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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 29, 2015	2015_205129_0002	H-001230-14	Critical Incident System

Licensee/Titulaire de permis

BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED
600 Lake Street St. Catharines ON L2N 4J4

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

HEIDEHOF LONG TERM CARE HOME
600 Lake Street St. Catharines ON L2N 4J4

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

PHYLLIS HILTZ-BONTJE (129)

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): February 18, 20 and March 3, 2015

During the course of the inspection, the inspector(s) spoke with staff involved in the incident, the Director of Care and the Administrator.
The inspector also reviewed investigative notes made by the Director of Care, clinical documentation, training records and the home's policy "Zero Tolerance of Abuse and Neglect", in relation to Log # H-001230-14.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **1 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that right of a resident to be protected from abuse was fully respected and promoted, in relation to the following: [3(1) 2]

a) The licensee did not promote the right of residents to be protected from abuse when they failed to ensure that staff who provide direct care to residents received, as a condition of continuing to have contact with residents annual training in the area of abuse recognition and prevention. The Director of Care (DOC) confirmed that training in the area mentioned above was not provided to staff in 2014.
b) The licensee did not promote the right of residents to be protected from abuse when the home failed to provide annual retraining in the area of the Resident's Bill of Rights and the long term care home's policy to promote zero tolerance of abuse and neglect of residents.
c) The licensee did not promote the right of residents to be protected from abuse when they failed to complete an annual evaluation of the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents or to determine what changes and improvements were required to prevent further incidents of resident abuse. The DOC confirmed that an annual review of the effectiveness of the home's policy to promote zero tolerance of abuse and neglect was completed.
d) The licensee did not respect the right of resident #001 to be protected from abuse, when on an identified date two staff members were assigned to provide care to the resident even though they had not received the required training related to abuse recognition and prevention. The DOC confirmed that the two staff people assigned to provide care to resident #001 on the identified date had not received the required training. On the identified date a Personal Support Worker (PSW)providing care to the resident used physical force while attempting to providing care. Staff interviewed and investigative notes collected following the incident confirmed that resident #001 received extensive bruising as a result of one of the identified staff applying physical force in order to overcome the resident's refusal of the care. Nine photographs taken by the home documented the extensive bruising the resident suffered as a result of staffs actions.
e) The licensee did not respect the right of resident #001 to be protected from abuse, when a staff who had a history of inappropriate contact and care of residents was assigned to provide care to this resident during the evening shift on an identified date. An incident confirmed during staff interviews and documented in records created by the home indicated that on the identified date a PSW providing care to resident #001 used physical force that caused a physical injury to the resident. Nine photographs taken by the home documented the extensive bruising suffered by resident #001. The DOC confirmed that at the time of this incident there was not a monitoring program in place related to the care this staff person provided to residents and that the staff person was under sanctions to only provide care to residents with a PSW partner. [s. 3. (1) 2.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, in relation to the following: [6(7)]
Staff did not provide care to resident #001 as specified in the resident's plan of care on an identified date in 2014.
Resident #001's plan of care identified the following care focuses and interventions to manage those focuses:
a) A chronic progressive decline in intellectual functioning was identified as a care focus and an intervention put in place to manage this care focus specifically directed staff to explain each activity/care procedure prior to beginning the procedure.
b) A decreased ability to verbally communicate related to a decline in cognitive function was identified as a care focus and an intervention put in place to manage this care focus specifically directed staff to provide reassurance and patience when communicating with the resident.
c) A problematic manner in which the resident acts characterized by agitation related to anxiety was identified as a care focus and an intervention put in place to manage this care focus specifically directed staff to be careful of not invading the resident's personal space.
d) A problematic manner in which the resident acts characterized by resistance to treatment/care related to cognitive impairment was identified as a care focus and an intervention put in place to manage this care focus specifically directed staff to allow for flexibility in activity of daily living routines in order to accommodate the resident's mood and staff were directed that if the resident refuses care staff were to leave the resident and return in five to ten minutes.
The above noted care was not provided to the resident when staff interviewed and documentation collected by the home confirmed that on an identified date in 2014 a PSW attempted to provide care without communicating their intentions related to the care to be provided, staff invaded the resident's personal space without communicating with the resident and staff did not respond to the resident's resistance/refusal of care in accordance with the directions in the plan of care. [s. 6. (7)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect resident #001 from abuse, in relation to the following: [19(1)]
a) The licensee failed to ensure that staff assigned to provide care to resident #001 received the required training in accordance with LTCHA, 2007, S.O., c. 8, 76(2)1,3 and 76(7)1, before continuing to have contact with the resident.
d) The licensee failed to protect resident #001, when a staff who had a history of inappropriate contact and care of residents was assigned to provide care to this resident during the evening shift on an identified date in 2014. An incident confirmed during staff interviews and documented in records created by the home indicated that on the identified date a PSW providing care to resident #001 used physical force that caused a physical injury to the resident. Nine photographs taken by the home confirmed the extensive bruising suffered by resident #001 as a result of the PSW's actions. The DOC confirmed that at the time of this incident there was not a monitoring program in place related to the care this staff person provided to residents and that the staff person was under sanctions to only provide care to residents with a PSW partner.
Documents related to the identified staff’s performance and provided by the home indicated:
- A written letter of warning was provided related to unsafe care, roughness, impatient care, not listening to resident’s issues and inappropriate behaviour.
- A note in the staff’s file indicated that this staff was observed to "rip" bed sheets off a resident and then left resident uncovered, swear in front of a resident, talk about co-residents in front of other residents, not to provide proper care to a resident following an episode of incontinence and appeared to be unaware of the functional limitations of a resident while providing care.
-A Disciplinary Warning Notice and one day suspension related to unprofessional and unpredictable job performance as well as rough and abrupt approach to care of residents
- A note in the staff’s file indicating the DOC felt the staff person was not stable enough to provide care and as requested the staff person was sent home.
- A Disciplinary Warning Notice related to speaking loudly to residents and not providing care as directed in the plan of care.
- A Disciplinary Warning Notice and suspension with pay pending the outcome of an investigation related to an allegation of abuse.
- A notice of termination of employment as a result of the above noted investigation related to an allegation of abuse. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the licensee protect residents form abuse by anyone, to be implemented voluntarily.

WN #4: 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 failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with, in regard to the following: [20(1)]
The home provided the policy "Zero Tolerance of Abuse and Neglect Policy", identified as #N-06.50 and last reviewed in February 2014. This policy provides the following directions to staff:
a) This policy directed that the Policy on Zero Tolerance of Abuse and Neglect will be reviewed with each new employee during orientation and annually thereafter. Staff did not comply with this direction when the DOC confirmed that annual retraining had not occurred in 2014.
b) This policy directed that all incidents of physical abuse that caused physical injury must be reported to the police and or Ministry of Health and Long Term Care (MOHLTC). Staff did not comply with this direction when the DOC confirmed that police were not notified when on an identified date in 2014 the home became aware of a witnessed incident of physical abuse that caused physical injury to resident #001.
c) This policy directed that staff should immediately report under the Home's staff reporting policy any incidents that may lead to a mandatory report under section 24(1). Staff did not comply with this direction when a PSW who witnessed another PSW using force when attempting to provide care to resident #001 did not report this incident according to the directions contained in the policy. The PSW who witnessed this incident confirmed that they considered what they witnessed to be abuse, but did not report it until the following day when extensive bruising was noted. The PSW who witnessed this incident confirmed that they were aware of the requirement in the home's policy to immediately report this incident, but wanted to give the PSW involved in the incident a chance to report the incident first.
d) Section four (page 7 of 7) directed that the home is to annually evaluate the effectiveness of the policy for the prevention of abuse and neglect. Staff did not comply with this direction when the DOC confirmed that an annual evaluation to determine the effectiveness of the home's policy was not completed. [s. 20. (1)]

WN #5: 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. (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).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that in accordance with section 76(1) of the Act, all staff at the home received annual retraining, in accordance with O. Reg. 79/10, s. 219(1) in the area of the Residents’ Bill of Rights, the long term care home’s policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the protections afforded by section 26. [76(2) 1, 3, 4, 5]
The DOC confirmed that there were no records available at the time of this inspection to indicate that staff in the home received training in the area of the Residents’ Bill of Rights, the long-term care home’s policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the protections afforded by section 26 in 2014. [s. 76. (2)]

2. The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in abuse recognition and prevention. [76(7) 1]
The DOC confirmed that training in abuse recognition and prevention was not provided to staff who provide direct care to residents in 2014. [s. 76. (7) 1.]

WN #6: 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 ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents contained the required information, in relation to the following: [96 (a), (b), (c), and (e)]
1. In accordance with O. Reg.79/10, s. 96(a) the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents is to contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. The policy material provided by the home contained a seven page policy, Appendix A, B, C, D, E, F and an additional page of definitions. These documents did not contain procedures and interventions to assist and support residents who had been abused or had allegedly been abused. [96(a)]
2. In accordance with O. Reg.79/10, s. 96(b) the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents is to contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate. The above noted material the home provided as representing the policy required under section 20 of the Act did not contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents. [96(b)]
3. In accordance with O. Reg.79/10, s. 96(c) the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents is to identify measures and strategies to prevent abuse and neglect. The above noted material the home provided as representing the policy required under section 20 of the Act did not identify measures and strategies to prevent abuse and neglect. [96(c)]
4. In accordance with O. Reg.79/10, s. 96(e) the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents is to identify the training and retraining requirements for all staff. The regulation identifies that specific training on the relationship between power imbalances between staff and resident and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care as well as situations that may lead to abuse and neglect and how to avoid such situations are to be included in the home's policy. The above noted material the home provided as representing the policy required under section 20 of the Act did not identify specific training requirements. [96(e)] [s. 96.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence, in relation to the following: [98]
The DOC confirmed that the appropriate police force was not contacted when on an identified date in 2014 a PSW reported that they witnessed an incident of resident abuse that resulted in physical injuries to resident #001. The DOC and records kept by the home also confirmed that the staff person who was alleged to have used physical force when attempting to provide care that caused physical injury to the resident had a documented four year history of providing unsafe care, roughness when providing care, providing improper care, having a rough and abrupt approach to the care of residents as well as not providing care as specified in the plan of care. [s. 98.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences. [99(b)]
The DOC confirmed an evaluation of the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents had not been completed. [s. 99. (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, at least annually, the training and orientation program was evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [216(2)]
At the time of this inspection the home was identified as non-compliant in providing mandatory retraining in the areas of the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, the protection afforded by section 26 and abuse recognition and prevention. The DOC confirmed that an annual evaluation of the training and orientation program was not completed. [s. 216. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes

Specifically failed to comply with the following:

s. 305. (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home. O. Reg. 79/10, s. 305 (3).
2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents. O. Reg. 79/10, s. 305 (3).

Findings/Faits saillants :

1. The licensee failed to receive the approval of the Director prior to commencing work in the home that significantly disturbed and inconvenienced the residents, in relation to the following: [305(3) 2]
The licensee did not notify the Ministry or receive approval for renovations to the second floor home area dining room. On March 3, 2015 it was noted that residents were not in the dining room at 1215hrs in preparation for the noon meal. Workmen were noted to be in the dining room, the furniture had been removed and the flooring had been removed. Staff indicated that the flooring in the dining room was being replaced and the room was being repainted. Staff confirmed that the work had started on March 2, 2015, was expected to continue through March 4, 2015 and during the course of the renovations residents were being transported down elevators to the auditorium three times a day to eat meals, family members had agreed to attend the home to assist for some of the meals and were noted on March, 3, 2015 to be assisting five residents to eat in the lounge on the second floor home area. The residents were significantly inconvenienced in relation to the time taken for the residents to be transported to and from the auditorium three times a day over a three day period to consume meals. The Administrator confirmed that the home did not inform the Director of the changes being made in the home. [s. 305. (3) 2.]

Issued on this 10th day of July, 2015

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

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) :	PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2015_205129_0002
Log No. / Registre no:	H-001230-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 29, 2015
Licensee / Titulaire de permis :	BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED 600 Lake Street, St. Catharines, ON, L2N-4J4
LTC Home / Foyer de SLD :	HEIDEHOF LONG TERM CARE HOME 600 Lake Street, St. Catharines, ON, L2N-4J4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ELENA CADDIS

To BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

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

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

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

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

iv. have his or her personal health information within the meaning of the Personal

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

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

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

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall train all staff who provide direct care to residents in the area of abuse recognition and prevention, the Resident's Bill of Rights and the home's policy to promote zero tolerance of abuse and neglect of residents, shall repeat this training, at a minimum, every year as well as complete, at a minimum, annual evaluations of the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents to determine what changes and improvements maybe required to prevent resident abuse.

The licensee shall refrain from assigning staff who have not received the required annual training related to abuse recognition and prevention to provide care to residents and shall assign a person who has the authority to supervise and direct care to appropriately monitor any staff who have been identified as having had inappropriate contact and/or provided inappropriate care to residents.

Grounds / Motifs :

1. Previously identified as non-compliant on 2011/10/26 as a WN (3(1)) and on 2013/11/20 as a VPC (3(1)(11).

2. Resident #001 received physical injures when on an identified date in 2014 a PSW providing care to the resident used force in an attempt to have the resident comply with care. Staff interviewed and investigative notes collected following the incident confirmed that resident #001 received extensive soft tissue injuries as a result of staff action when the staff attempted to force the resident to receive care.

3. The licensee did not promote the right of residents to be protected from abuse when they failed to ensure that staff who provide direct care to residents received, as a condition of continuing to have contact with residents annual training in the area of abuse recognition and prevention. The DOC confirmed that training in the area mentioned above was not provided to staff in 2014.
4. The licensee did not promote the right of residents to be protected from abuse when the home failed to provide annual retraining in the area of the Resident's Bill of Rights and the long term care home's policy to promote zero tolerance of abuse and neglect of residents.
5. The licensee did not promote the right of residents to be protected from abuse when they failed to complete an annual evaluation of the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents or to determine what changes and improvements were required to prevent further incidents of resident abuse. The DOC confirmed that an annual review of the effectiveness of the home's policy to promote zero tolerance of abuse and neglect was not completed.
6. The licensee did not respect the right of resident #001 to be protected from abuse, when on an identified date in September 2014 two staff members were assigned to provide care to the resident even though they had not received the required training related to abuse recognition and prevention. As a result of care provided by one of the staff members the resident received soft tissue injuries as a result of a PSW using physical force while care was being provided. The DOC confirmed that the two staff people assigned to provide care to resident #001 on the identified date had not received the required training.
7) The licensee did not respect the right of resident #001 to be protected from abuse, when a staff member who had a history of inappropriate contact and care of residents was assigned to provide care to this resident on the identified date. An incident confirmed during staff interviews and documented in records created by the home indicated that a PSW providing care to resident #001used physical force that caused a physical injury to the resident. The DOC confirmed that at the time of this incident there was not a monitoring program in place related to the care this staff person provided to residents and that the staff person was under sanctions to only provide care to residents with a PSW partner. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure staff who provide direct care to residents, including resident #001, provide that care as it is specified in the plan of care. The plan is to include, but is not limited to the following:
1. The development and implementation of auditing process to regularly evaluate staffs knowledge of the specific care to be provided to residents.
2. The development and implementation of a mechanism to ensure that when additions or deletions are made to resident's plans of care that staff who provide direct care are made aware of those changes.
3. The development and implementation of a schedule to monitor staff performance in the actual provision of care to ensure that care is being provided as it is specified in the plan of care.
The plan is to be submitted to Phyllis Hiltz-Bontje on or before May 13, 2015 by e-mail at Phyllis.Hiltzbontje@Ontario.ca

Grounds / Motifs :

1. Previously identified as non-compliant on May 5, 2011 as a VPC and on November 20, 2013 as a VPC.
2.Staff did not provide care to resident #001 as specified in the resident's plan of care on an identified date in September 2014.
Resident #001's plan of care identified the following care focuses and interventions to manage those focuses:
a) A chronic progressive decline in intellectual functioning was identified as a care focus and an intervention put in place to manage this care focus specifically directed staff to explain each activity/care procedure prior to beginning the procedure.
b) A decreased ability to verbally communicate related to a decline in cognitive function was identified as a care focus and an intervention put in place to manage this care focus specifically directed staff to provide reassurance and patience when communicating with the resident.
c) A problematic manner in which the resident acts characterized by agitation related to anxiety was identified as a care focus and an intervention put in place to manage this care focus specifically directed staff to be careful of not invading the resident's personal space.
d) The resident demonstrated a specific responsive behaviour and an intervention put in place to manage this care focus specifically directed staff to allow for flexibility in activity of daily living routines in order to accommodate the resident's mood and staff were directed that if the resident refuses care staff were to leave the resident and return in five to ten minutes.
The above noted care was not provided to the resident when staff interviewed and documentation collected by the home confirmed that on an identified date in September 2014 a PSW was observed to attempt to provide care to the resident without explaining the care to be provided or asking the resident if staff could provide the care. The resident became upset about this action and the staff person continued to force the resident to receive the care. The resident responded to the staffs action in an attempt to stop the staff person from proceeding. The PSW responded to the resident's action and as a result the resident received soft tissue injuries. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

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.

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 29th day of April, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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