Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 1, 2018	2018_565647_0011	010018-17, 001359-18, 003257-18, 006075-18, 006082-18, 006086-18, 006088-18, 006089-18, 006093-18, 006095-18, 006307-18, 006313-18, 006366-18, 006368-18	Critical Incident System

Licensee/Titulaire de permis

Lakeland Long Term Care Services Corporation
6 Albert Street PARRY SOUND ON P2A 3A4

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

Lakeland Long Term Care Services
6 Albert Street PARRY SOUND ON P2A 3A4

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

JENNIFER BROWN (647), MICHELLE BERARDI (679), SHELLEY MURPHY (684), SYLVIE BYRNES (627)

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): April 9 - 12, 2018.

The following critical incidents which were reported to the Director were completed during this inspection:
-One intake related to plan of care and reporting to the director,
-One intake related to neglect and continence care,
-One intake related to plan of care and prevention of abuse,
-One intake related to transferring and positioning and prevention of abuse,
-One intake related to plan of care,
-Two intakes related to responsive behaviours,
-Three intakes related to prevention of abuse, and
-Four intakes related to fall prevention.

A Complaint Inspection, #2018_565647_0010 and Follow Up Inspection, #2018_565647_0012, were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (DOC), Social Service Worker, Behaviour Response Lead, Supervisor of Support Services, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW), Residents, Family Members and Substitute Decision Makers.

During the course of the inspection, the inspectors conducted observation in resident home areas, observation of care delivery processes, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

3 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #627 reviewed the home's policy titled "Abuse Policy - Investigation", last reviewed January 2017, which indicated that: Any person (including all Lakeland employees) who had reasonable grounds" to suspect that any of the following had occurred or may have occurred must report it immediately to the Nurse Manger or a member of the Leadership Team. The Administrator, Director of Nursing and Personal Care or designate will immediately report the suspicion and the information upon which it is based to the Director, as per LTCHA (2007) s. 24 (1).
1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.
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.

A Critical Incident (CI) report was submitted to the Director, alleging improper care to resident #001 from Registered staff member #110. The report indicated that direct care staff member #109 alleged that while providing care to resident #001, Registered staff member #110 had placed an identified intervention on resident #001's upper body, to prevent them from exhibiting an identified responsive behaviour.

Inspector #627 reviewed the home's investigation notes which indicated that the direct care staff member had reported to the Acting Director of Care (DOC), that Registered staff member had helped them to provide care to resident #001. Direct care staff member #109 had reported that Registered staff member #110 had been afraid that resident #001 was going to exhibit their responsive behaviour, therefore, they had gotten

an identified intervention and placed it on the resident's upper body. It was documented from an interview that direct care staff member #109 had informed the Acting DOC that they had reported the incident to Registered staff member #103 immediately.

Inspector #627 conducted a telephone interview with Registered staff member #103, who stated that direct care staff member #109 had not reported this alleged occurrence to them, or they would have immediately reported it to the management team. They further stated that the home had a zero tolerance of abuse policy and when allegations of abuse or neglect were brought forth by a PSW, the registered staff immediately notified the administration on call and removed the staff member from the floor.

Inspector #627 interviewed Registered staff member #111 who indicated, at the beginning of the identified shift, direct care staff member #109 had reported to them that Registered staff member #110 had assisted them to provide care to resident #001. The resident had been exhibiting their responsive behaviour, and that Registered staff member #110 had held a specific intervention item over the resident's face. Direct care staff member #109 reported to them concern for the resident's safety. When Registered staff member #111 indicated to direct care staff member #109 that this had to be reported immediately, the direct care staff member stated they would report it when they had the time. Registered staff member #111 sent an email to the Acting DOC to ensure that they would be made aware. When asked by the Inspector if direct care staff member #109 had reported the incident, they said that direct care staff member #109 had not told Registered staff member #111 that they had reported the incident to Registered staff member #103 when it had occurred. Registered staff member #111 indicated that the home's policy directed staff to report every incident of alleged abuse or neglect immediately to registered staff.

Inspector #627 interviewed the Acting DOC who stated that the incident was reported to them, via email by Registered staff member #111. The Acting DOC stated that the home's process for every allegation of abuse or suspected abuse was to report immediately to the registered staff who reported it to the management staff. The Acting DOC acknowledged that the incident should have been report to them on that day. [s. 20. (1)]

2. A CI report was submitted to the Director, for an alleged incident of resident to resident abuse, between resident #016 and #017. The report indicated that resident #016 and #017 were found to be struggling over an identified item. Resident #016 was noted to have injuries after the altercation. Resident #016 was teary eyed and verbalized being

afraid to return to their room.

Inspector #627 conducted a telephone interview with Registered staff member #135 who stated that they had received a call from the Registered staff member alerting them that residents #016 and #017 had a physical altercation which required immediate interventions. Registered staff member #135 had gone to the floor to assess both residents for injuries. Both residents had appeared to be calm by this time. Registered staff member #135 indicated that they had reported the incident to the Acting DOC immediately.

Inspector #627 interviewed the Acting DOC who indicated that when an incident of resident to resident altercations which caused injuries occurred, the direct care staff member was to notify the Registered staff member, who would notify the Nurse Manager (RN). The Nurse Manager would notify the Acting DOC, or the designated person and a CI report would be submitted immediately. The Acting DOC stated that regarding this incident, they had been notified by the Nurse Manager, the following morning when they arrived, at which time they had submitted a CI report. The Acting DOC acknowledged that the home's abuse policy was not complied with. [s. 20. (1)]

3. A CI report was submitted to the Director, for an alleged incident of resident to resident abuse, between resident #016 and #015. The report indicated that resident #016 and #015 were heard arguing. Resident #015 was observed raising their arm towards resident #016 to which resident #016 raised their hand making contact with resident's #015's upper body causing an injury.

Inspector #627 conducted a telephone interview with Registered staff member #138 who indicated that they did not recall the incident completely, however they recalled that resident #015 sustained an injury. Registered staff member #138 indicated that the home's policy was to notify the Registered staff member when an altercation between residents which caused injury occurred. The Registered staff member would notify the Acting DOC. They further stated that if the Registered staff member was busy, they would fill out the incident report and notify the Acting DOC of the incident. Registered staff member #138 could not recall what the home's abuse policy indicated regarding resident to resident abuse. Registered staff member #138 could not recall if they had notified the Registered staff member or the Acting DOC.

Inspector #627 interviewed the Acting DOC who indicated that when an incident of resident to resident altercations which caused injuries occurred, the direct care staff

member was to notify the Registered staff member, who would notify the Nurse Manager (RN). The Nurse Manager would notify the Acting DOC, or the designated person and a CI report would be submitted immediately. The Acting DOC stated that regarding this incident, they had not been notified by the Nurse Manager or the Registered staff member. They believe they became aware of the incident during a Quality/Risk management meeting and had submitted a CI report immediately upon become aware of the alleged abuse. The Acting DOC acknowledged that the home's abuse policy indicated that any abuse to a resident by anyone had be to immediately reported to the Nurse Manager, who would immediately reported it to the Acting DOC and that in this instance, the home's policy was not followed. [s. 20. (1)]

4. A CI report was submitted to the Director, for an incident of improper or incompetent treatment of a resident that resulted in harm or a risk of harm to a resident. The CI report identified that Registered staff member #118 was made aware by the direct care staff member that resident #007, #008, #009, and #010 required continence care. The four residents were under the care of direct care staff member #116.

A review of the CI report identified that Registered staff member #118 had become aware of the incident.

In an interview with direct care staff member #107 they identified if they had suspected that a staff member had not provided continence care to a resident they would report it to a Registered staff member.

In an interview with Registered staff member #139 they identified that improper care would entail residents not receiving continence care, not receiving assistance for hygiene, dressing, or not assisting a resident with their activities of daily living. Registered staff member #139 indicated that any incidents of improper were are to be reported immediately.

In an interview with the Acting DOC, they identified that Registered staff member #118 notified the Acting DOC of the incident in an interview regarding a separate CI investigation. The Acting DOC further indicated that any incidents that met the criteria of abuse or improper care were to be reported immediately. Registered staff member #118 brought the concerns forward to them during an interview. The Acting DOC identified that Registered staff member #118 should have brought the concerns forward immediately. [s. 20. (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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the 24-hour admission care plan was based on the resident's assessed needs and preferences and on the assessments, reassessments and information provided by the placement co-ordinator.

A CI report was submitted to the Director, indicating that there had been an incident with injury. A review of the CI report, by Inspector#647 indicated that resident #020 had been assisted to bed, and later had been found on the floor beside their bed. Upon assessment, the resident had complained of pain and was transferred to hospital.

A review of resident #020's clinical records indicated that the resident had been newly admitted. During the admission process, it had been identified on the Community Care Access Centre (CCAC) admission assessment documents that resident #020 had used an identified intervention at their previous placement.

A record review of a document titled "Resident profile and 24 hour admission care plan", that had been initiated, as part of the admission process of the home indicated that the section on falls, including any risk of falling and interventions to mitigate those risks, had not been completed by the admitting nurse.

Interviews with Registered staff member's #129, #130, and #137 indicated that upon admission, information from the resident profile and 24 hour admission care plan document build the 24 hour care plan which then provides direct care staff direction on how to care for the newly admitted resident. The above mentioned Registered staff members, acknowledged at the time of interview, that the resident profile and 24 hour admission care plan for resident #020, had not been completed, and specifically did not include the risk of falling and any interventions to mitigate those risks, as identified from the CCAC admission assessment documents.

During an interview with the Acting DOC, they indicated that the purpose for the resident profile and 24 hour admission care plan document was to provide information of the primary needs and risks to all staff in order for them to provide safe care to the newly admitted resident. The Acting DOC reviewed the resident profile and 24 hour admission care plan document for resident #020 and confirmed at the time of interview it had not been completed. [s. 24. (4)]

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 care set out in the 24-hour admission care plan was based on the resident's assessed needs and preferences and on the assessments, reassessments and information provided by the placement co-ordinator, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff had received retraining annually relating to Residents' Bill of Rights.

Ontario Regulation (O. Reg) 79/10, subsection 219(1) states that the intervals for the purposes of subsection 74(4) of the Act are annual intervals.

A CI report was submitted to the Director, alleging staff to resident abuse from Registered staff member #110 to resident #001.

Inspector #627 reviewed the education records for Registered staff member #110 and noted that the Resident Bill of Rights education had not been completed.

Inspector #627 reviewed the education records for Resident Bill of Rights, and noted that 127 staff out of 155 staff members, or 81.9 per cent had not completed the Resident Bill of Rights course.

During separate interviews with the Inspector, direct care staff member's #131, #128 and Registered staff member #133 verified they had not completed the Resident's Bill of Rights education.

Inspector #627 interviewed the Acting DOC who explained that the Resident Bill of Rights course had been removed by error as a mandatory course from the online Surge training, therefore, many staff members had not completed the required training and that this had been rectified. [s. 76. (4)]

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 had received retraining annually relating to Residents' Bill of Rights, to be implemented voluntarily.

Issued on this 14th day of May, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BROWN (647), MICHELLE BERARDI (679), SHELLEY MURPHY (684), SYLVIE BYRNES (627)
Inspection No. / No de l'inspection :	2018_565647_0011
Log No. / No de registre :	010018-17, 001359-18, 003257-18, 006075-18, 006082-18, 006086-18, 006088-18, 006089-18, 006093-18, 006095-18, 006307-18, 006313-18, 006366-18, 006368-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 1, 2018
Licensee / Titulaire de permis :	Lakeland Long Term Care Services Corporation 6 Albert Street, PARRY SOUND, ON, P2A-3A4
LTC Home / Foyer de SLD :	Lakeland Long Term Care Services 6 Albert Street, PARRY SOUND, ON, P2A-3A4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Steve White

To Lakeland Long Term Care Services Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the LTCHA.

Specifically, the licensee shall ensure:

a) The licensee shall report all actual or alleged incidents of abuse to the Director as specified by the legislation.
b) The licensee shall provide education to all staff related to the reporting requirements to the Director as specified by the legislation.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #627 reviewed the home's policy titled "Abuse Policy - Investigation", last reviewed January 2017, which indicated that: Any person (including all Lakeland employees) who had reasonable grounds" to suspect that any of the following had occurred or may have occurred must report it immediately to the Nurse Manger or a member of the Leadership Team. The Administrator, Director of Nursing and Personal Care or designate will immediately report the suspicion and the information upon which it is based to the Director, as per LTCHA (2007) s. 24 (1).
1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.
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.

A CI report was submitted to the Director, for an incident of improper or incompetent treatment of a resident that resulted in harm or a risk of harm to a resident. The CI report identified that Registered staff member #118 was made aware by the direct care staff member that resident #007, #008, #009, and #010 required continence care. The four residents were under the care of direct care staff member #116.

A review of the CI report identified that Registered staff member #118 had become aware of the incident.

In an interview with direct care staff member #107 they identified if they had suspected that a staff member had not provided continence care to a resident they would report it to a Registered staff member.

In an interview with Registered staff member #139 they identified that improper care would entail residents not receiving continence care, not receiving assistance for hygiene, dressing, or not assisting a resident with their activities of daily living. Registered staff member #139 indicated that any incidents of improper were are to be reported immediately.

In an interview with the Acting DOC, they identified that Registered staff member #118 notified the Acting DOC of the incident in an interview regarding a separate CI investigation. The Acting DOC further indicated that any incidents that met the criteria of abuse or improper care were to be reported immediately. Registered staff member #118 brought the concerns forward to them during an interview. The Acting DOC identified that Registered staff member #118 should have brought the concerns forward immediately. [s. 20. (1)] (679)

2. A CI report was submitted to the Director, for an alleged incident of resident to resident abuse, between resident #016 and #015. The report indicated that resident #016 and #015 were heard arguing. Resident #015 was observed raising their arm towards resident #016 to which resident #016 raised their hand making contact with resident's #015's upper body causing an injury.

Inspector #627 conducted a telephone interview with Registered staff member #138 who indicated that they did not recall the incident completely, however they recalled that resident #015 sustained an injury. Registered staff member #138 indicated that the home's policy was to notify the Registered staff member when

an altercation between residents which caused injury occurred. The Registered staff member would notify the Acting DOC. They further stated that if the Registered staff member was busy, they would fill out the incident report and notify the Acting DOC of the incident. Registered staff member #138 could not recall what the home's abuse policy indicated regarding resident to resident abuse. Registered staff member #138 could not recall if they had notified the Registered staff member or the Acting DOC.

Inspector #627 interviewed the Acting DOC who indicated that when an incident of resident to resident altercations which caused injuries occurred, the direct care staff member was to notify the Registered staff member, who would notify the Nurse Manager (RN). The Nurse Manager would notify the Acting DOC, or the designated person and a CI report would be submitted immediately. The Acting DOC stated that regarding this incident, they had not been notified by the Nurse Manager or the Registered staff member. They believe they became aware of the incident during a Quality/Risk management meeting and had submitted a CI report immediately upon become aware of the alleged abuse. The Acting DOC acknowledged that the home's abuse policy indicated that any abuse to a resident by anyone had be to immediately reported to the Nurse Manager, who would immediately reported it to the Acting DOC and that in this instance, the home's policy was not followed. [s. 20. (1)] (627)

3. A CI report was submitted to the Director, for an alleged incident of resident to resident abuse, between resident #016 and #017. The report indicated that resident #016 and #017 were found to be struggling over an identified item. Resident #016 was noted to have injuries after the altercation. Resident #016 was teary eyed and verbalized being afraid to return to their room.

Inspector #627 conducted a telephone interview with Registered staff member #135 who stated that they had received a call from the Registered staff member alerting them that residents #016 and #017 had a physical altercation which required immediate interventions. Registered staff member #135 had gone to the floor to assess both residents for injuries. Both residents had appeared to be calm by this time. Registered staff member #135 indicated that they had reported the incident to the Acting DOC immediately.

Inspector #627 interviewed the Acting DOC who indicated that when an incident of resident to resident altercations which caused injuries occurred, the direct care staff member was to notify the Registered staff member, who would notify

the Nurse Manager (RN). The Nurse Manager would notify the Acting DOC, or the designated person and a CI report would be submitted immediately. The Acting DOC stated that regarding this incident, they had been notified by the Nurse Manager, the following morning when they arrived, at which time they had submitted a CI report. The Acting DOC acknowledged that the home's abuse policy was not complied with. [s. 20. (1)] (627)

4. A Critical Incident (CI) report was submitted to the Director, alleging improper care to resident #001 from Registered staff member #110. The report indicated that direct care staff member #109 alleged that while providing care to resident #001, Registered staff member #110 had placed an identified intervention on resident #001's upper body, to prevent them from exhibiting an identified responsive behaviour.

Inspector #627 reviewed the home's investigation notes which indicated that the direct care staff member had reported to the Acting Director of Care (DOC), that Registered staff member had helped them to provide care to resident #001. Direct care staff member #109 had reported that Registered staff member #110 had been afraid that resident #001 was going to exhibit their responsive behaviour, therefore, they had gotten an identified intervention and placed it on the resident's upper body. It was documented from an interview that direct care staff member #109 had informed the Acting DOC that they had reported the incident to Registered staff member #103 immediately.

Inspector #627 conducted a telephone interview with Registered staff member #103, who stated that direct care staff member #109 had not reported this alleged occurrence to them, or they would have immediately reported it to the management team. They further stated that the home had a zero tolerance of abuse policy and when allegations of abuse or neglect were brought forth by a PSW, the registered staff immediately notified the administration on call and removed the staff member from the floor.

Inspector #627 interviewed Registered staff member #111 who indicated, at the beginning of the identified shift, direct care staff member #109 had reported to them that Registered staff member #110 had assisted them to provide care to resident #001. The resident had been exhibiting their responsive behaviour, and that Registered staff member #110 had held a specific intervention item over the resident's face. Direct care staff member #109 reported to them concern for the resident's safety. When Registered staff member #111 indicated to direct care

staff member #109 that this had to be reported immediately, the direct care staff member stated they would report it when they had the time. Registered staff member #111 sent an email to the Acting DOC to ensure that they would be made aware. When asked by the Inspector if direct care staff member #109 had reported the incident, they said that direct care staff member #109 had not told Registered staff member #111 that they had reported the incident to Registered staff member #103 when it had occurred. Registered staff member #111 indicated that the home's policy directed staff to report every incident of alleged abuse or neglect immediately to registered staff.

Inspector #627 interviewed the Acting DOC who stated that the incident was reported to them, via email by Registered staff member #111. The Acting DOC stated that the home's process for every allegation of abuse or suspected abuse was to report immediately to the registered staff who reported it to the management staff. The Acting DOC acknowledged that the incident should have been report to them on that day. [s. 20. (1)]

The severity of this issue was determined to be a level 1 as it related to minimum risk. The scope of the issue was a level 2 as it related to more than the fewest number of residents affected. The home had a level 4 history as they had a non-compliance with this section of the LTCHA that included:

-voluntary plan of correction (VPC) issued February 13, 2017 (2017_616542_0005),
-VPC issued April 4, 2016 (2016_264609_0012),
-written notification (WN) issued July 22, 2015 (2015_332575_0013). (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2018

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 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, 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:

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

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) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

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 1st day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Jennifer Brown

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