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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 27, 2016	2016_268604_0011	5084-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE ONTARIO MISSION OF THE DEAF
2395 BAYVIEW AVENUE NORTH YORK ON M2L 1A2

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

BOB RUMBALL HOME FOR THE DEAF
1 Royal Parkside Drive BARRIE ON L4M 0C4

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

SHIHANA RUMZI (604), DIANE BROWN (110), VALERIE JOHNSTON (202), VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 16, 17, 18, 21, 22, 24, 29, 30, and 31, 2016 and April 1, 4, 5, 6, 7, 8, 11, 12, 13, and 14, 2016.

The following intakes were inspected concurrently with the Resident Quality Inspection:
Critical Incident Systems (CIS) related to alleged abuse: Log #T-643-13, Log #001177-14, Log #001630-15, Log #025417-15, and Log #029535-15.

Complaints related to care: Log #002589-14, Log #007089-14, Log #007264-14, Log #001871-15, Log #028891-15, Log #029620-15, Log #000438-14, and Log #005508-16.

Follow-up related to orders log #022125-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Reception/Translation Services, Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Private Sitters (PS), Programs Coordinator (PA), Environmental Services Manager (ESM), Staffing Clerk, Registered Dietitian (RD), Food Service Manager (FSM), Dietary Aids (DA), Resident Care Manager (RCM), Residents, Substitute Decision Makers (SDMs), and Presidents of Residents' and Family Councils.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (1)	CO #004	2015_168202_0006	202
O.Reg 79/10 s. 110. (2)	CO #002	2015_168202_0006	202
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2015_168202_0006	202
O.Reg 79/10 s. 69.	CO #003	2015_168202_0006	202

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

On March 29, 2016, during an interview with Registered Practical Nurse (RPN) #114, the RPN indicated that there is seldom an Registered Nurse (RN) on duty and present in the home on the evening shift and that this has been happening for some time.

A review of Bob Rumball Home for the Deaf, registered staffing schedule indicated that the day shift is from 0700 to 1500 Hours (hrs), the evening shift is 1500 to 2300 hrs, and the night shift is 2300 to 0700 hrs.

A review of the home's staffing schedule from November 01, 2015 to March 31, 2016, indicated that there had been no RN in the building for the following dates and shifts:

-November 2015: 1, day and evening, 4, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 25, 27, evening, 28 both day and evening and on November 29, the evening shift.

-December 2015: 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, all evening shifts.

-January 2016: 1, 2, 3, 4, 5, 6, 7, 8, evening,9 and 10 both day and evening, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, evening, 23 and 24 day and evening, 25, 26, 27, 28, 29, 30, 31 evening.

-February 2016: 1, 2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 24, 25,

26, 27, 28, 29, evening.

-March 2016: 1, 2, 3, 4, evening, 5 day and evening, 6, day, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31 evening.

An interview with the Associate Director of Care (ADOC) confirmed that there had been no RN in the home on the above mentioned dates. The ADOC indicated that there has only been a shortage of RNs in the home since November 2015.

The ADOC indicated that the home has utilized agency staff and made attempts to recruit staff.

A review of the registered staffing schedule for the home from August 01 to October 31, 2015, was conducted to determine if the lack of RN coverage had actually started in November 2015, as indicated by the ADOC. The following dates and shifts were found to have no RN present in the home and confirmed that the home did not have a RN in the building at all times prior to November 2015 as follows:

-August 2015: 5, 8, 9, 14, 20, 22, 23, 28, 2015, evening shifts.

-September 2015: 2, evening, 5, 6, day and evening, 9, 11, 12, 15, 18, evening, 19, 20 day and evening, 25, 28 evening.

-October 2015: 3, 4, day and evening, 8, 10, 17, 18, 19, 20, 21, 23, 30, 31, evening.

A subsequent interview with the ADOC confirmed that the home has been short RNs well before the initially stated time line of November 2015. The ADOC indicated that because it had been difficult to obtain and hire RNs for the home, a decision had been made to hire an extra RPN for the evening shifts and to have both him/herself and the Director of Care (DOC) alternate on call by telephone while there is no RN in the building.

The licensee is required to have at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except in the case of an emergency, whereby a RPN who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone. The utilization of an RPN in conjunction with either the DOC or the ADOC being available by telephone, on the above

mentioned dates and shifts between August 01, 2015 to March 31, 2016, does not constitute an emergency.

The severity of the non-compliance and the severity of the harm and risk of further harm is potential.

The scope of the non-compliance is widespread.

A review of the compliance history revealed that there has been no previous non-compliance related to the Long-Term Care Homes Act, O.Reg. 79/10.,s. 45 (1). [s. 8. (3)]

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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1.The licensee has failed to ensure that the residents were protected from neglect by the licensee or staff in the home.

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

Review of the CIS report submitted by the home on an identified date, identified resident #014 was found in a soiled incontinent brief on an identified date.

Record review of the Point of Care (POC) revealed the resident’s last incontinent brief change was on the evening shift on an identified date. The resident was then checked as follows: five hours later, eight hours later, and three and a half hours later, the resident remained dry. The resident was next checked approximately eight hours later on the evening shift of the next day and was found to be incontinent of urine.

An interview with PSW #126, confirmed the resident was checked during the eight hour period but had forgot to document this in PCC and confirmed the resident had not voided on the day shift and this is why the resident’s incontinent brief was not changed.

An interview with the Resident Care Manager (RCM) identified it is the home's practice to at least change a resident’s incontinent brief at a minimum once per shift for sanitary reasons even if not incontinent.

An interview with the ADOC and DOC confirmed resident #014 was neglected and the resident was not cared for in a 24hr period. [s. 19. (1)] (557)

Review of the CIS report submitted on an identified date, identified resident #011, was found in a soiled incontinent brief on an identified date.

Record review of resident #011’s plan of care revealed documentation in PCC by RN #110 indicating resident was found on an identified date, to be unclean at the beginning of the day shift.

An interview with PSW #119 confirmed when he/she did their rounds two days later, that he/she found resident #011 in a soiled incontinent brief.

An interview with the DOC confirmed that PSW #127 left resident #011 in an unclean manner and neglected to provide care for resident #011. [s. 19. (1)] (557)

Review of CIS report submitted by the home on an identified date, identified resident #012 being found at risk of choking in an identified location of the home.

Record review of resident #012’s plan of care revealed there was no documentation in resident #012’s progress notes.

Interviews with PSW #119 and #128 confirmed when they conducted rounds on an identified date; they observed resident #012 to be at risk for choking in an identified

location of the home.

An interview with the DOC confirmed that PSW #127 left resident #012 at risk for choking in an identified location of the home and neglected to ensure resident #012 was safe. [s. 19. (1)] (557)

Review of the CIS report submitted by the home on an identified date, identified resident #015 had asked PSW #133 for something to eat and PSW failed to provide the resident with food.

Staff interview with PSW #128, revealed on an identified shift and date he/she arrived early for his/her shift. The PSW indicated they observed resident #015 sitting in an identified area of the home and overheard him/her stating they were hungry and requested something to eat. PSW #128 revealed they heard PSW #133 refer to resident as fat and did not proceed to offer resident #015 something to eat.

Interview with PSW #134, who also arrived early for his/her shift, revealed he/she heard resident #015 screaming for food and PSW #133 stating resident #015 had been eating on an identified shift. PSW #134 confirmed PSW #133 did not provide resident #015 with something to eat prior to leaving at the end of his/her shift. PSW #134 revealed that he/she went into the servery and provided resident #015 with something to eat and drink.

An interview with PSW #133 revealed he/she replied to resident #015, "it is close to breakfast time can you wait". PSW #133 confirmed they did not offer resident #015 something to eat but had fed resident #015 more than once throughout the shift and it was time for the PSW to go.

An interview with the ADOC confirmed their investigation of the incident resulted in disciplinary action of staff PSW #133 related to neglect. [s. 19. (1)] (110)

Review of the CIS report submitted by the home on an identified date, identified an allegation of neglect whereby resident #017 asked PSW #124 for his/her personal resident equipment and the PSW walked away without providing the requested equipment to the resident.

Record review of resident #017's Point Click Care (PCC) documentation revealed on an identified date, resident #017 spoke with RN #123 and disclosed that PSW #124 walked away when he/she requested personal resident equipment.

An interview conducted with RN #123 identified resident #017 was at high risk for incidents and the personal resident equipment was not provided during an identified shift to accommodate resident needs. The RN indicated he/she gave the resident the personal resident equipment and provided care as needed. The RN stated they reported the incident to the DOC and ADOC in writing the next morning.

Interview with PSW #124 identified resident #017 used identified personal resident equipment during an identified shift, as the resident was at high risk for incidents when attempting to ambulate. PSW indicated the home suspended him/her for neglecting to provide resident #017 with the personal resident equipment when requested.

Interview conducted with the ADOC indicated the resident confirmed to the home that PSW #124 didn't provide him/her with the personal resident equipment when requested and walked out of an identified location of the home. ADOC stated PSW #124 neglected resident #017's request. The resident was not protected from neglect by the home's staff. [s. 19. (1)] (604)

Review of CIS report submitted by the home on an identified date, identified resident #010 was left on the toilet for an extended period of time.

Record review of resident #010's plan of care revealed documentation in the progress notes by RPN #100 supporting that the resident was found left on the toilet for an extended period of time.

Review of the room activity report confirmed a staff member was in the identified location at an identified time, and the next time a staff member went to the identified area was 111 minutes later.

An interview with PSW #103 confirmed he/she did leave the resident on the toilet but it was an accident. The PSW further indicated that RPN #111 and he/she had toileted the resident and when they removed resident #010 from the toilet the resident indicated he/she was not ready to leave the area and was assisted back on the toilet.

An interview with the ADOC and DOC confirmed the resident had been neglected as resident #010 was left on the toilet for an extended period of time. [s. 19. (1)] (557)

The licensee has failed to ensure that the long-term care home shall protect residents

from abuse by anyone.

"Physical abuse" means, (a) the use of physical force by anyone other than a resident that causes physical injury or pain. O. Reg. 79/10, s. 2. (1) (a)

Review of the CIS report submitted by the home on an identified date involving resident #016 who informed RPN #132 that PSW #134 provided inappropriate care on an identified shift when resident requested PSW to assist with identified ADL's. The resident revealed the PSW was not gentle when he/she assisted with requested ADL's by the resident and caused resident discomfort.

PCC documentation review for resident #016 on an identified date, indicated an identified shift, PSW#134 provided inappropriate care to resident by not being gentle when proving ADL's to the resident causing the resident discomfort.

An interview conducted with resident #016's SDM indicated resident #016 called them to report an incident which occurred a couple of days ago on an identified shift. The SDM informed the inspector resident stated a PSW on an identified shift provided inappropriate care by handling him/her inappropriately causing the resident discomfort. The SDM indicated they called the home and reported the incident immediately to RPN #132.

An interview conducted with RPN #132 confirmed resident #016's SMD informed the licensee of the allegation involving inappropriate care. The RPN indicated he/she spoke with the resident who stated on an identified shift confirmed the above incident with PSW #134 which had occurred couple of days ago. The RPN indicated during his/her conversation with resident #016, the resident appeared to be afraid and was emotional about the incident. RPN indicated the incident was abuse and no resident should be treated in that manner.

An interview with the home's DOC confirmed the above incident occurred and staff was abusive to resident #016 in providing inappropriate care. DOC indicated PSW #134 was terminated and no longer works in the home. [S. 19. (1)] (604)

Every licensee of a long-term care home shall protect residents from abuse by the licensee or staff.

"Verbal abuse" means, (a) any form of verbal communication of a threatening or

intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

The licensee has failed to ensure that the residents were protected from abuse by the licensee or
staff in the home.

On an identified date, the home submitted an abuse/neglect CIS report involving resident #005.

Record review of resident #005's progress notes revealed documentation by RN #131 prior to the identified incident with resident #005. Resident #005 had been complaining of health concerns. The RN indicated that the resident did not appear to be in distress and the RN directed the resident to return to an identified location of the home. The RN went to conduct a thorough assessment within an identified duration of time. Resident #005 accused the RN of arguing and yelling at him/her. The RN left the situation and called the ADOC for support. When RN #131 and the ADOC arrived to resident #005's identified location and the arguing started once again. The RN was waving her finger and yelling at the resident calling him/her a liar.

An interview with RN #131 confirmed that he/she did argue with the resident and make a gesture with his/her finger in the air. He/she denied yelling but was talking fast in a raised voice.

An interview with resident #005 and the ADOC confirmed the above incident did occur as indicated in the resident's progress notes.

An interview with the ADOC and DOC confirmed that staff in the home verbally and emotionally abused resident #005. [S. 19. (1)] (557)

The home is being served an order as the inspectors conducted ten CIS report inspections which were submitted with in an identified period of time. The inspector found nine incidents where the home did not protect resident's from abuse/neglect from the staff.

The severity of the non-compliance and the severity of harm and risk are potential for actual harm/risk.

The scope of the non-compliance is widespread.

A review of the compliance history revealed no previous non-compliance related to the Long-Term Care Homes Act, Or.Reg c. 8, s. 19 (1).

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. 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 shall ensure that 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: neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Review of the CIS report submitted by the home on an identified date involving resident #014 who was found in a soiled incontinent brief on an identified date and an identified

duration of time.

The home initiated the CIS report on an identified date; this report was submitted to the Director three days later.

An interview with the DOC confirmed he/she did initiate the CIS but neglected to call the Ministry's after-hours line to inform the Director immediately upon becoming aware of the incident of alleged neglect in not providing care to resident #014. [s. 24. (1)] (557)

Review of the CIS report submitted by the home on an identified date involving resident #013 related to neglect.

The home initiated the CIS report on an identified date; this report was submitted to the Director one day later.

An interview with the ADOC confirmed he/she did initiate the CIS report but neglected to call the Ministry's after-hours line to inform the Director immediately upon becoming aware of the incident of alleged neglect in not providing care to resident #013. [s. 24. (1)] (557)

Review of the CIS report submitted by the home on an identified date involving resident #012 related to neglect.

The CIS report was submitted to the Director one day late.

An interview with the ADOC confirmed he/she did initiate the CIS report but neglected to call the Ministry's after-hours line to inform the Director immediately upon becoming aware of the incident of alleged neglect to provide care to resident #012. [s. 24. (1)] (557)

Review of the CIS report submitted by the home on an identified date involving resident #011. The CIS report indicated resident #011 was found in a soiled incontinent brief on an identified date and an identified duration of time.

The CIS report was submitted to the Director one day later.

An interview with the ADOC confirmed he/she did initiate the CIS report but neglected to call the Ministry's after-hours line to inform the Director immediately upon becoming aware of the incident of alleged neglect to provide care for resident #011. [s. 24. (1)]

(557)

Review of the CIS report submitted by the home on an identified date involving resident #015. The CIS report identified staff neglected to provided resident with a request for a meal.

The CIS report was submitted to the Director one day later.

An interview with the ADOC confirmed he/she did initiate the CIS report but misunderstood the time line for reporting to the Director, thinking he/she had 10 days to submit the CIS involving an allegation of neglect involving resident #015. [s. 24. (1)] (110)

Review of the CIS report alleging abuse towards resident #005 was submitted by the home to the MOH on an identified date .

The CIS report was submitted to the Director three days later.

An interview with the ADOC confirmed he/she did initiate the CIS report but neglected to call the Ministry's after-hours line to inform the Director immediately upon becoming aware of the incident alleged verbal and emotional abuse by a staff member. [s. 24. (1)] (557)

The home is being served an order as the inspectors conducted ten CIS report inspections, which were submitted during a period of time. The inspectors found six mandatory abuse/neglect CIS reports to be submitted late to the Director.

Legislation s. 24. (1) directs 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: neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, legislation was not followed.

The home historically has an ongoing non-compliance with legislation s.24. (1), the ongoing non-compliance is as follows:
1)Resident Quality Inspection conducted October 7, 2014 – VPC was issued
2)Resident Quality Inspection conducted April 24, 2015 – VPC was issued

The severity of the non-compliance and the severity of harm and risk is minimal.

The scope of the non-compliance is a pattern.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure in making a report to the Director under subsection 23 (2) of the Act, the licensee will include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: a description of the individuals involved in the incident, including, names of any staff members or other persons who were present at or discovered the incident.

On an identified date the home submitted a CIS report which was initiated for resident #014 after being found in a soiled incontinent brief on an identified date and identified period of time where resident care was not provided.

The CIS report submitted by the home did not contain the name of the PSW involved in

the incident.

Interviews conducted with the ADOC and DOC confirmed that the CIS report did not identify PSW #126's name and was not reported to the Director as required by legislation. [s. 104. (1) 2.] (557)

On an identified date the home submitted a CIS report which was initiated for resident #013 after being found in a soiled incontinent brief on an identified date.

The CIS report submitted by the home did not contain the name of the PSW involved in the incident.

An interview conducted with the ADOC confirmed that the CIS report did not identify PSW #127's name and was not reported to the Director as required by legislation. [s. 104. (1) 2.] (557)

On an identified date the home submitted a CIS report which was initiated for resident #012 after being found at high risk for choking.

The CIS report submitted by the home did not contain the name of the PSW involved in the incident.

An interview conducted with the ADOC confirmed that the CIS report did not identify PSW #127's name and was not reported to the Director as required by legislation. [s. 104. (1) 2.] (557)

On an identified date the home submitted a CIS report which was initiated for resident #011 after being found in a state of uncleanliness on an identified date and identified period of time where resident care was not provided.

The CIS did not contain the PSW's name who was involved in the incident.

An interview conducted with the ADOC confirmed that the CIS report did not identify PSW #127's name and was not reported to the Director as required by legislation. [s. 104. (1) 2.] (557)

On an identified date the home submitted a CIS which was initiated for resident #005 after being abused by a staff member.

The CIS report submitted by the home did not contain the name of the RN who was involved in the incident.

An interview conducted with the ADOC confirmed that the CIS report did not identify RN #131's name and was not reported to the Director as required by legislation. [s. 104. (1) 2.] (557)

On an identified date the home submitted a CIS report which was initiated for four identified residents #019, #020, #021 and #022.

Record review of the home's investigation notes revealed there were four additional residents who were not identified within the submitted CIS report. The following residents were not identified in the CIS report: resident #019, #020, #021 and #022.

Interviews with the ADOC and DOC failed to explain the reason why the above identified residents were not added to the CIS report, and confirmed the four identified residents involved in the incident where not reported to the Director. [s. 104. (1) 2.] (557)

The home is being served an order as the inspectors conducted ten CIS report inspections which were submitted within an identified period of time. The inspectors found six mandatory abuse/neglect CIS reports to be submitted with no names of residents and staff members or other persons who were present or discovered the incident.

The severity of the non-compliance and the severity of harm and risk is minimal.

The scope of the non-compliance is widespread.

A review of the compliance history revealed that there have been no previous non-compliances related to the Long-Term Care Homes Act O.Reg. 79/10., r. 104. (1)

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

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 shall ensure that the resident's SDM and any other person specified by the resident shall be notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of neglect of the resident.

The home submitted an abuse/neglect CIS report on an identified date. The CIS report indicated resident #017 requested a specific resident personal equipment from PSW #124 who walked away and did not provide the equipment to the resident.

Review of home's CIS report indicated SDM was not contacted related to the incident of alleged abuse/neglect.

A review of the home's amended CIS submitted 10 days later on an identified date, indicated SDM was contacted and SDM was appreciative of the call.

Record review was conducted on resident #017's PCC documentation for an identified

period of time failed to identify any documentation that the SDM was contacted related to the alleged abuse/neglect.

An interview with the ADOC revealed SDM should be called for any alleged abuse/neglect issue in the home. ADOC confirmed the SDM was not called and was unable to provide an explanation as to the reason the SDM was not contacted about the allegation. [s. 97. (1) (b)] (604)

On an identified date, the home submitted an abuse/neglect CIS report involving resident #011 after being found in a soiled incontinent brief on an identified date and duration of time.

An interview with resident #011's SDM revealed that he/she was not notified of the incident on an identified date. He/she stated the home calls them about medication changes, changes in condition but did not recall being informed about resident #011 being found in an uncleanly manner for the identified period of time.

An interview with the ADOC and DOC confirmed they had no evidence to confirm that the home notified the SDM about this incident. [s. 97. (1) (b)] (557)

On an identified date, the home submitted an abuse/neglect CIS report involving resident #015. The CIS report indicated PSW #128 overheard resident #015 requesting food to eat and PSW #133 referred to the resident as fat and refused to give the resident something to eat.

Review of home's CIS report indicated the SDM was not contacted related to the incident of alleged abuse/neglect.

An interview with the ADOC confirmed the SDM was not contacted and should have been called for the alleged abuse/neglect issue identified in the home. [s. 97. (1) (b)] (110)

The licensee failed to 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.

On an identified date, the home submitted a CIS which was initiated for resident #014 after being found in a soiled incontinent brief on an identified date and an identified

duration of time.

An interview conducted with resident #014's SDM confirmed that he/she was not notified of the results of the investigation upon completion.

An interview with the ADOC and DOC confirmed the home was unable to provide evidence the SDM was notified upon the completion of the home's investigation. [s. 97. (2)] (557)

On an identified date, the home submitted a CIS report which was initiated for resident #011 after being found with an a state of uncleanliness on an identified date and duration of time.

An interview with resident #011's SDM confirmed that he/she was not notified of the results of the investigation upon completion.

An interview with the ADOC and DOC confirmed the home was unable to provide evidence the SDM was notified upon the completion of the home's investigation. [s. 97. (2)] (557)

On an identified date, the home submitted a CIS report which was initiated for resident #010 after being found on the toilet for an extended period of time.

An interview with resident #011's SDM confirmed that he/she was not notified of the results of the investigation upon completion.

An interview with the ADOC and DOC confirmed the home was unable to provide evidence the SDM was notified upon the completion of the home's investigation. [s. 97. (2)] (557)

On an identified date, the home submitted a CIS report which was initiated for resident #005 after being abused by a staff member.

An interview with resident #005's SDM confirmed that he/she was not notified of the results of the investigation upon completion.

An interview with the ADOC and DOC could not confirm that the home notified the SDM upon the completion of the home's investigation. [s. 97. (2)] (557)

The home is being served an order as the inspectors conducted ten CIS report inspects which were submitted with in an identified period of time. The inspectors found six mandatory abuse/neglect CIS reports to be submitted late to the Director.

The severity of the non-compliance and the severity of harm and risk is minimal.

The scope of the non-compliance is a pattern.

A review of the compliance history revealed that there have been no previous non-compliances related to the Long-Term Care Homes Act O.Reg. 79/10., r. 97.(1).

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place were complied with.

On an identified date, the home submitted a controlled substance missing/unaccounted CIS report indicating a narcotic medication error.

A review of the home's identified documentation for resident #074 and resident #075 revealed no date for narcotic removal was entered by the second registered staff.

The home's policy "Medication Disposal – Controlled Substances/LTC's", policy number: 5.8.1, with a revision date of July 2014. Under "Procedure", #2 directs staff to do the following: In the presence of 2 registered personnel, the remaining quantity of drug is "Circled" on the individual count sheet and subsequently document in the space provided. Procedure #4 directs 2 registered personnel to sign and date the form (individual and shift count) in the space provided.

Interviews conducted with the home's DOC and ADOC confirmed RPN #120 and agency RPN #121 did not follow the home's policy for medication disposal. The ADOC further indicated RPN #120 signed the resident's individual narcotic and controlled drug count sheet on his/her own for both residents indicated above on evening shift on an identified date in March 2015, and the agency RPN #121 signed the form and did not date the form. The agency RPN did not work in the home until the day shift the following day. The resident's individual narcotic and controlled drug count sheets for resident #074 and #075 were found seven days later in the narcotics destruction box by the ADOC. The DOC further indicated as the narcotics were left on the top of the counter in the locked medication room only RPN #120 and agency RPN #121 had access to the narcotics, the DOC confirmed the narcotics were missing when the medication disposal form was found. [s. 8. (1) (b)]

2. On an identified date, during stage resident observation the inspector observed resident #018's medication to be stored in an identified area of the home, which identified the prescription order date and duration of the prescription.

The home's policy "Processing New Orders, Changes and Discontinuation for Weekly Batched Medications", policy number: 3.3, with a revision date of July 2014. Under "Situation", directs staff to remove discontinued medications and medications are to be discarded.

Interviews conducted with RPN #111 and the DOC confirmed staff did not follow the home's policy for discontinued medication. The DOC further confirmed it is the home's expectation that the policies are complied with by the home's staff. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with the Narcotic and Controlled Drug Count policy, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

An interview with resident #51 indicated that at times he/she has to wait up to an identified duration of time for staff assistance after pressing the call bell. The Residents' Council meeting minutes and the home's response to the Residents' Council for an identified period of time were reviewed.

The meeting notes for an identified month stated, "residents still feel that the call bell wait times are still long. One resident said, "no one responds to my call until 7:15 p.m. I asked for help at 4:15 p.m.”. The home's response signed by the administrator on an identified date stated " I read your minutes that you are still having issues with the call-bell system. We are currently reviewing the wait times and I hope to have a report to you soon".

The meeting notes for another identified period of time, stated "resident expressed concern at the lengthy wait time when he/she rings for assistance, stating he/she has pressed the call bell four times with no response". Resident seconded the complaint, stating that he/she has often had to wait up to 15-20 minutes in the bathroom before a staff member comes to assist him/her”. The home's response signed by the administrator on an identified date, did not reveal any response to the call bell concern as indicated above.

An interview with the Residents' Council president indicated that the response time of staff answering call bells is always brought up at Residents' Council meetings, and that the council is told by management that they are working on it, however, nothing ever changes. The president further confirmed that no response has been received regarding the call bell issue as indicated above. An interview with both the Programs Coordinator (PC) and the DOC confirmed that the home had not responded to the call bell concern that had been documented as raised at two identified Residents' Council meetings. [s. 57. (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 the licensee responds in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items were offered and were available at each meal and snack.

On an identified date and location of the home, the inspector observed meal services. The inspector observed and confirmed with Dietary Aide (DA) #135 the portions sizes required according to the planned menu and the actual portion sizes of menu items served.

The regular entrée, macaroni and cheese with ham was served using a #6 scoop yielding 158mls and not a 250ml serving/portion; pureed macaroni and cheese was served using two x #10 scoops yielding 250mls and not a #6 scoop or 158mls serving/portion.

The DA confirmed the serving sizes used were incorrect and was not in keeping with the planned menu.

An interview with the Dietary Manager (DM) revealed that portion sizes are part of the planned menu and staff are required to follow the menu when serving meals and snacks. The DM confirmed that staff did not follow the planned menu portions when serving the lunch entree. [s. 71. (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 planned menu items were offered and were available at each meal and snack., to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that is secure and locked.

On an identified date, the inspector observed ordered medication to be stored in an identified area of the home for resident #018.

Interviews conducted with RPN #111 and the DOC confirmed that ordered treatment is not to be stored in an unlocked cupboard. The DOC confirmed it is the home's expectation that all medications be secured and stored in an area that is locked. [s. 129. (1) (a) (ii)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The home submitted a CIS report on an identified date indicating a medication were missing on an identified shift for two residents, the CIS identified the specific medication dose for resident #074 and resident #075.

Interviews conducted with the home's DOC and ADOC identified RPN #120 had left the narcotic cards for resident #074 and #075 on an identified location of the home for destruction and did not lock the narcotics in a secure location in the home and went home after the end of the shift. The DOC indicated agency RPN #121 was the last person in the medication room and had access to the missing narcotics, the agency was informed of the incident and the RPN is no longer allowed to come to the home. Agency RPN #121 could not be reached. DOC indicated the narcotics were missing and the home's expectation is narcotics be stored in the narcotic lock box in the medication cart. [s. 129. (1) (b)]

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;
-Drugs are stored in an area or a medication cart that is secure and locked
-Controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

A review of CIS report identified an incident on an identified date, whereby resident #015 used an identified object and struck the chair of another resident who was sitting.

Review of the physician orders revealed an order for an identified medication twice daily as part of the resident's plan of care for the management of his/her responsible behaviours.

Review of the Electronic Medication Administration Record (EMAR) for an identified period, revealed the medication had not been signed as administered on three identified dates.

An interview conducted with RN #137 identified the medication administration was not provided to resident #015 on the identified dates.

An interview with the ADOC confirmed resident #015 was not administered medication in accordance with the directions for use specified by the prescriber for the three identified dates leading up to the reported incident. [s. 131. (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 drugs were administered to the resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On an identified date, during stage one observation, resident #003 was noted to have poor oral hygiene.

Record review of the progress notes revealed on an identified date, resident was seen by a health care provider for assessment. The note revealed resident's oral hygiene needed to be improved.

Interviews conducted with PSW #138 and #128 on identified shifts, revealed resident #003 does not like oral hygiene to be performed due to discomfort.

Record review of resident #003's written plan of care indicated staff are to provide constant supervision with physical assistance when providing oral hygiene with assistance and his/her goal is to be clean.

Interviews conducted with the DOC, RPN #132 and #112 confirmed that staff are expected to provide oral hygiene to the resident and staff is to report to the nurse if the resident refused or expressed discomfort. Staff interviews further confirmed that the plan of care was not followed for resident #003. [s. 6. (7)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was easily seen, accessed and used by residents, staff and visitors at all times.

The home's resident-staff communication and response system required each resident to wear an alert badge which is easily seen and can be activated by residents, staff and visitors at all times.

An interview with the Environmental Services Manager (ESM) and RPN #132 confirmed that nursing staff are to complete an audit on the Pager and Badge Control form, of resident pagers at the beginning of each shift coding "W" for working, "M" for missing and "B" for battery needs changing.

Resident #035's written plan of care identified the resident was at an identified risk. Interventions included placing resident on an identified home's list and that the resident must have his/her alert badge on.

On an identified date, the inspector observed resident #035 not to have their identified alert badge. An interview with resident #035 confirmed he/she did not have their alert badge and he/she had reported it missing on an identified period of time. Resident stated

that it was not right that he/she did not have the alert badge and that an alternative was not provided by the home in the meantime.

An interview with RPN #132 on an identified date , revealed that he/she was not aware resident #035's alert badge was missing, but confirmed from viewing the monitor that it was in fact missing.

A review of the "Pager and Badge Control" form for an identified date and shift was signed by RPN #132 identified a "M" for missing badge next to resident #035's name. A further review of the Pager and Badge Control forms identified resident #035's badge was missing on four identified dates and last identified as working on an identified date.

An interview conducted with the ESM who oversees with nursing, the resident-staff communication and response system, revealed that he/she was not aware resident #035's alert badge had been missing since an identified date, and that a replacement was immediately provided. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the resident-staff communication and response system clearly indicates when activated where the signal was coming from.

On an identified date, the inspector observed resident #076 sitting in an identified location of the home. Resident had an alert badge. PSW #128 alerted the alert badge upon the request of this inspector in order to test the resident equipment. The resident's alert badge indicated on PSW #128's pager and to an identified monitoring screen located at an identified area of the home. The monitoring screen indicated the resident #076 was in an identified area of the home.

An interview with PSW#128 confirmed that his/her equipment indicated resident #076 as being in an identified location of the home. The PSW confirmed the resident #076's location identified was incorrect. [s. 17. (1) (f)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that the temperature of the hot water serving all bathtubs and showers used by residents were maintained at a temperature of at least 40 degrees Celsius.

Interviews conducted with PSWs #119 and #128 identified the hot water shower temperature in two identified location of the home were not hot enough and too cold for residents comfort.

Interview with PSW #103 confirmed the hot water temperature was only luke warm and not hot.

Interviews with residents #32, #33 and #34 indicated in two identified locations of the home the hot water temperature is not hot enough and too cold.

An interview with Housekeeping Aide (HA) #139 confirmed he/ she randomly monitors the hot water temperatures in resident areas but not in the identified location. Hot water temperatures in two identified locations of the home were requested and observed being taken by HA #139 on an identified date. The hot water temperature was confirmed by HA #139 to be 32 and 34 degrees Celsius respectively, and did not meet the minimum requirement of 40 degrees Celsius.

An interview with RPN #100 confirmed that nursing staff do not monitor water temperatures in the identified locations of the home.

An interview with ESM confirmed that there is no monitoring hot water temperatures in the two identified locations of the home and that 32 and 34 degrees Celsius does not meet the home's minimum standard of 40 degrees Celsius temperatures. The ESM further confirmed that maintenance staff had not received any maintenance requests related to this issue, and that the two identified home areas had temperature regulators replaced. [s. 90. (2) (i)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(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
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

During stage one resident #008's SDM identified he/she had complained to the homes Social Services Manager (SSM) that resident #008 was missing personal items.

An interview conducted with resident #008's SDM indicated he/she had reported to the SSM that resident #008 was missing identified personal items. SDM stated SSM was informed of the missing personal items and indicated they were labelled with resident #008's initials.

The home's policy "Resident Lost Items" number: EVN-VII-29 Date: O:Jul 06 R:Jun 08 under procedure directs staff to initiate and record in the "Lost Items Tracking Form" complaints of missing items.

Interview conducted with the SSM confirmed SDM of resident #008 did speak with him/her related to missing items. SSM indicated as the complaint was related to lost/missing items she/he was expected to complete a "Lost Items Tracking Form" which identifies the date of the complaint, lost/missing items, action, and resolution. SSM confirmed she/he did not document the "Lost Items Tracking Form" for the complaint brought to them by resident #008's SDM. [s. 101. (2)]

Issued on this 14th day of September, 2016

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) :	SHIHANA RUMZI (604), DIANE BROWN (110), VALERIE JOHNSTON (202), VALERIE PIMENTEL (557)
Inspection No. / No de l'inspection :	2016_268604_0011
Log No. / Registre no:	5084-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 27, 2016
Licensee / Titulaire de permis :	THE ONTARIO MISSION OF THE DEAF 2395 BAYVIEW AVENUE, NORTH YORK, ON, M2L-1A2
LTC Home / Foyer de SLD :	BOB RUMBALL HOME FOR THE DEAF 1 Royal Parkside Drive, BARRIE, ON, L4M-0C4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shirley Cassel

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

To THE ONTARIO MISSION OF THE DEAF, 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. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

1.Within one week of receipt of this order, provide a plan to the inspector on how the home will ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

2.The plan shall include ways to obtain and sustain registered nurses, time lines and the person (s) responsible for completing the tasks. The plan shall be submitted to valerie. johnston@ontario.ca.

Grounds / Motifs :

1. Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

On March 29, 2016, during an interview with Registered Practical Nurse (RPN) #114, the RPN indicated that there is seldom a Registered Nurse (RN) on duty and present in the home on the evening shift and that this has been happening for some time.

A review of Bob Rumball Home for the Deaf, registered staffing schedule indicated that the day shift is from 0700 to 1500 Hours (hrs), the evening shift is 1500 to 2300 and the night shift is 2300 to 0700 hrs.

A review of the home's staffing schedule from November 01, 2015, to March 31,

2016, indicated that there had been no RN in the building for the following dates and shifts:

-November 2015: 1, day and evening, 4, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 22, 25, 27, evening, 28 both day and evening and on November 29, the evening shift.

-December 2015: 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, all evening shifts.

-January 2016: 1,2,3,4,5,6,7,8, evening, 9 and 10 both day and evening, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, evening, 23 and 24 day and evening, 25, 26, 27, 28, 29, 30, 31 evening.

-February 2016: 1, 2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, 29, evening.

-March 2016: 1, 2, 3, 4, evening, 5 day and evening, 6, day, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31 evening.

An interview with the Associate Director of Care (ADOC) confirmed that there had been no RN in the home on the above mentioned dates. The ADOC indicated that there has only been a shortage of RNs in the home since November 2015.

The ADOC indicated that the home has utilized agency staff and made attempts to recruit staff.

A review of the registered staffing schedule for the home from August 01 to October 31 2015, was conducted to determine if the lack of RN coverage had actually started in November 2015, as indicated by the ADOC. The following dates and shifts were found to have no RN present in the home and confirmed that the home did not have a RN in the building at all times prior to November 2015 as follows:

-August 2015: 5, 8, 9, 14, 20, 22, 23, 28, 2015, evening shifts.

-September 2015: 2, evening, 5, 6, day and evening, 9, 11, 12, 15, 18, evening, 19, 20 day and evening, 25, 28 evening.

-October 2015: 3, 4, day and evening, 8, 10, 17, 18, 19, 20, 21, 23, 30, 31, evening.

A subsequent interview with the ADOC confirmed that the home has been short RNs well before the initially stated time line of November 2015. The ADOC indicated that because it had been difficult to obtain and hire RNs for the home, a decision had been made to hire an extra RPN for the evening shifts and to have both him/herself and the Director of Care (DOC) alternate on call by telephone while there is no RN in the building.

The licensee is required to have at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times, except in the case of an emergency, whereby a registered practical nurse (RPN) who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone. At Bob Rumball Home, the utilization of an RPN in conjunction with either the DOC or the ADOC being available by telephone, on the above mentioned dates and shifts between August 01, 2015 to March 31, 2016, is lengthy not indicative of an emergency. Interviews with the ADOC revealed that the home has attempted to recruit RN'S, with minimal success.

The severity of the non-compliance and the severity of the harm and risk of further harm is potential.

The scope of the non-compliance is widespread.

A review of the compliance history revealed that there has been no previous non-compliance related to the Long-Term Care Homes Act, O.Reg. 79/10.,s. 45 (1).
(202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

1) Within one week of receiving this order, provide a plan to the inspector, identifying when all staff will receive education on abuse and neglect of residents. The education shall include staff recognition of all forms of abuse defined under the legislation, and the immediate reporting of such.

2) The plan shall also include education of all staff on the home's Zero Tolerance Of Abuse and Neglect policy.

3) The person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to shihana.rumzi@ontario.ca within one week of receipt of the order.

Grounds / Motifs :

1. The licensee has failed to ensure that the residents were protected from neglect by the licensee or staff in the home.

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

Review of the CIS report submitted by the home on an identified date, identified resident #014 was found in a soiled incontinent brief on an identified date.

Record review of the Point of Care (POC) revealed the resident's last incontinent brief change was on the evening shift on an identified date. The resident was then checked as follows: five hours later, eight hours later, and three and a half

hours later, the resident remained dry. The resident was next checked approximately eight hours later on the evening shift of the next day and was found to be incontinent of urine.

An interview with PSW #126, confirmed the resident was checked during the eight hour period but had forgot to document this in PCC and confirmed the resident had not voided on the day shift and this is why the resident's incontinent brief was not changed.

An interview with the Resident Care Manager (RCM) identified it is the home's practice to at least change a resident's incontinent brief at a minimum once per shift for sanitary reasons even if not incontinent.

An interview with the ADOC and DOC confirmed resident #014 was neglected and the resident was not cared for in a 24hr period. [s. 19. (1)] (557)

Review of the CIS report submitted on an identified date, identified resident #011, was found in a soiled incontinent brief on an identified date.

Record review of resident #011's plan of care revealed documentation in PCC by RN #110 indicating resident was found on an identified date, to be unclean at the beginning of the day shift.

An interview with PSW #119 confirmed when he/she did their rounds two days later, that he/she found resident #011in a soiled incontinence brief.

An interview with the DOC confirmed that PSW #127 left resident #011 in an unclean manner and neglected to provide care for resident #011. [s. 19. (1)] (557)

Review of CIS report submitted by the home on an identified date, identified resident #012 being found at risk of choking in an identified location of the home.

Record review of resident #012's plan of care revealed there was no documentation in resident #012's progress notes.

Interviews with PSW #119 and #128 confirmed when they conducted rounds on an identified date; they observed resident #012 to be at risk for choking in an identified location of the home.

An interview with the DOC confirmed that PSW #127 left resident #012 at risk for choking in an identified location of the home and neglected to ensure resident #012 was safe. [s. 19. (1)] (557)

Review of the CIS report submitted by the home on an identified date, identified resident #015 had asked PSW #133 for something to eat and PSW failed to provide the resident with food.

Staff interview with PSW #128, revealed on an identified shift and date he/she arrived early for his/her shift. The PSW indicated they observed resident #015 sitting in an identified area of the home and overheard him/her stating they were hungry and requested something to eat. PSW #128 revealed they heard PSW #133 refer to resident as fat and did not proceed to offer resident #015 something to eat.

Interview with PSW #134, who also arrived early for his/her shift, revealed he/she heard resident #015 screaming for food and PSW #133 stating resident #015 had been eating on an identified shift. PSW #134 confirmed PSW #133 did not provide resident #015 with something to eat prior to leaving at the end of his/her shift. PSW #134 revealed that he/she went into the servery and provided resident #015 with something to eat and drink.

An interview with PSW #133 revealed he/she replied to resident #015, "it is close to breakfast time can you wait". PSW #133 confirmed they did not offer resident #015 something to eat but had fed resident #015 more than once throughout the shift and it was time for the PSW to go.

An interview with the ADOC confirmed their investigation of the incident resulted in disciplinary action of staff PSW #133 related to neglect. [s. 19. (1)] (110)

Review of the CIS report submitted by the home on an identified date, identified an allegation of neglect whereby resident #017 asked PSW #124 for his/her personal resident equipment and the PSW walked away without providing the requested equipment to the resident.

Record review of resident #017's Point Click Care (PCC) documentation revealed on an identified date, resident #017 spoke with RN #123 and disclosed that PSW #124 walked away when he/she requested personal resident

equipment.

An interview conducted with RN #123 identified resident #017 was at high risk for incidents and the personal resident equipment was not provided during an identified shift to accommodate resident needs. The RN indicated he/she gave the resident the personal resident equipment and provided care as needed. The RN stated they reported the incident to the DOC and ADOC in writing the next morning.

Interview with PSW #124 identified resident #017 used identified personal resident equipment during an identified shift, as the resident was at high risk for incidents when attempting to ambulate. PSW indicated the home suspended him/her for neglecting to provide resident #017 with the personal resident equipment when requested.

Interview conducted with the ADOC indicated the resident confirmed to the home that PSW #124 didn't provide him/her with the personal resident equipment when requested and walked out of an identified location of the home. ADOC stated PSW #124 neglected resident #017's request. The resident was not protected from neglect by the home's staff. [s. 19. (1)] (604)

Review of CIS report submitted by the home on an identified date, identified resident #010 was on the toilet for an extended period of time.

Record review of resident #010's plan of care revealed documentation in the progress notes by RPN #100 supporting that the resident was found on the toilet for an extended period of time.

Review of the rooms activity report confirmed a staff member was in the identified location at an identified time, and the next time a staff member went to the identified area was111 minutes later.

An interview with PSW #103 confirmed he/she did leave the resident on the toilet but it was an accident. The PSW further indicated that RPN #111 and he/she had toileted the resident and when they removed resident #010 from the toilet the resident indicated he/she was not ready to leave the area and was assisted back on the toilet.

An interview with the ADOC and DOC confirmed the resident had been

neglected as resident #010 was left on the toilet for an extended period of time. [s. 19. (1)] (557)

The licensee has failed to ensure that the long-term care home shall protect residents from abuse by anyone.

"Physical abuse" means, (a) the use of physical force by anyone other than a resident that causes physical injury or pain. O. Reg. 79/10, s. 2. (1) (a)

Review of the CIS report submitted by the home on an identified date involving resident #016 who informed RPN #132 that PSW #134 provided inappropriate care on an identified shift when resident requested PSW to assist with identified ADL's. The resident revealed the PSW was not gentle when he/she assisted with requested ADL's by the resident and caused resident discomfort.

PCC documentation review for resident #016 on an identified date, indicated an identified shift, PSW#134 provided inappropriate care to resident by not being gentle when proving ADL's to the resident causing the resident discomfort.

An interview conducted with resident #016's SDM indicated resident #016 called them to report an incident which occurred a couple of days ago on an identified shift. The SDM informed the inspector resident stated a PSW on an identified shift provided inappropriate care by handling him/her inappropriately causing the resident discomfort. The SDM indicated they called the home and reported the incident immediately to RPN #132.

An interview conducted with RPN #132 confirmed resident #016's SMD informed the licensee of the allegation involving inappropriate care. The RPN indicated he/she spoke with the resident who stated on an identified shift confirmed the above incident with PSW #134 which had occurred couple of days ago. The RPN indicated during his/her conversation with resident #016, the resident appeared to be afraid and was emotional about the incident. RPN indicated the incident was abuse and no resident should be treated in that manner.

An interview with the home's DOC confirmed the above incident occurred and staff was abusive to resident #016 in providing inappropriate care. DOC indicated PSW #134 was terminated and no longer works in the home. [S. 19. (1)] (604)

Every licensee of a long-term care home shall protect residents from abuse by the licensee or staff.

"Verbal abuse" means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

The licensee has failed to ensure that the residents were protected from abuse by the licensee or
staff in the home.

On an identified date, the home submitted an abuse/neglect CIS report involving resident #005.

Record review of resident #005's progress notes revealed documentation by RN #131 prior to the identified incident with resident #005. Resident #005 had been complaining of health concerns. The RN indicated that the resident did not appear to be in distress and the RN directed the resident to return to an identified location of the home. The RN went to conduct a thorough assessment within an identified duration of time. Resident #005 accused the RN of arguing and yelling at him/her. The RN left the situation and called the ADOC for support. When RN #131 and the ADOC arrived to resident #005's identified location and the arguing started once again. The RN was waving her finger and yelling at the resident calling him/her a liar.

An interview with RN #131 confirmed that he/she did argue with the resident and make a gesture with his/her finger in the air. He/she denied yelling but was talking fast in a raised voice.

An interview with resident #005 and the ADOC confirmed the above incident did occur as indicated in the resident's progress notes.

An interview with the ADOC and DOC confirmed that staff in the home verbally and emotionally abused resident #005. [S. 19. (1)] (557)

The home is being served an order as the inspectors conducted ten CIS report inspections which were submitted with in an identified period of time. The

inspector found nine incidents where the home did not protect resident's from abuse/neglect from the staff.

The severity of the non-compliance and the severity of harm and risk are potential for actual harm/risk.

The scope of the non-compliance is widespread.

A review of the compliance history revealed no previous non-compliance related to the Long-Term Care Homes Act, Or.Reg c. 8, s. 19 (1).
(604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

1) Within one week of receiving this order, provide a plan to the inspector, identifying when all staff who is able to complete and submit a Critical Incident System (CIS) report will receive education. The education shall include the time lines of reporting incidents to the Director under the legislation, and the immediate reporting of such incidents of alleged abuse/neglect.

2) The person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to shihana.rumzi@ontario.ca within one week of receipt of the order.

Grounds / Motifs :

1. The licensee shall ensure that 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: neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Review of the CIS report submitted by the home on an identified date involving resident #014 who was found in a soiled incontinent brief on an identified date and an identified duration of time.

The home initiated the CIS report on an identified date; this report was submitted to the Director three days later.

An interview with the DOC confirmed he/she did initiate the CIS but neglected to call the Ministry's after-hours line to inform the Director immediately upon becoming aware of the incident of alleged neglect in not providing care to resident #014. [s. 24. (1)] (557)

Review of the CIS report submitted by the home on an identified date involving resident #013 related to neglect.

The home initiated the CIS report on an identified date; this report was submitted to the Director one day later.

An interview with the ADOC confirmed he/she did initiate the CIS report but neglected to call the Ministry's after-hours line to inform the Director immediately upon becoming aware of the incident of alleged neglect in not providing care to resident #013. [s. 24. (1)] (557)

Review of the CIS report submitted by the home on an identified date involving resident #012 related to neglect.

The CIS report was submitted to the Director one day late.

An interview with the ADOC confirmed he/she did initiate the CIS report but neglected to call the Ministry's after-hours line to inform the Director immediately upon becoming aware of the incident of alleged neglect to provide care to resident #012. [s. 24. (1)] (557)

Review of the CIS report submitted by the home on an identified date involving resident #011. The CIS report indicated resident #011 was found in a soiled incontinent brief on an identified date and an identified duration of time.

The CIS report was submitted to the Director one day later.

An interview with the ADOC confirmed he/she did initiate the CIS report but neglected to call the Ministry's after-hours line to inform the Director immediately upon becoming aware of the incident of alleged neglect to provide care for

resident #011. [s. 24. (1)] (557)

Review of the CIS report submitted by the home on an identified date which involving resident #015. The CIS report identified staff neglected to provided resident with a request for a meal.

The CIS report was submitted to the Director one day later.

An interview with the ADOC confirmed he/she did initiate the CIS report but misunderstood the time line for reporting to the Director, thinking he/she had 10 days to submit the CIS involving an allegation of neglect involving resident #015. [s. 24. (1)] (110)

Review of the CIS report alleging abuse towards resident #005 was submitted by the home to the MOH on an identified date .

The CIS report was submitted to the Director three days later.

An interview with the ADOC confirmed he/she did initiate the CIS report but neglected to call the Ministry's after-hours line to inform the Director immediately upon becoming aware of the incident alleged verbal and emotional abuse by a staff member. [s. 24. (1)] (557)

The home is being served an order as the inspectors conducted ten CIS report inspections, which were submitted during a period of time. The inspectors found six mandatory abuse/neglect CIS reports to be submitted late to the Director.

Legislation s. 24. (1) directs 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: neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, legislation was not followed.

The home historically has an ongoing non-compliance with legislation s.24. (1), the ongoing non-compliance is as follows:
1)Resident Quality Inspection conducted October 7, 2014 – VPC was issued
2)Resident Quality Inspection conducted April 24, 2015 – VPC was issued

The severity of the non-compliance and the severity of harm and risk is minimal.

The scope of the non-compliance is a pattern.
(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

2. A description of the individuals involved in the incident, including,

i. names of all residents involved in the incident,

ii. names of any staff members or other persons who were present at or discovered the incident, and

iii. names of staff members who responded or are responding to the incident.

3. Actions taken in response to the incident, including,

i. what care was given or action taken as a result of the incident, and by whom,

ii. whether a physician or registered nurse in the extended class was contacted,

iii. what other authorities were contacted about the incident, if any,

iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and

v. the outcome or current status of the individual or individuals who were involved in the incident.

4. Analysis and follow-up action, including,

i. the immediate actions that have been taken to prevent recurrence, and

ii. the long-term actions planned to correct the situation and prevent recurrence.

5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Order / Ordre :

1) Within one week of receiving this order, provide a plan to the inspector, identifying when all staff who are able to complete and submit a CIS are aware of the required information needed under the requirements of the legislation.

2) The person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to shihana.rumzi@ontario.ca within one week of receipt of the order.

Grounds / Motifs :

1. The licensee has failed to ensure in making a report to the Director under subsection 23 (2) of the Act, the licensee will include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: a description of the individuals involved in the incident, including, names of any staff members or other persons who were present at or discovered the incident.

On an identified date the home submitted a CIS report which was initiated for resident #014 after being found in a soiled incontinent brief on an identified date and identified period of time where resident care was not provided.

The CIS report submitted by the home did not contain the name of the PSW involved in the incident.

Interviews conducted with the ADOC and DOC confirmed that the CIS report did not identify PSW #126's name and was not reported to the Director as required by legislation. [s. 104. (1) 2.] (557)

On an identified date the home submitted a CIS report which was initiated for resident #013 after being found in a soiled incontinent brief on an identified date.

The CIS report submitted by the home did not contain the name of the PSW involved in the incident.

An interview conducted with the ADOC confirmed that the CIS report did not identify PSW #127's name and was not reported to the Director as required by legislation. [s. 104. (1) 2.] (557)

On an identified date the home submitted a CIS report which was initiated for

resident #012 after being found at high risk for choking.

The CIS report submitted by the home did not contain the name of the PSW involved in the incident.

An interview conducted with the ADOC confirmed that the CIS report did not identify PSW #127's name and was not reported to the Director as required by legislation. [s. 104. (1) 2.] (557)

On an identified date the home submitted a CIS report which was initiated for resident #011 after being found in a soiled incontinent brief on an identified date and identified period of time where resident care was not provided.

The CIS did not contain the PSW's name who was involved in the incident.

An interview conducted with the ADOC confirmed that the CIS report did not identify PSW #127's name and was not reported to the Director as required by legislation. [s. 104. (1) 2.] (557)

On an identified date the home submitted a CIS which was initiated for resident #005 after being abused by a staff member.

The CIS report submitted by the home did not contain the name of the RN who was involved in the incident.

An interview conducted with the ADOC confirmed that the CIS report did not identify RN #131's name and was not reported to the Director as required by legislation. [s. 104. (1) 2.] (557)

On an identified date the home submitted a CIS report which was initiated for four identified residents #019, #020, #021 and #022.

Record review of the home's investigation notes revealed there were four additional residents who were not identified within the submitted CIS report. The following residents were not identified in the CIS report: resident #019, #020, #021 and #022.

Interviews with the ADOC and DOC failed to explain the reason why the above identified residents were not added to the CIS report, and confirmed the four

identified residents involved in the incident where not reported to the Director. [s. 104. (1) 2.] (557)

The home is being served an order as the inspectors conducted ten CIS report inspections which were submitted with in an identified period of time. The inspectors found six mandatory abuse/neglect CIS reports to be submitted with no names of residents and staff members or other persons who were present or discovered the incident.

The severity of the non-compliance and the severity of harm and risk is minimal.

The scope of the non-compliance is widespread.

A review of the compliance history revealed that there have been no previous non-compliances related to the Long-Term Care Homes Act O.Reg. 79/10., r. 104. (1)
(557)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Order / Ordre :

1) Within one week of receiving this order, provide a plan to the inspector, identifying when all staff will receive education on reporting incidents such as any alleged, suspected, or witnessed incidents of neglect to SDM under the requirements of the legislation.

2) The person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to shihana.rumzi@ontario.ca within one week of receipt of the order.

Grounds / Motifs :

1. The licensee shall ensure that the resident's SDM and any other person specified by the resident shall be notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of neglect of the resident.

The home submitted an abuse/neglect CIS report on an identified date. The CIS report indicated resident #017 requested a specific personal resident equipment from PSW #124 who walked away and did not provide the equipment to the resident.

Review of home's CIS report indicated SDM was not contacted related to the incident of alleged abuse/neglect.

A review of the home's amended CIS submitted 10 days later on an identified date, indicated SDM was contacted and SDM was appreciative of the call.

Record review was conducted on resident #017's PCC documentation for an identified period of time failed to identify any documentation that the SDM was contacted related to the alleged abuse/neglect.

An interview with the ADOC revealed SDM should be called for any alleged abuse/neglect issue in the home. ADOC confirmed the SDM was not called and was unable to provide an explanation as to the reason the SDM was not contacted about the allegation. [s. 97. (1) (b)] (604)

On an identified date, the home submitted an abuse/neglect CIS report involving resident #011 after being found in a soiled incontinent brief on an identified date and duration of time.

An interview with resident #011's SDM revealed that he/she was not notified of the incident on an identified date. He/she stated the home calls them about medication changes, changes in condition but did not recall being informed about resident #011 being found in an uncleanly manner for the identified period of time.

An interview with the ADOC and DOC confirmed they had no evidence to confirm that the home notified the SDM about this incident. [s. 97. (1) (b)] (557)

On an identified date, the home submitted an abuse/neglect CIS report involving resident #015. The CIS report indicated PSW #128 overheard resident #015 requesting food to eat and PSW #133 and refused to give the resident something to eat.

Review of home's CIS report indicated the SDM was not contacted related to the incident of alleged abuse/neglect.

An interview with the ADOC confirmed the SDM was not contacted and should have been called for the alleged abuse/neglect issue identified in the home. [s.

97. (1) (b)] (110)

The licensee failed to 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.

On an identified date, the home submitted a CIS which was initiated for resident #014 after being found in a soiled incontinent brief on an identified date and an identified duration of time.

An interview conducted with resident #014's SDM confirmed that he/she was not notified of the results of the investigation upon completion.

An interview with the ADOC and DOC confirmed the home was unable to provide evidence the SDM was notified upon the completion of the home's investigation. [s. 97. (2)] (557)

On an identified date, the home submitted a CIS report which was initiated for resident #011 after being found with an a state of uncleanliness on an identified date and duration of time.

An interview with resident #011's SDM confirmed that he/she was not notified of the results of the investigation upon completion.

An interview with the ADOC and DOC confirmed home was unable to provide evidence the SDM was notified upon the completion of the home's investigation. [s. 97. (2)] (557)

On an identified date, the home submitted a CIS report which was initiated for resident #010 after being found on the toilet for an extended period of time.

An interview with resident #011's SDM confirmed that he/she was not notified of the results of the investigation upon completion.

An interview with the ADOC and DOC confirmed home the was unable to provide evidence the SDM was notified upon the completion of the home's investigation. [s. 97. (2)] (557)

On an identified date, the home submitted a CIS report which was initiated for resident #005 after being verbally and emotionally abused by a staff member.

An interview with resident #005's SDM confirmed that he/she was not notified of the results of the investigation upon completion.

An interview with the ADOC and DOC could not confirm that the home notified the SDM upon the completion of the home's investigation. [s. 97. (2)] (557)

The home is being served an order as the inspectors conducted ten CIS report inspects which were submitted with in an identified period of time. The inspectors found six mandatory abuse/neglect CIS reports to be submitted late to the Director.

The severity of the non-compliance and the severity of harm and risk is minimal.

The scope of the non-compliance is a pattern.

A review of the compliance history revealed that there have been no previous non-compliances related to the Long-Term Care Homes Act O.Reg. 79/10., r. 97.(1).

(604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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
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 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 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 27th day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shihana Rumzi

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