Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

**Rapport d'inspection prévue 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**

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 1, 2019 | 2019_822613_0003 | 014042-19, 016778-19, 016992-19 | Critical Incident System |

### 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

LISA MOORE (613), LAUREN TENHUNEN (196), MELISSA HAMILTON (693)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): October 21-24, 2019.**

**The following intakes were inspected during this Critical Incident System Inspection:**

**Two Critical Incident reports that were submitted to the Director regarding alleged staff to resident neglect;**

**One Critical Incident report that was submitted to the Director regarding a fall; resulting in an injury and transfer to the hospital.**

**A concurrent Complaint Inspection #2019_822613_0003, was also conducted during this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Director of Care (DOC), Clinical Manager (CM), Physiotherapy Assistant (PTA), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.**

**The Inspector also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, human resource files and policies, procedures and programs.**

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

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with related to two separate incidents of neglect involving resident #001 and resident #002.

Inspector #693 reviewed a Critical Incident (CI) report that was submitted to the Director, related to an allegation of neglect of resident #001 by staff regarding an incident that occurred. The CI report identified that on a specific date and time, resident #001's family member reported to PSW #113 and the Clinical Manager (CM) that the resident was still in bed, wearing a soiled continent care product and had not received a specific meal. The report further indicated that the home's investigation, identified that neglect of resident #001 on a specific date, was substantiated.

O. Reg. 79/10 defines neglect as 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 jeopardized the health, safety or well-being of one or more residents.

A review of the licensee's policy, titled, "Abuse and Neglect Zero Tolerance Policy" (ORG-II-PAT-10) last revised June 2019, identified that the home was committed to providing an environment of zero tolerance of abuse or neglect of residents by any person. Appendix C of the policy, titled, "Possible Signs of Abuse or Neglect", identified signs of neglect as clothing soiled, failure to provide a resident with food, or fluid, and needs not being met.

A review of the licensee's policy, titled "Meal Service" (RC-18-01-07) last updated February 2017, identified that staff were to monitor all residents during dining service, and consumption, and to have ensured residents who were missing from the dining room were accounted for.

A review of the licensee's policy, titled "Daily Personal Care and Grooming", (RC-06-01-01), last updated April 2017, identified that nurses and care staff were to provide care as documented on the care plan.

A review of resident #001's care plan, that was current at the time of the incident, identified that resident #001 required assistance from staff members for their care and for mobility.

A review of the home's investigation file contained a written letter by the CM, that indicated that on a specific date and time, resident #001's family member approached them and asked why the resident was still in bed. The CM and PSW #113 immediately provided the resident with care and nourishment and assisted the resident out of bed. The CM indicated in this letter that when they spoke with staff as part of their investigation, the PSW staff reported that they did not check resident #001's room, or provide care to the resident, before going to the dining room to serve the scheduled meal, as the resident's door was closed, and after the meal the staff had forgotten to return to resident #001's room.

During an interview with PSW #104, they stated that resident #001 required assistance from staff members with all care. The PSW identified that resident's regular routine was for staff to assist with all personal care, and bring resident to the dining room, for a specific meal.

During an interview with the CM, they identified that on a specific date, during a specific shift on a specific unit of the home, the home was short PSW staff. The CM stated that they came in to help the staff with care, as they were the manager on call. The CM stated that resident #001 was not provided with any care for four hours or checked on by PSW staff, and that resident #001 was not offered a specific meal. The CM stated that together with a PSW, they provided resident #001 with all missed care at a specific time and offered nourishment, as the staff had forgotten to provide care or specific meal to resident #001. The CM stated that the resident should have been provided with care, a specific meal and checked on every two hours by the PSW staff.

During an interview with the DOC, they indicated that staff had forgotten to provide resident #001 with care or a specific meal. Consequently, the DOC identified that the home's policy with respect to zero tolerance of abuse and neglect, was not complied with. [s. 20. (1)]

2. Inspector #613 reviewed a CI report that was submitted to the Director, related to an allegation of neglect of resident #002 by staff regarding an incident that occurred on a specific date. The CI report identified resident #002's substitute decision-maker (SDM) arrived to the home on this date, at a later time, and found the resident in the same clothing they were wearing the previous day and that their clothing and a certain object were soiled. The report further indicated that the home's investigation, identified that neglect of resident #002 on a specific date, was substantiated.

A review of the licensee's policy, titled, "Abuse and Neglect Zero Tolerance Policy" (ORG-II-PAT-10) last revised June 2019, identified that the home was committed to providing an environment of zero tolerance of abuse or neglect of residents by any person. Appendix C of the policy, titled, "Possible Signs of Abuse or Neglect", identified signs of neglect as clothing soiled, bed and linens visibly soiled with stool or urine, unclean lingering offensive odours and needs not met.

A review of the licensee's policy titled, "A review of the Care Plan titled, "Daily Personal Care and Grooming" (RC-06-01-01) last revised April 2017, identified that the nurse/care staff would provide individualized care as documented on the care plan. The nurse/care staff would provide personal hygiene and grooming in accordance with assessed needs, at minimum, twice daily. Twice daily hygiene care includes cleaning of the face, hands, axilla, perineum and oral hygiene. The nurse/staff would ensure each resident was appropriately dressed, suitable for the season and time of day.

A review of the resident's care plan indicted that resident #002 required assistance of staff member for their dressing and personal hygiene twice daily and for toilet use. Staff were to check resident #002 at least every two hours for incontinence, wash, rinse and dry soiled areas and change clothing after incontinence episodes as required.

A review of the home's internal investigation file identified that the investigation had been completed and substantiated that neglect had occurred. The investigation file revealed that PSW #107, PSW #110 and PSW #111 had checked on resident #002 during rounds and had observed the resident lying in bed with their clothes on; therefore, all PSW's had assumed that the resident had already been provided with care. The investigation file identified that all PSW's working on a specific shift on a specific date, had not provided care, changed the resident clothes, or assisted them to the washroom or changed their continent care product. The investigation also concluded that resident #002 had become incontinent sometime after the specific meal and remained soiled until the SDM visited at a specific time.

During an interview with PSW #107, they stated that they had observed the resident in their bed already dressed at the start of the shift and had assumed that one of the other PSWs had already washed and dressed them or that staff from the previous shift had got them ready. PSW #107 confirmed they had not checked the resident's continent care product or offered assistance to the washroom on that shift.

During an interview with RPN #108, they stated that when resident #002's SDM approached them with the care concern for resident #002, they went to the resident's room with the SDM. The RPN stated that resident #002 and a certain object were soiled. RPN #108 stated they provided care to the resident and Housekeeper #112 washed the certain object. RPN #108 stated that when she asked PSWs #107, #110 and #111 if they had checked and changed resident #002's continent care products that they all had responded no.

During an interview with the Director of Care (DOC) and Clinical Manager (CM), they stated that the PSWs should have checked the resident's continent care products and changed them; they should have confirmed that resident #002 had been provided care; they should have never assumed that care had been done by another staff member and that the resident should have been checked every two hours. The Clinical Manager further stated that their investigation substantiated that neglect had occurred. The DOC further stated that care was not provided as per resident #002's care plan and that the home's policy with respect to zero tolerance of abuse and neglect, was not complied with. [s. 20. (1)]

***Additional Required Actions:***

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

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #001 and #002, as specified in the plan.

Inspector #693 reviewed a CI report that was submitted to the Director, for an incident related to neglect of resident #001. Refer to WN #1-1 for further information.

The Inspector observed resident #001 in bed on October 21, 2019. The resident's bed was placed in the lowest position, with a device in use and a certain object was located across the room, against the wall of the room.

A review of resident #001's most current care plan, indicated that resident #001 was a risk for injury and required their bed in the lowest position with a certain object to be placed on the floor.

During an interview with PSW #101, they stated that the resident was a risk for injury and that when they were in bed, they utilized a certain object on the floor beside the bed. Together with the Inspector, PSW #101 observed resident #001 in bed, with no certain object in place. PSW #101 stated that according to the resident's care plan the certain object should have been placed beside the bed and it was not.

A review of the licensee's policy, titled, "Care Planning" (RC-05-01-01) last updated in April 2017, indicated that the resident's plan of care, which included the care plan, was a guide that directed care that was provided to the resident, served as a communication tool which enhanced the provision of individualized care, assisted the provision of continuity of care, and promoted safe and effective resident care.

During an interview with the CM, they stated that when resident #001 was in bed and the certain object was not in place, the care plan was not followed, and the care was not provided as outlined in the plan of care. [s. 6. (7)]

2. Inspector #613 reviewed a CI report that was submitted to the Director, related to resident #003 having a fall resulting in an injury and transfer to the hospital. The CI report identified that the resident was found to have fallen from their mobility device onto the floor. The CI further stated that a certain object was not on their mobility device.

A review of resident #003's care plan indicated for a fall prevention intervention, a certain

object was to be applied to the mobility device for safety.

A review of the licensee's policy titled, "Daily Personal Care and Grooming" (RC-06-01-01) last revised April 2017, identified that the nurse/care staff would provide individualized care as documented on the care plan.

During an interview with the Director of Care (DOC), they stated that resident #003's certain object was in the laundry and that PSW #109 had put a "another type of a certain object" on the mobility device instead of getting another certain object to apply to the mobility device. The DOC stated that the home had sufficient supply of the certain objects that PSW #109 could have applied to the mobility device. The DOC confirmed that PSW #109 did not follow the resident's care plan. [s. 6. (7)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care was provided to residents #001 and #002 and all other residents, as specified in the plan, to be implemented voluntarily.***

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**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 has failed to ensure that a person who had reasonable grounds to suspect that 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 had occurred, or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #693 reviewed a CI report that was submitted to the Director, related to an allegation of neglect of resident #001 by staff regarding an incident that occurred on a specific date. Refer to WN #1-1 for further information.

A review of the CI report identified that the incident occurred on a specific date and time, and that a "INFOLINE - LTC Homes After Hours" report was submitted to the Director at a specific time, one day later, as well a CI report was submitted to the Director at a specific time, one day after the incident had occurred.

During an interview with the CM, they stated that they immediately investigated the incident involving resident #001 on the date it occurred, and made handwritten notes, but did not submit a CI report until one day later, when the Acting Administrator had submitted the INFOLINE- LTC Homes After Hours report.

Inspector #693 reviewed the licensee's policy, titled, "Abuse and Neglect Zero Tolerance - All Staff Procedure" (ORG-II-PAT-10) last revised June 2019, indicated that the Administrator, DOC or designate must report any suspected abuse or neglect of a resident, as required by provincial legislation and jurisdictional requirements, including, but not limited to the MOHLTC Director through the Critical Incident Reporting System or after-hours number.

During an interview with the DOC, they stated that the CI report for the incident involving the neglect of resident #001, on a specific date, was submitted one day later, and that a report should have been submitted to the Director, immediately on the date the incident occurred. [s. 24. (1)]

**Issued on this 1st day of November, 2019**

**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**

**Ministère de la Santé et des Soins de longue durée**

## 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

## 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) :** | LISA MOORE (613), LAUREN TENHUNEN (196), MELISSA HAMILTON (693) |
| **Inspection No. / No de l'inspection :** | 2019_822613_0003 |
| **Log No. / No de registre :** | 014042-19, 016778-19, 016992-19 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Nov 1, 2019 |
| **Licensee / Titulaire de permis :** | Riverside Health Care Facilities Inc.<br>110 Victoria Avenue, FORT FRANCES, ON, P9A-2B7 |
| **LTC Home / Foyer de SLD :** | Rainycrest<br>550 Osborne Street, FORT FRANCES, ON, P9A-3T2 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Barbara Harten |

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(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

## 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

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**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

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

Specifically the licensee must:

A) Ensure all staff comply with the licensee's current policy titled, "Abuse and Neglect Zero Tolerance Policy".

**Grounds / Motifs :**

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with related to two separate incidents of neglect involving resident #001 and resident #002.

Inspector #693 reviewed a Critical Incident (CI) report that was submitted to the Director, related to an allegation of neglect of resident #001 by staff regarding an incident that occurred. The CI report identified that on a specific date and time, resident #001's family member reported to PSW #113 and the Clinical Manager (CM) that the resident was still in bed, wearing a soiled continent care product and had not received a specific meal. The report further indicated that the home's investigation, identified that neglect of resident #001 on a specific date, was substantiated.

O. Reg. 79/10 defines neglect as 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 jeopardized the health, safety or well-being of one or more residents.

A review of the licensee's policy, titled, "Abuse and Neglect Zero Tolerance Policy" (ORG-II-PAT-10) last revised June 2019, identified that the home was committed to providing an environment of zero tolerance of abuse or neglect of residents by any person. Appendix C of the policy, titled, "Possible Signs of Abuse or Neglect", identified signs of neglect as clothing soiled, failure to provide a resident with food, or fluid, and needs not being met.

A review of the licensee's policy, titled "Meal Service" (RC-18-01-07) last updated February 2017, identified that staff were to monitor all residents during dining service, and consumption, and to have ensured residents who were missing from the dining room were accounted for.

A review of the licensee's policy, titled "Daily Personal Care and Grooming", (RC-06-01-01), last updated April 2017, identified that nurses and care staff were to provide care as documented on the care plan.

A review of resident #001's care plan, that was current at the time of the incident, identified that resident #001 required assistance from staff members for their care and for mobility.

A review of the home's investigation file contained a written letter by the CM, that indicated that on a specific date and time, resident #001's family member approached them and asked why the resident was still in bed. The CM and PSW #113 immediately provided the resident with care and nourishment and assisted the resident out of bed. The CM indicated in this letter that when they spoke with staff as part of their investigation, the PSW staff reported that they did not check resident #001's room, or provide care to the resident, before going to the dining room to serve the scheduled meal, as the resident's door was closed, and after the meal the staff had forgotten to return to resident #001's room.

During an interview with PSW #104, they stated that resident #001 required assistance from staff members with all care. The PSW identified that resident's regular routine was for staff to assist with all personal care, and bring resident to the dining room, for a specific meal.

During an interview with the CM, they identified that on a specific date, during a

specific shift on a specific unit of the home, the home was short PSW staff. The CM stated that they came in to help the staff with care, as they were the manager on call. The CM stated that resident #001 was not provided with any care for four hours or checked on by PSW staff, and that resident #001 was not offered a specific meal. The CM stated that together with a PSW, they provided resident #001 with all missed care at a specific time and offered nourishment, as the staff had forgotten to provide care or specific meal to resident #001. The CM stated that the resident should have been provided with care, a specific meal and checked on every two hours by the PSW staff.

During an interview with the DOC, they indicated that staff had forgotten to provide resident #001 with care or a specific meal. Consequently, the DOC identified that the home's policy with respect to zero tolerance of abuse and neglect, was not complied with. (693)

2. Inspector #613 reviewed a CI report that was submitted to the Director, related to an allegation of neglect of resident #002 by staff regarding an incident that occurred on a specific date. The CI report identified resident #002's substitute decision-maker (SDM) arrived to the home on this date, at a later time, and found the resident in the same clothing they were wearing the previous day and that their clothing and a certain object were soiled. The report further indicated that the home's investigation, identified that neglect of resident #002 on a specific date, was substantiated.

A review of the licensee's policy, titled, "Abuse and Neglect Zero Tolerance Policy" (ORG-II-PAT-10) last revised June 2019, identified that the home was committed to providing an environment of zero tolerance of abuse or neglect of residents by any person. Appendix C of the policy, titled, "Possible Signs of Abuse or Neglect", identified signs of neglect as clothing soiled, bed and linens visibly soiled with stool or urine, unclean lingering offensive odours and needs not met.

A review of the licensee's policy titled, "A review of the Care Plan titled, "Daily Personal Care and Grooming" (RC-06-01-01) last revised April 2017, identified that the nurse/care staff would provide individualized care as documented on the care plan. The nurse/care staff would provide personal hygiene and grooming in accordance with assessed needs, at minimum, twice daily. Twice daily hygiene

care includes cleaning of the face, hands, axilla, perineum and oral hygiene. The nurse/staff would ensure each resident was appropriately dressed, suitable for the season and time of day.

A review of the resident's care plan indicted that resident #002 required assistance of staff member for their dressing and personal hygiene twice daily and for toilet use. Staff were to check resident #002 at least every two hours for incontinence, wash, rinse and dry soiled areas and change clothing after incontinence episodes as required.

A review of the home's internal investigation file identified that the investigation had been completed and substantiated that neglect had occurred. The investigation file revealed that PSW #107, PSW #110 and PSW #111 had checked on resident #002 during rounds and had observed the resident lying in bed with their clothes on; therefore, all PSW's had assumed that the resident had already been provided with care. The investigation file identified that all PSW's working on a specific shift on a specific date, had not provided care, changed the resident clothes, or assisted them to the washroom or changed their continent care product. The investigation also concluded that resident #002 had become incontinent sometime after the specific meal and remained soiled until the SDM visited at a specific time.

During an interview with PSW #107, they stated that they had observed the resident in their bed already dressed at the start of the shift and had assumed that one of the other PSWs had already washed and dressed them or that staff from the previous shift had got them ready. PSW #107 confirmed they had not checked the resident's continent care product or offered assistance to the washroom on that shift.

During an interview with RPN #108, they stated that when resident #002's SDM approached them with the care concern for resident #002, they went to the resident's room with the SDM. The RPN stated that resident #002 and a certain object were soiled. RPN #108 stated they provided care to the resident and Housekeeper #112 washed the certain object. RPN #108 stated that when she asked PSWs #107, #110 and #111 if they had checked and changed resident #002's continent care products that they all had responded no.

During an interview with the Director of Care (DOC) and Clinical Manager (CM), they stated that the PSWs should have checked the resident's continent care products and changed them; they should have confirmed that resident #002 had been provided care; they should have never assumed that care had been done by another staff member and that the resident should have been checked every two hours. The Clinical Manager further stated that their investigation substantiated that neglect had occurred. The DOC further stated that care was not provided as per resident #002's care plan and that the home's policy with respect to zero tolerance of abuse and neglect, was not complied with.

The severity of this issue was determined to be a level 3 as there was actual harm or actual risk to the residents. The scope was a level 2 as it related to 2 of 2 residents reviewed. The home had a level 3 history as they had previous non-compliance with this section of the LTCHA that included:

-Voluntary Plan of Correction (VPC) issued August 1, 2019 (#2019_740621_0022)
-VPC issued April 8, 2019 (#2019_679638_0011)

(613)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Nov 29, 2019

## 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

**Issued on this 1st day of November, 2019**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Lisa Moore

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