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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 20, 2018	2018_655679_0020	014217-18	Complaint

Licensee/Titulaire de permis

Riverside Health Care Facilities Inc.
110 Victoria Avenue FORT FRANCES ON P9A 2B7

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

Rainycrest
550 Osborne Street FORT FRANCES ON P9A 3T2

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

MICHELLE BERARDI (679), JULIE KUORIKOSKI (621), KATHERINE BARCA (625)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 16-20, 2018, and 23-26, 2018.

The following intake was inspected upon during this Complaint inspection: One intake related to resident care concerns.

A Critical Incident System inspection #2018_655679_0021 and a Follow Up Inspection #2018_655679_0022 were conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Physician, Registered Nurse Unit Coordinator, Infection Prevention and Control Practitioner, Chief Executive Officer (CEO) of Novo Peak Health, Financial Services, Occupational Health and Safety Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Administrative Assistant, Receptionist, Physiotherapy Assistants, Personal Support Workers (PSWs), Canadian Mental Health Association Outreach PSW, Support Workers, family members and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records, complaint records, manufacturer instructions, as well as relevant policies.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse or neglect that the licensee knew of, or that was reported was immediately investigated.

Inspector #679 reviewed a complaint submitted to the Director which outlined concerns related to resident #002's care. The complaint identified that on a particular date, resident #002 rang their call bell to be assisted with an activity. The complaint further identified that staff responded by saying a specific statement, and that the resident had sat in their mobility aid for a specific amount of time. The complaint identified that they had notified the Director of Care of the above incident.

Inspector #679 reviewed an "Internal Complaint Documentation Form". The form identified that a complaint was made to the DOC alleging that staff had made an inappropriate comment to resident #002. The complaint documentation form identified that the investigation into the complaint was started on a particular date.

A review of the policy entitled "Abuse and Neglect Zero Tolerance Policy" last revised April 11, 2018, identified that the Administrator or designate will investigate all suspected/actual incidents of abuse or neglect immediately upon notification.

In an interview with the DOC they identified that investigations into alleged abuse or neglect were to be started immediately. The DOC and Inspector #679 reviewed the

documentation which outlined that the staff involved in the incident were contacted the following date, as well as the complaint document which outlined that the investigation started the day following the home becoming aware of the incident. The DOC identified that they believed that the investigation was started immediately; however, could not locate any documentation to support this. [s. 23. (1) (a)]

2. Inspector #679 reviewed a complaint submitted to the Director which outlined concerns related to resident #002's care.

In an interview with the DOC they identified that resident #002's family member approached them and identified that resident #002 stated that they were scared to complete a specified activity.

A review of the policy entitled "Abuse and Neglect Zero Tolerance Policy" last revised April 11, 2018, identified an unusual fear of consequences of doing or not doing things necessarily within their control as a possible sign of abuse or neglect.

Inspector #679 asked if the DOC had attempted to speak with resident #002 to inquire why they were afraid to participate in a specified activity. The DOC identified that they had not spoken with resident #002 about their fear of participating in the specified activity.

3. On a particular date, Inspector #679 was notified of an allegation of verbal/emotional abuse.

On the same date, Inspector #679 brought forth the allegation of abuse to the home's Administrator.

A review of the Critical Incident (CI) report identified that on a specified date, the day after the allegation was brought forward, the Administrator met with the family of resident #045 to request a meeting to discuss the incident. The CI report further identified that the meeting to discuss the incident was held on a specific date.

In an interview with the Administrator they identified that investigations into an allegation of abuse or neglect were to be started immediately. The Administrator identified that they were made aware of this allegation by the Inspector on a particular date, and that they had attempted to start the investigation the following date, however didn't. [s. 23. (1) (a)]

4. A Critical Incident (CI) report was submitted to the Director on a specific date for an allegation of staff to resident verbal abuse. The CI report identified that on a particular date resident #045 brought forth an allegation of staff to resident verbal abuse.

The CI report identified that PSW #100 told resident #011 an inappropriate statement. A further review of the CI report identified that the Administrator had spoken with resident #011 on a specified date which was one day after the incident was reported.

In an interview with the Administrator they identified that investigations into an allegation of abuse or neglect were to be started immediately. The Administrator identified that they were made aware of this allegation on a particular date and that they started their investigation the following day. [s. 23. (1) (a)]

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who had reasonable grounds to

suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director: 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.

Inspector #679 reviewed a complaint submitted to the Director which outlined concerns related to resident #002's care. The complaint identified that on a particular date, resident #002 rang their call bell to be assisted with an activity. The complaint further identified that staff responded by saying a specific statement, and that the resident had sat in their mobility aid for a specific amount of time. The complaint identified that they had notified the Director of Care of the above incident.

Inspector #679 reviewed the Ministry of Health and Long Term Care's CI reporting portal and was unable to identify that a CI report was submitted for this incident.

In an interview with the DOC they identified that there was a CI report submitted to the Director, and that they would provide the investigation file to the Inspector. In a separate interview with Inspector #679, the DOC identified that the home did not submit a CI report to the Director, but that the home's internal complaint form was completed.

Inspector #679 reviewed the complaint file provided by the DOC. The file contained a written document which identified that on a particular date, resident #002's family member approached the DOC and identified that staff had made an inappropriate comment to resident #002

A review of the policy entitled "Abuse and Neglect Zero Tolerance Policy" last revised April 11, 2018, identified that staff were to immediately report any suspected abuse or neglect of a resident to the Administrator, Director of care, or their designate, and that the Administrator, Director of care or their designate must report the incident as required by provincial legislation and jurisdictional requirements, including but not limited to the Ministry of Health and Long Term Care.

In an interview with the DOC they identified that they had spoken with the Administrator regarding submitting the complaint as a critical incident; however, they had decided to investigate the complaint to determine the outcome. The DOC identified that they had talked about reporting the complaint as there was the potential that it was an allegation of abuse. The DOC acknowledged that allegations of abuse were typically reported right away as per the legislation. [s. 24. (1)]

2. On a particular date, Inspector #679 was notified of an allegation of verbal/emotional abuse.

On the same date Inspector #679 brought forth the allegation of abuse to the home's Administrator.

Inspector #679 conducted a review of the Ministry of Health and Long Term Care's online CI reporting system and identified that a CI report was submitted to the Director on a specified date, nine days after the allegation was brought forward to the Administrator. The CI report identified that the Administrator acknowledged this report to be late reporting.

In an interview with the Administrator they identified that allegations of abuse or neglect were to be reported to the Director immediately. The Administrator acknowledged that this report was submitted late. [s. 24. (1)]

3. A Critical Incident (CI) report was submitted to the Director on a specific date for an allegation of staff to resident verbal abuse. The CI report identified that on a particular date resident #045 brought forth an allegation of staff to resident verbal abuse.

In an interview with the Administrator they identified that allegations of abuse or neglect were to be reported to the Director immediately. The Administrator acknowledged that this report was submitted late. [s. 24. (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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Inspector #679 reviewed a complaint submitted to the Director which outlined concerns related to resident #002's care.

Inspector #679 reviewed the "PSW Flow Sheets" for resident #002 over a specified period. It was identified that documentation regarding resident #002's specified care was missing on a number of shifts. It was also identified that on a specified number of the shifts, documentation was missing for other personal care areas.

In an interview with PSW #109 they identified that the provision of care was to be documented on the PSW flow sheets. PSW #109 identified that the lack of documentation was related to staffing shortages.

In an interview with RPN #108 they identified that the PSW's document the provision of care on the "PSW Flow Sheet", as well as the bowel monitoring record or the dietary sheets. Inspector #679 and RPN #108 reviewed the PSW flow sheets for resident #002. RPN #108 identified that it would the expectation that the documentation was completed.

Inspector #679 and the DOC reviewed the flow sheets for resident #002. The DOC identified that it was the expectation that the documentation was completed as it was a legal document. [s. 6. (9) 1.]

2. Inspector #679 reviewed a Critical Incident (CI) report submitted to the Director for an incident of resident to resident physical abuse.

Inspector #679 conducted a review of the "PSW Flow Sheets" for resident #003 over a

specified time period. It was identified that documentation regarding resident #003's care, including a specified type of care, was missing on a specified number of shifts.

In an interview with PSW #109 they identified that the provision of care was to be documented on the PSW flow sheets. PSW #109 identified that the lack of documentation was related to staffing shortages.

In an interview with RN #112 they identified that PSWs document the provision of care on the "PSW Flow Sheets". Inspector #679 and RN #112 reviewed the PSW flow sheets. RN #112 identified that the expectation would be that the documentation was complete.

Inspector #679 and the DOC reviewed the flow sheets for resident #002. The DOC identified that it was the expectation that the documentation was completed as it was a legal document. [s. 6. (9) 1.]

3. During the inspection, Inspector #621 was following up on an outstanding compliance order associated with s.6 (7) and residents' toileting plans of care.

On review of the a specified section of resident #011's Activities of Daily Living (ADL) Assistance care plan, it identified that the resident required a specified level of assistance for care and specified interventions.

On review of the PSW Flow Sheet for resident #011, the Inspector found missing documentation for a specified number of shifts.

During interviews with RN #112, they reported that resident #011 required a specified level of assistance for care. Additionally, RN #112 identified that PSW staff were to document all care provided during a shift for the resident. During a review of resident #011's PSW Flow Sheet, RN #112 confirmed that documentation was missing for a number of the residents personal care areas.

During an interview with the Administrator, they confirmed with Inspector #621 that it was their expectation that home's staff ensured that the provision of care as per the residents' plan of care was documented. [s. 6. (9) 1.]

4. On review of the specified section of resident #013's Activities of Daily Living (ADL) Assistance care plan, it identified that the resident required a specified level of assistance for care and specified interventions. .

On review of the PSW Flow Sheet for resident #013, Inspector found missing documentation for a specified number of shifts.

During interviews with PSW #100 and RN #112, they reported that resident #013 required a specific level of assistance for care. Additionally, PSW #100 and RN #112 identified that PSW staff were to document all care provided during a shift for the resident. During a review of resident #013's PSW Flow Sheet, PSW #100 and RN #112 confirmed that documentation was missing for a number of the residents' personal care areas.

During an interview with the Administrator, they confirmed with Inspector #621 that it was their expectation that home's staff ensured that the provision of care as per the residents' plan of care was documented. [s. 6. (9) 1.]

5. On review of a specified section of resident #002's Activities of Daily Living (ADL) Assistance care plan, it identified that the resident required a specified level of assistance for care and specified interventions.

On review of the PSW Flow Sheet for resident #002, Inspector found missing documentation for a specified number of shifts.

During interviews with PSW #100 and RN #112, they reported that resident #002 required a specific level of assistance for care. Additionally, PSW #100 and RN #112 identified that PSW staff were to document all care provided during a shift for the resident. During a review of resident #002's PSW Flow Sheet, PSW #100 and RN #112 confirmed that documentation was missing for a number of the residents' personal care areas.

During an interview with the Administrator, they confirmed with Inspector #621 that it was their expectation that home's staff ensured that the provision of care as per the residents' plan of care was documented. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #4: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response was made to the person who made a complaint, indicating what the licensee had done to resolve the complaint, or that the licensee believed the complaint was unfounded and the reasons for the belief.

A complaint was submitted to the Director outlining concerns regarding resident #002's care.

Inspector #679 reviewed the "Internal Complaint Documentation Form" dated a specified date. The form identified that a complaint was made to the DOC from an individual known to resident #002 that staff had made an inappropriate comment to resident #002. A further review of the complaint form identified under section four "correspondence to the person making the complaint" that a different individual was updated with information regarding the complaint.

A review of the policy entitled "Managing Complaints Policy" with no revision date, identified that staff were to communicate back (verbal or in writing) with the complainant to indicate what was done to solve the complaint, or, that the complaint was unfounded with reason.

In an interview with the DOC they identified that they had followed up with a specific individual regarding the complaint, rather than the individual who submitted the complaint. [s. 101. (1) 3.]

Issued on this 19th day of September, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MICHELLE BERARDI (679), JULIE KUORIKOSKI (621), KATHERINE BARCA (625)
Inspection No. / No de l'inspection :	2018_655679_0020
Log No. / No de registre :	014217-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 20, 2018
Licensee / Titulaire de permis :	Riverside Health Care Facilities Inc. 110 Victoria Avenue, FORT FRANCES, ON, P9A-2B7
LTC Home / Foyer de SLD :	Rainycrest 550 Osborne Street, FORT FRANCES, ON, P9A-3T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marva Griffiths

To Riverside Health Care Facilities Inc., 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. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The Licensee must comply with s. 23. (1) of the Long Term Care Home's Act, 2007.

The Licensee shall ensure that every alleged, suspected or witnessed incident of abuse or neglect is immediately investigated. Specifically, the licensee shall:

(a) Retrain the Administrator and the Management team on the home's policy, procedures and responsibilities regarding investigation requirements/timelines, as outlined in the home's policy titled "Abuse and Neglect Zero Tolerance Policy".
(b) Implement a monitoring system to ensure that the Administrator and the Management team comply with the home's policy titled "Abuse and Neglect Zero Tolerance Policy".
(c) Maintain a written record of the steps outlined in part "a" and "b".

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse or neglect that the licensee knew of, or that was reported was

immediately investigated.

A Critical Incident (CI) report was submitted to the Director on a specific date for an allegation of staff to resident verbal abuse. The CI report identified that on a particular date resident #045 brought forth an allegation of staff to resident verbal abuse.

The CI report identified that PSW #100 told resident #011 an inappropriate statement. A further review of the CI report identified that the Administrator had spoken with resident #011 on a specified date which was one day after the incident was reported.

A review of the policy entitled "Abuse and Neglect Zero Tolerance Policy" last revised April 11, 2018, identified that the Administrator or designate will investigate all suspected/actual incidents of abuse or neglect immediately upon notification.

In an interview with the Administrator they identified that investigations into an allegation of abuse or neglect were to be started immediately. The Administrator identified that they were made aware of this allegation on a particular date and that they started their investigation the following day. (679)

2. On a particular date, Inspector #679 was notified of an allegation of verbal/emotional abuse.

On the same date, Inspector #679 brought forth the allegation of abuse to the home's Administrator.

A review of the Critical Incident (CI) report identified that on a specified date, the day after the allegation was brought forward, the Administrator met with the family of resident #045 to request a meeting to discuss the incident. The CI report further identified that the meeting to discuss the incident was held on a specific date.

In an interview with the Administrator they identified that investigations into an allegation of abuse or neglect were to be started immediately. The Administrator identified that they were made aware of this allegation by the Inspector on a particular date, and that they had attempted to start the investigation the following date, however didn't.

(679)

3. Inspector #679 reviewed a complaint submitted to the Director which outlined concerns related to resident #002's care.

In an interview with the DOC they identified that resident #002's family member approached them and identified that resident #002 stated that they were scared to complete a specified activity.

A review of the policy entitled "Abuse and Neglect Zero Tolerance Policy" last revised April 11, 2018, identified an unusual fear of consequences of doing or not doing things necessarily within their control as a possible sign of abuse or neglect.

Inspector #679 asked if the DOC had attempted to speak with resident #002 to inquire why they were afraid to participate in a specified activity. The DOC identified that they had not spoken with resident #002 about their fear of participating in the specified activity.
(679)

4. Inspector #679 reviewed a complaint submitted to the Director which outlined concerns related to resident #002's care. The complaint identified that on a particular date, resident #002 rang their call bell to be assisted with an activity. The complaint further identified that staff responded by saying a specific statement, and that the resident had sat in their mobility aid for a specific amount of time. The complaint identified that they had notified the Director of Care of the above incident.

Inspector #679 reviewed an "Internal Complaint Documentation Form". The form identified that a complaint was made to the DOC alleging that staff had made an inappropriate comment to resident #002. The complaint documentation form identified that the investigation into the complaint was started on a particular date.

In an interview with the DOC they identified that investigations into alleged abuse or neglect were to be started immediately. The DOC and Inspector #679 reviewed the documentation which outlined that the staff involved in the incident were contacted the following date, as well as the complaint document which outlined that the investigation started the day following the home becoming

aware of the incident. The DOC identified that they believed that the investigation was started immediately; however, could not locate any documentation to support this.

The severity of this issue was determined to be a level 2, minimum harm or potential for harm. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 3 history of non-compliance, with one related non-compliance being issued within this section of the Act that included:
• A Voluntary plan of correction (VPC) issued October, 2016 during inspection #2016_320612_0018 (679)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 04, 2018

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 : 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. 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 :

The Licensee must comply with s. 24. (1) of the Long Term Care Home's Act, 2007.

The Licensee shall ensure that any person who has reasonable grounds to suspect that abuse of a resident or neglect of a resident has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director. Specifically, the licensee shall:
(a) Retrain the Administrator and the Management team on the home's policy, procedures and responsibilities regarding reporting requirements, as outlined in the home's policy titled "Abuse and Neglect Zero Tolerance Policy".
(b) Implement a monitoring system to ensure that the Administrator and the Management team comply with the home's policy titled "Abuse and Neglect Zero Tolerance Policy"
(c) Maintain a written record of the steps outlined in part "a" and "b".

Grounds / Motifs :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the

licensee or staff that resulted in harm or a risk of harm to the resident.

A Critical Incident (CI) report was submitted to the Director on a specific date for an allegation of staff to resident verbal abuse. The CI report identified that on a particular date resident #045 brought forth an allegation of staff to resident verbal abuse.

A review of the policy entitled "Abuse and Neglect Zero Tolerance Policy" last revised April 11, 2018, identified that staff were to immediately report any suspected abuse or neglect of a resident to the Administrator, Director of care, or their designate, and that the Administrator, Director of care or their designate must report the incident as required by provincial legislation and jurisdictional requirements, including but not limited to the Ministry of Health and Long Term Care.

In an interview with the Administrator they identified that allegations of abuse or neglect were to be reported to the Director immediately. The Administrator acknowledged that this report was submitted late.
(679)

2. On a particular date, Inspector #679 was notified of an allegation of verbal/emotional abuse.

On the same date Inspector #679 brought forth the allegation of abuse to the home's Administrator.

Inspector #679 conducted a review of the Ministry of Health and Long Term Care's online CI reporting system and identified that a CI report was submitted to the Director on a specified date, nine days after the allegation was brought forward to the Administrator. The CI report identified that the Administrator acknowledged this report to be late reporting.

In an interview with the Administrator they identified that allegations of abuse or neglect were to be reported to the Director immediately. The Administrator acknowledged that this report was submitted late.
(679)

3. Inspector #679 reviewed a complaint submitted to the Director which outlined concerns related to resident #002's care. The complaint identified that on a

particular date, resident #002 rang their call bell to be assisted with an activity. The complaint further identified that staff responded by saying a specific statement, and that the resident had sat in their mobility aid for a specific amount of time. The complaint identified that they had notified the Director of Care of the above incident.

Inspector #679 reviewed the Ministry of Health and Long Term Care's CI reporting portal and was unable to identify that a CI report was submitted for this incident.

In an interview with the DOC they identified that there was a CI report submitted to the Director, and that they would provide the investigation file to the Inspector. In a separate interview with Inspector #679, the DOC identified that the home did not submit a CI report to the Director, but that the home's internal complaint form was completed.

Inspector #679 reviewed the complaint file provided by the DOC. The file contained a written document which identified that on a particular date, resident #002's family member approached the DOC and identified that staff had made an inappropriate comment to resident #002.

In an interview with the DOC they identified that they had spoken with the Administrator regarding submitting the complaint as a critical incident; however, they had decided to investigate the complaint to determine the outcome. The DOC identified that they had talked about reporting the complaint as there was the potential that it was an allegation of abuse. The DOC acknowledged that allegations of abuse were typically reported right away as per the legislation.

The severity of this issue was determined to be a level 1, minimum risk. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 3 history of non-compliance with this section of the Act that included:
• A Voluntary Plan of Correction (VPC) issued August 2018, during inspection #2017_703625_0014;
• A VPC issued September, 2017, during Inspection #2017_463616_0011;
• A VPC issued July 2017, during inspection #2017_435621_0016;
• A VPC issued October 2016, during inspection #2016_320612_0018; and,
• A VPC issued February 2016, during inspection #2016_246196_0001 (679)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 04, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 20th day of August, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Michelle Berardi

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