Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 24, 2017	2017_491647_0006	002834-17	Follow up

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

JENNIFER BROWN (647), JOVAIRIA AWAN (648)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 3, 4, 5, 6, 7, 10, 11, 12, 2017

The following intake related to previously issued compliance orders during inspection 2016_268604_0011 was inspected:
005084-16

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental and Nutrition Services Manager, Environmental Coordinator, Registered Nurses (RN), Registered Practical Nurses
(RPN), Personal Support Workers (PSW), Housekeeping Aides, Physician Assistant, Residents, Family Members, Substitute Decision Makers, and former employees.

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

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **2 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. 104. (1)	CO #004	2016_268604_0011	647
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2016_268604_0011	648
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #003	2016_268604_0011	647
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2016_268604_0011	647
O.Reg 79/10 s. 97. (1)	CO #005	2016_268604_0011	647

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 had failed to ensure at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff was on duty and present in the home at all times.

This follow up inspection had been initiated related to a previously issued order under LTCHA, 2007, c.8.s.8(3), issued to the home, on June 27, 2016, within report #2016_268604_0011. The home was ordered to be in compliance with the above mentioned legislation by September 30, 2016.

A review of the home's staffing schedule from a specific period of seven months, indicated that there had been no Registered Nurse (RN) in the building on 40 occasions.

An interview with the Director of Care (DOC) confirmed that there had been no RN in the home on the above mentioned occasions. The DOC indicated that himself/herself and the ADOC alternated to be available by phone when an RN is not available to be 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 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, the utilization of an RPN in conjunction with either the DOC or the ADOC being available by telephone on the above mentioned dates in the seven month period, is lengthy and frequent and is not indicative of 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 had been a previously issued compliance order from inspection 2016_268604_0011 to the licensee. [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 failed to ensure residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The home submitted a Critical Incident Report (CIS) report on an identified date, identifying an allegation of abuse by direct care staff member #117 towards resident #002. The report identified the direct care staff member #117 had been found in an identified area during an identified shift, at which time resident #002 was found on the floor during shift change.

Review of resident #002's clinical records indicated resident #002 had activated the call bell at an identified time. At an identified shift change, the resident was found on the floor. The progress notes indicated the resident's call bell had remained unanswered for approximately one hour and thirty minutes.

Review of resident #002's current written plan of care, identified staff were directed to complete thirty minute checks throughout an identified shift. The written plan of care also identified that resident #002 was at risk of falls. Review of resident #002's flow sheet for an identified month indicated that routine thirty minute checks for the resident were not documented over the course of the above mentioned shift.

Interview with the alleged, direct care staff member #117 could not be conducted as the staff member could not be reached by the information provided by the home.

Review of direct care staff member #117's tracking records of his/her GPS badge report that he/she had entered resident #002's room for an identified duration of time. The direct care staff member #117 did not re-enter room for remainder of shift. The badge report further identified the direct care staff member #117 entered an identified room for an identified extended amount of time.

During a staff interview, direct care staff member #112 stated he/she found direct care staff member #117 asleep in an identified room and notified the Registered staff member at the beginning of the identified shift while completing resident room rounds. The direct care staff member #112 reported he/she found resident #002 in his/her room on the floor at change of shift. Direct care staff member #112 identified resident #002 had not been provided care for thirty minute routine checks had not been completed.

Interview with Registered staff member #103 reported he/she found direct care staff member #117 in an identified room at the beginning of an identified shift upon being notified by direct care staff member #112. Registered staff member #103 revealed he/she found resident #002 on the floor in his/her room on the floor due to lack of monitoring as indicated in the written plan of care. Registered staff member #103 identified that resident #002 had not been provided care.

Interview with Registered staff #114, revealed registered staff were to check with direct care staff throughout the shift, after rounds, and obtain report from them prior to shift change. Registered staff member #114 stated he/she had checked on direct care staff member #117 once during the shift at an identified time prior to break. Registered staff member #114 revealed he/she was unaware of direct care staff member #117's whereabouts for the remainder of that shift and did not see the direct care staff member #117 to obtain report before end of shift.

Review of direct care staff member #117 staff records identified he/she had been previously disciplined with suspension for abuse towards residents. Direct care staff member #117 was terminated, by the home following the above mentioned incident.

Interview with homes DOC identified that registered staff were expected to check in with direct care staff members throughout the shift. The DOC confirmed that resident #002 had not been provided care for by direct care staff member #117 as routine checks were not performed as directed in the written plan of care and he/she was found on the floor in his/her room after ringing the call bell for assistance. [s. 19. (1)]

2. The home submitted a CIS report on an identified date, identifying an allegation of abuse by direct care staff member #117 towards resident #003. The report identified direct care staff member had not been available during an identified shift, and was not able to provide care to resident #003 who was found in an identified manner.

Review of resident #003's clinical records, indicated he/she was found by an identified shift of staff in an identified manner.

Review of resident #003's current written plan of care, identified that he/she required staff assistance for transferring. The written plan of care directed staff to complete hourly checks while resident #003 was in bed. The written plan of care further indicated that staff were to ensure resident #003 was safe and comfortable.

Review of resident #003's flow sheet in point of care (POC) for an identified date, indicated that direct care staff member #117 had documented for routine checks on the identified shift every hour to ensure resident #003 was in bed.

Interview with the alleged, direct care staff member #117 could not be conducted as the staff member could not be reached at the information provided by the home.

Review of direct care staff member #117's tracking records of his/her GPS badge report for an identified date, indicated that he/she had entered resident #003's room for an identified period of time. Direct care staff member #117 did not re-enter resident #003's room for remainder of the shift. The badge report further identified direct care staff member #117 entered an identified room for an identified extended amount of time.

Interview with the Assistant Director of Care (ADOC) clarified that direct care staff member #117 was not in resident #003's room after an identified time frame, and confirmed the documented care in the POC flow sheet was inaccurate and had not been provided to resident #003.

During the staff interview, direct care staff member #112 stated he/she found the above mentioned direct care staff member #117 in an identified room and notified the Registered staff member at the beginning of the shift while completing resident room rounds. Direct care staff member #112 reported he/she found resident #003 in an identified position at the beginning of the shift. Direct care staff member #112 identified resident #003 had not been provided care as routine checks had not been completed by direct care staff member #117.

Interview with Registered staff member #103 reported he/she found direct care staff member #117 asleep in an identified room at the beginning of the shift upon being notified by direct care staff member #112. Registered staff member #103 revealed he/she found resident #003 in the early part of the shift in an identified position. Registered staff member #103 identified resident #003 had been at risk as the resident was not monitored while in bed, and had not been provided care by direct care staff member #117.

Interview with an identified Registered staff member #114, revealed registered staff were to check with direct care staff throughout the shift, after rounds, and obtain report from them prior to shift change. Registered staff member #114 stated he/she had checked on direct care staff member #117 once during the shift and prior to break. Registered staff member #114 revealed he/she was unaware of direct care staff member #117's whereabouts for the remainder of that shift and did not see the direct care staff member #117 to obtain report before end of shift.

Interview with the DOC identified that registered staff were expected to check on the direct care staff member throughout the shift. The DOC confirmed that resident #003 had not been provided care as routine checks were not performed as directed by direct care staff member #117.

Review of direct care staff member #117's staff records identified he/she had been previously disciplined with suspension for abuse towards residents. Direct care staff member #117 was terminated, by the home for the above mentioned incident. [s. 19. (1)]

3. The home submitted a CIS on an identified date, identifying an allegation of abuse by direct care staff member #117 towards resident #004. The report identified direct care staff member #117 had been found in an identified area during an identified shift, and had not provided care to resident #004.

Review of resident #004's current written plan of care, required staff to check for resident every hour on rounds.

Review of resident #004's clinical records, indicated she/he was found by staff to not have an identified care completed. Review of the hourly check flow sheet for resident #004 for an identified period of time, did not identify documented checks for the entire shift. Additional clinical records reviewed on an identified date, had documented resident

#004 had altered skin integrity.

Interview with the alleged, direct care staff member #117 could not be conducted as the staff member could not be reached at the contact coordinates provided by the home.

Review of direct care staff member #117 tracking records of his/her GPS badge report for an identified date, indicated he/she had entered resident #004's room for an identified period of time and did not re-enter resident #004's room for remainder of the shift. The badge report further identified direct care staff member #117 entered an identified room for an identified extended amount of time.

During the staff interview, direct care staff member #112 stated he/she found direct care staff member #117 in an identified room and notified the Registered staff member at the beginning of the shift while completing resident room rounds.

Interview with Registered staff member #103 reported he/she found direct care staff member #117 in an identified room at the beginning of the shift upon being notified by direct care staff member #112. Registered staff member #103 revealed he/she found resident #004 in the early part of the shift without having care completed. Registered staff member #103 identified resident #004 had not been provided care by direct care staff member #117.

Interview with the Registered staff member #114, revealed registered staff were to check with PSW staff throughout the shift, after rounds, and obtain report from them prior to shift change. Registered staff member #114 stated he/she had checked on direct care staff member #117 once during the shift and prior to break. Registered staff member #114 revealed he/she was unaware of the direct care staff member #117's whereabouts for the remainder of that shift and did not see direct care staff member #117 to obtain report before end of shift.

Interview with homes DOC identified that registered staff were expected to check on direct care staff throughout the shift. The DOC confirmed that resident resident #004 had not been provided care as routine checks were not performed as directed by direct care staff member #117.

Review of direct care staff member #117 staff records identified he/she had been previously disciplined with suspension for abuse towards residents. Direct care staff member #117 was terminated by the home for the above mentioned incident.

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

The scope of the non-compliance is isolated.

A review of the compliance history revealed that there had been a previously issued order under LTCHA, 2007, c.8, s.19 (1), issued to the home, on June 27, 2016, within report # 2016_268604_0011. The home was ordered to be in compliance with the above mentioned legislation by September 30, 2016. [s. 19. (1)]

Additional Required Actions:

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

Issued on this 24th day of May, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BROWN (647), JOVAIRIA AWAN (648)
Inspection No. / No de l'inspection :	2017_491647_0006
Log No. / Registre no:	002834-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 24, 2017
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

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:

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 : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 :

Upon receipt of this order the licensee shall:

Prepare, submit and implement a plan 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.

The plan must include the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to jennifer.brown6@ontario.ca by June 9, 2017, and implemented by July 31, 2017.

Grounds / Motifs :

1. The licensee had failed to ensure at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present in the home at all times.

This follow up inspection had been initiated related to a previously issued order under LTCHA, 2007, c.8.s.8(3), issued to the home, on June 27, 2016, within report #2016_268604_0011. The home was ordered to be in compliance with the above mentioned legislation by September 30, 2016.

A review of the home's staffing schedule from a period of seven months, indicated that there had been no Registered Nurse (RN) in the building on 40 occasions.

An interview with the Director of Care (DOC) confirmed that there had been no RN in the home on the above mentioned dates. The DOC indicated that himself/herself and the ADOC alternated to be available by phone when an RN is not available to be 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 registered practical nurse (RPN) who is a member of the regular nursing staff may be used if the Director of 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, 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 during a period of seven months, is lengthy and not indicative of 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 had been a previously issued compliance order from inspection 2016_268604_0011 to the licensee. (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 :

Upon receipt of this order the licensee shall,

Develop and submit a plan that includes the following requirements and the person responsible for completing the tasks.

Provide re-education and training to all staff in the home on the home's policy to promote zero tolerance of abuse and neglect of residents.

The policy review and training shall include all definitions of abuse, and not be limited to neglect, as identified within the home's abuse policy and within the Long-Term Care Homes Act, 2007, Ontario Regulations 79/10.

The plan is to be submitted to jovairia.awan@ontario.ca by , June 9, 2017 and implemented by July 31, 2017.

Grounds / Motifs :

1. 3. The home submitted a CIS on an identified date, identifying an allegation of abuse by direct care staff member #117 towards resident #004. The report identified direct care staff member #117 had been found in an identified area during an identified shift, and had not provided care to resident #004.

Review of resident #004's current written plan of care, required staff to check for resident every hour on rounds.

Review of resident #004's clinical records, indicated she/he was found by staff to not have an identified care completed. Review of the hourly check flow sheet for resident #004 for an identified period of time, did not identify documented checks

for the entire shift. Additional clinical records reviewed on an identified date, had documented resident #004 had altered skin integrity.

Interview with the alleged, direct care staff member #117 could not be conducted as the staff member could not be reached at the contact coordinates provided by the home.

Review of direct care staff member #117 tracking records of his/her GPS badge report for an identified date, indicated he/she had entered resident #004's room for an identified period of time and did not re-enter resident #004's room for remainder of the shift. The badge report further identified direct care staff member #117 entered an identified room for an identified extended amount of time.

During the staff interview, direct care staff member #112 stated he/she found direct care staff member #117 in an identified room and notified the Registered staff member at the beginning of the shift while completing resident room rounds.

Interview with Registered staff member #103 reported he/she found direct care staff member #117 in an identified room at the beginning of the shift upon being notified by direct care staff member #112. Registered staff member #103 revealed he/she found resident #004 in the early part of the shift without having care completed. Registered staff member #103 identified resident #004 had not been provided care by direct care staff member #117.

Interview with the Registered staff member #114, revealed registered staff were to check with PSW staff throughout the shift, after rounds, and obtain report from them prior to shift change. Registered staff member #114 stated he/she had checked on direct care staff member #117 once during the shift and prior to break. Registered staff member #114 revealed he/she was unaware of the direct care staff member #117's whereabouts for the remainder of that shift and did not see direct care staff member #117 to obtain report before end of shift.

Interview with homes DOC identified that registered staff were expected to check on direct care staff throughout the shift. The DOC confirmed that resident resident #004 had not been provided care as routine checks were not performed as directed by direct care staff member #117.

Review of direct care staff member #117 staff records identified he/she had been previously disciplined with suspension for abuse towards residents. Direct care staff member #117 was terminated by the home for the above mentioned incident.

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

The scope of the non-compliance is isolated.

A review of the compliance history revealed that there had been a previously issued order under LTCHA, 2007, c.8, s.19 (1), issued to the home, on June 27, 2016, within report # 2016_268604_0011. The home was ordered to be in compliance with the above mentioned legislation by September 30, 2016. [s. 19. (1)] (648)

2. 2. The home submitted a CIS report on an identified date, identifying an allegation of abuse by direct care staff member #117 towards resident #003. The report identified direct care staff member had not been available during an identified shift, and was not able to provide care to resident #003 who was found in an identified manner.

Review of resident #003's clinical records, indicated he/she was found by an identified shift of staff in an identified manner.

Review of resident #003's current written plan of care, identified that he/she required staff assistance for transferring. The written plan of care directed staff to complete hourly checks while resident #003 was in bed. The written plan of care further indicated that staff were to ensure resident #003 was safe and comfortable.

Review of resident #003's flow sheet in point of care (POC) for an identified date, indicated that direct care staff member #117 had documented for routine checks on the identified shift every hour to ensure resident #003 was in bed.

Interview with the alleged, direct care staff member #117 could not be conducted as the staff member could not be reached at the information provided by the home.

Review of direct care staff member #117's tracking records of his/her GPS badge report for an identified date, indicated that he/she had entered resident #003's room for an identified period of time. Direct care staff member #117 did not re-enter resident #003's room for remainder of the shift. The badge report further identified direct care staff member #117 entered an identified room for an identified extended amount of time.

Interview with the Assistant Director of Care (ADOC) clarified that direct care staff member #117 was not in resident #003's room after an identified time frame, and confirmed the documented care in the POC flow sheet was inaccurate and had not been provided to resident #003.

During the staff interview, direct care staff member #112 stated he/she found the above mentioned direct care staff member #117 in an identified room and notified the Registered staff member at the beginning of the shift while completing resident room rounds. Direct care staff member #112 reported he/she found resident #003 in an identified position at the beginning of the shift. Direct care staff member #112 identified resident #003 had not been provided care as routine checks had not been completed by direct care staff member #117.

Interview with Registered staff member #103 reported he/she found direct care staff member #117 asleep in an identified room at the beginning of the shift upon being notified by direct care staff member #112. Registered staff member #103 revealed he/she found resident #003 in the early part of the shift in an identified position. Registered staff member #103 identified resident #003 had been at risk as the resident was not monitored while in bed, and had not been provided care by direct care staff member #117.

Interview with an identified Registered staff member #114, revealed registered staff were to check with direct care staff throughout the shift, after rounds, and obtain report from them prior to shift change. Registered staff member #114 stated he/she had checked on direct care staff member #117 once during the shift and prior to break. Registered staff member #114 revealed he/she was unaware of direct care staff member #117's whereabouts for the remainder of that shift and did not see the direct care staff member #117 to obtain report before end of shift.

Interview with the DOC identified that registered staff were expected to check on

the direct care staff member throughout the shift. The DOC confirmed that resident #003 had not been provided care as routine checks were not performed as directed by direct care staff member #117.

Review of direct care staff member #117's staff records identified he/she had been previously disciplined with suspension for abuse towards residents. Direct care staff member #117 was terminated, by the home for the above mentioned incident. [s. 19. (1)] (648)

3. 1. The licensee failed to ensure residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The home submitted a Critical Incident Report (CIS) report on an identified date, identifying an allegation of abuse by direct care staff member #117 towards resident #002. The report identified the direct care staff member #117 had been found in an identified area during an identified shift, at which time resident #002 was found on the floor during shift change.

Review of resident #002's clinical records indicated resident #002 had activated the call bell at an identified time. At an identified shift change, the resident was found on the floor. The progress notes indicated the resident's call bell had remained unanswered for approximately one hour and thirty minutes.

Review of resident #002's current written plan of care, identified staff were directed to complete thirty minute checks throughout an identified shift. The written plan of care also identified that resident #002 was at risk of falls. Review of resident #002's flow sheet for an identified month indicated that routine thirty minute checks for the resident were not documented over the course of the above mentioned shift.

Interview with the alleged, direct care staff member #117 could not be conducted as the staff member could not be reached by the information provided by the home.

Review of direct care staff member #117's tracking records of his/her GPS badge report that he/she had entered resident #002's room for an identified duration of time. The direct care staff member #117 did not re-enter room for remainder of shift. The badge report further identified the direct care staff member #117 entered an identified room for an identified extended amount of

time.

During a staff interview, direct care staff member #112 stated he/she found direct care staff member #117 asleep in an identified room and notified the Registered staff member at the beginning of the identified shift while completing resident room rounds. The direct care staff member #112 reported he/she found resident #002 in his/her room on the floor at change of shift. Direct care staff member #112 identified resident #002 had not been provided care for thirty minute routine checks had not been completed.

Interview with Registered staff member #103 reported he/she found direct care staff member #117 in an identified room at the beginning of an identified shift upon being notified by direct care staff member #112. Registered staff member #103 revealed he/she found resident #002 on the floor in his/her room on the floor due to lack of monitoring as indicated in the written plan of care. Registered staff member #103 identified that resident #002 had not been provided care.

Interview with Registered staff #114, revealed registered staff were to check with direct care staff throughout the shift, after rounds, and obtain report from them prior to shift change. Registered staff member #114 stated he/she had checked on direct care staff member #117 once during the shift at an identified time prior to break. Registered staff member #114 revealed he/she was unaware of direct care staff member #117's whereabouts for the remainder of that shift and did not see the direct care staff member #117 to obtain report before end of shift.

Review of direct care staff member #117 staff records identified he/she had been previously disciplined with suspension for abuse towards residents. Direct care staff member #117 was terminated, by the home following the above mentioned incident.

Interview with homes DOC identified that registered staff were expected to check in with direct care staff members throughout the shift. The DOC confirmed that resident #002 had not been provided care for by direct care staff member #117 as routine checks were not performed as directed in the written plan of care and he/she was found on the floor in his/her room after ringing the call bell for assistance. [s. 19. (1)] (648)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2017

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 24th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

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