontario.ca by August 29, 2014.

Grounds / Motifs :



**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

1. The licensee has failed to ensure that no staff performs their responsibilities before receiving training in the duty under section 24 of the Long Term Care Homes Act (LTCHA), to make mandatory reports.

Interviews with multiple members of the home's front line staff and management confirm that employees are not trained in the area of mandatory reporting under section 24 of the LTCHA, of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities. Staff interviews confirmed that staff are made aware of the need to report abuse of a resident to their supervisor, but most staff, including management staff, were not aware of the requirement for anyone who suspects abuse of a resident to immediately report the suspected abuse to the Director under the LTCHA, and that it is an offense under the LTCHA to not do so.

Staff interviews and record review confirm that resident # 1, a cognitively intact resident, told four front line staff members that he/she had been handled roughly by a member of the staff on an identified date. None of these staff members reported the allegation to the Director under the LTCHA. All four staff members stated that they were unaware of the duty under section 24 of the LTCHA, for anyone who suspects abuse of a resident to report the suspected abuse to the Director under the LTCHA, and that it is an offense to not do so.

(178)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2014



**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

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



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Long-Term Care**

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

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de soins de longue durée*, L.O. 2007, chap. 8

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.



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Pursuant to section 153 and/or
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Ordre(s) de l'inspecteur
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de soins de longue durée, L.O. 2007, chap. 8*

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, 11^e 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**

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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 24th day of July, 2014

Signature of Inspector /
Signature de l'inspecteur :  (178)

Name of Inspector /
Nom de l'inspecteur : SUSAN LUI

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