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
Jan 4, 2018	2017_420643_0022	025044-17	Resident Quality Inspection

Licensee/Titulaire de permis

MILL CREEK CARE CENTRE
286 Hurst Drive BARRIE ON L4N 0Z3

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

MILL CREEK CARE CENTRE
286 Hurst Drive BARRIE ON L4N 0Z3

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

ADAM DICKEY (643), SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 27-30, December 1, and 4-8, 2017.

The following critical incident intakes were inspected concurrently with the RQI:
Log #015018-17; critical incident system report (CIR) #2981-000024-17 - related to falls prevention and management, and
Log #024707-17; CIR #2981-000037-17 - related to suspected abuse.

The following compliance order follow-ups were inspected concurrently with the RQI:
Log #022656-17 related to sufficient staffing, and
Log #023830-17 related to plan of care, and prevention of abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), nurse manager (NM), associate nurse managers (ANM), nursing administrative assistant, Social Worker (SW), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), personal support workers (PSW), housekeepers, Residents' Council and Family Council Representatives, residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **3 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_414110_0007	643
O.Reg 79/10 s. 31. (3)	CO #001	2017_491647_0010	604
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2017_414110_0007	643

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. 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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

The home submitted a Critical Incident System report (CIR) to the Ministry of Health and Long-Term Care (MOHLTC). Review of the CIR revealed an incident that caused an injury to a resident for which the resident is taken to hospital and which resulted in a significant change in the resident's health status related to a fall. The CIR indicated on an identified date, a Personal Support Worker (PSW) heard a sound, when he/she entered the room they found the resident on the floor. The PSW called for help, and the resident was noted to have sustained suspected injuries. The resident was turned and assessed, a specified injury was identified and the resident was transferred to hospital for further assessment.The CIS indicated the resident has had an identified number of falls within one quarter.

A review of resident #004's fall history was carried out for the above mentioned quarter, an identified number of fall incidents were documented. Resident #004 did not sustain any significant injuries from the prior falls until the incident reported in the CIR, in which he/she sustained identified injury and was transferred to hospital for further assessment.

A review of resident #004's written plans of care for the identified quarter was carried out. The written plans of care consisted of a focus related to risk of falls, characterized by history of falls/injury, and multiple fall risk factors. The plans of care indicated interventions for falls risk included an identified safety device to be applied while resident #004 is in bed and check every shift to ensure the device is functioning.

A review of resident #004's progress notes was carried out. A progress note from an identified date indicated writer went into resident room and saw that resident #004 was laying on the floor beside his/her bed. Resident #004 was assessed, no pain or new injuries were noted. The progress note further indicated that the batteries in the above mentioned safety device were loose and the device was not functioning and did not alert staff as intended. A progress note on the date of the CIR indicated resident #004 had a fall at an identified time, the assigned PSW and writer were in another resident room when the PSW had overheard a noise. PSW checked on resident #004 and found the resident laying on the floor with identified suspected injury. The progress note indicated the identified safety device was in place.

An interview conducted with PSW #126 confirmed he/she worked the shift at the date and time of the incident reported in the CIR, on resident #004's home area. PSW #126 stated it was the home's expectation that the PSW carryout safety and personal care rounds when arriving for the identified shift. PSW #126 further stated that as a part of the safety checks any fall prevention safety devices are to be checked to ensure they are functioning. The PSW indicated resident #004 has had multiple falls and has an identified safety device which he/she is to check at the beginning and end of his/her shift as a fall prevention intervention. The PSW indicated he/she is expected to check the identified safety device by disconnecting it and observing a beep indicating the device is in working order. The PSW acknowledged that he/she did not disconnect resident #004's identified safety device, only observed the light flashing on the device, and resident #004 had a fall that shift. PSW #126 stated he/she did not follow the set plan of care for fall interventions for resident #004.

Interviews conducted with the home's Director of Nursing (DON) who stated it was the homes expectation that the staff follow and provide the set plan of care to all residents in the home. The DOC stated all staff including PSWs are expected to carryout fall safety rounds on high risk residents when they arrive for their shift which includes checking all safety devices to ensure they are functioning. The DOC indicated all staff are educated on how to check the safety devices on orientation. The DOC stated he/she was aware of resident #004's fall, and the resident was transferred to hospital for further assessment as the resident sustained an identified injury. The DOC indicated the home carried out an investigation and the outcome was that PSW #126 did not carry out proper safety checks on resident #004's identified safety device as indicated in the plan of care.

The severity of this noncompliance was identified as actual harm to the resident. The

scope of the noncompliance was identified as isolated as it was limited to one resident. A review of the home's compliance history revealed noncompliance was issued related to LCTHA, 2007, S.O. 2007, c.8, s. 6. (7) and compliance order CO #002 was served on October 6, 2017, under inspection report #2017_414110_0007 with a compliance due date of November 17, 2017. A previous compliance order CO #001 was served February 18, 2016, under inspection report #2015_168202_0026 with a compliance due date of May 27, 2016. As a result of previous noncompliance related to LCTHA, 2007, S.O. 2007, c.8, s. 6. (7) with previous compliance orders being issued a compliance order is warranted. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised because care set out in the plan had not been effective, have different approaches been considered in the revision of the plan of care.

The home submitted a Critical Incident System report (CIR) to the Ministry of Health and Long-Term Care (MOHLTC). Review of the CIR revealed an incident that caused an injury to a resident for which the resident is taken to hospital and which resulted in a significant change in the resident’s health status related to a fall. The CIR indicated on an identified date, a Personal Support Worker (PSW) heard a sound, when he/she entered the room they found the resident on the floor. The PSW called for help, and the resident was noted to have sustained suspected injuries. The resident was turned and assessed, a specified injury was identified and the resident was transferred to hospital for further assessment.The CIS indicated the resident has had an identified number of falls within one quarter.

A review of resident #004’s fall history was carried out for the above mentioned quarter, an identified number of fall incidents were documented. Resident #004 did not sustain any significant injuries from the prior falls until the incident reported in the CIR, in which he/she sustained identified injury and was transferred to hospital for further assessment.

A review of resident #004’s written plans of care for the identified quarter was carried out. The written plans of care consisted of a focus related to risk of falls, characterized by history of falls/injury, and multiple fall risk factors. Planned interventions were included in the plans of care related to falls prevention and management. The review of the two quarterly written plans of care related to the fall focus failed to reveal evidence of the plan of care being revised and the resident being reassessed. A review of the current quarterly written plan of care revealed the same focus and interventions as indicated above.

Interviews conducted with RPN #122 and #123, indicated resident #004 was at high risk for falls and has had multiple falls in the last quarter. RPN #122 and #123 reviewed the current and two past quarterly written plans of care, and acknowledged that there were no changes in fall interventions or reassessment of the fall focus after each fall for resident #004.

In interviews the DON and ANM #114 stated it was the home's expectation that the plan of care be reviewed and revised after each fall and review of the interventions in place. The DON stated it was the unit nurse and unit supervisors' responsibility to review and revise the plan of care if the current interventions are not effective for the resident. The DON and ANM #114 stated resident #004 has had multiple falls within the quarter and reviewed the above written plans of care for resident #004, related to his/her fall risk. The DON and ANM acknowledged that the written plans of care did not show evidence that the fall focus and interventions where reviewed and revised after each fall or evidence of new interventions trialled for resident #004 as he/she was having multiple falls. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 with ensuring that residents are reassessed and the plan of care is reviewed and revised when care set out in the plan has not been effective, and consider different approaches in the revision of the plan of care,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee has failed to protect residents from abuse.

A CIR was submitted to the MOHLTC on an identified date. Review of the CIR revealed that on the previous day, a PSW witnessed resident #042 demonstrating an identified responsive behaviour toward co-resident #043. An amendment to the CIR submitted three weeks following the CIR, revealed that there were other incidents of a similar nature involving resident #042 spanning a three month period leading up to the incident reported in the CIR.

Review of resident #042's health records revealed that he/she was admitted to the home with identified medical diagnoses. Review of resident #042's Minimum Data Set (MDS) assessment from revealed cognitive impairment and impaired memory.

Review of resident #042's progress notes revealed the following incidents of resident #042 demonstrating responsive behaviours toward co-residents:
- On an identified date, resident #048 reported to RPN #132 that he/she witnessed resident #042 demonstrating identified responsive behaviours toward co-resident #047 in a common area;
- Three days later, it was reported that resident #042 was found demonstrating identified responsive behaviours toward co-resident #045;
- Two weeks following the first above mentioned incident, a PSW reported RPN #132 that resident #042 was found in a common area with resident #046. Resident #042 and #046 were engaged in a specified responsive behaviour;
- Seven weeks after the first incident, a PSW reported to RPN #132 that resident appeared to be demonstrating an identified responsive behaviour toward co-resident #049 in a common area;
- Ten weeks after the first incident, resident #044 reported that resident #042 had demonstrated a specified responsive behaviour toward him/her when leaving a program;
- Ten weeks following the first incident, resident #042 was witnessed by RPN #133 demonstrating an identified responsive behaviour toward co-resident #043; and
- 12 weeks following the first incident, a PSW reported witnessing resident #042 demonstrating a specified responsive behaviour toward co-resident #043.

In an interview, resident #042 stated that he/she did not recall any of the above mentioned incidents in which he/she demonstrated responsive behaviours toward any of the co-residents. When asked, resident #042 acknowledged that it would be wrong to

demonstrate the above mentioned responsive behaviours toward co-residents.

In interviews, PSWs #125, #128, #129 and #131 stated that resident #042 was known to exhibit specified responsive behaviours, toward co-residents and staff members. PSW #125 stated that resident #042 knows which residents are vulnerable, and has targeted residents #043, #044 and #047. PSW #125 further stated he/she had witnessed resident #042 demonstrating specified responsive behaviours toward resident #043 and resident #045. PSW #128 stated that resident #042 targeted residents #047, #043 and had once targeted resident #044. PSW #131 stated that resident #042 had targeted residents #043, #047 and #049, and that the co-residents were unable to prevent the behaviours from taking place which upset PSW #131. PSWs #125, #128, #129 and #131 stated that interventions were in place to manage resident #042's behaviours.

In an interview with RPN #130, he/she stated that resident #042 exhibited identified responsive behaviours, toward co-residents and staff. RPN #130 stated that resident #042 targeted residents #043, #044, #047 and #049. RPN #130 further stated that resident #042's behaviours were being managed by specified non-pharmacological interventions and a specified medication. In an interview, RPN #132 stated that he/she thought resident #042 knew what he/she was doing was wrong as he would look to see if staff members were watching. RPN #132 further stated that resident #042 had targeted residents #043 and #047.

Review of resident #047's health records revealed he/she was admitted to the home with identified medical diagnoses. Review of resident #047's MDS assessment revealed he/she was cognitively impaired and had memory problems. Review of resident #047's progress notes revealed that on an identified date, resident #048 had reported resident #042 was demonstrating identified responsive behaviours toward co-resident #047. The progress note further revealed that when asked about the incident resident #047 did not recall it occurring. In an interview, resident #047 did not know who resident #042 was, and did not recall the incident.

In an interview, resident #048 stated that he/she had witnessed resident #042 demonstrating identified responsive behaviours toward co-resident #047 in a common area. Resident #048 stated that resident #042 had been trying to bring co-residents into his/her room and seemed to target residents #043 and #047, and has intervened in the past stating that he/she felt the other residents needed to be protected. Review of resident #048's health records indicated intact cognition.

Review of resident #045's health records revealed he/she was admitted to the home with identified diagnoses. Review of resident #045's MDS assessment indicated cognitive impairment and memory problems. Review of resident #045's progress notes indicate that on an identified date, resident #042 had demonstrated identified responsive behaviours toward him/her, and appeared fine and had no issues following the incident. Resident #045 was not able to appropriately answer questions and was not able to be interviewed.

Review of resident #046's health records revealed she was admitted to the home with identified medical diagnoses. Review of resident #046's MDS assessment revealed he/she had cognitive impairment and memory problems. Review of resident #046's progress notes revealed a witnessed incident on an identified date, in which resident #042 demonstrated specified responsive behaviours toward resident #046. Resident #046 was not able to appropriately answer questions and was not able to be interviewed.

Review of resident #049's health records indicated that he/she was admitted to the home with an identified medical diagnosis. Review of resident #049's MDS assessment revealed he/she had mild cognitive impairment and had some ability to recall. Review of resident #049's progress notes revealed that on an identified date, a PSW observed him/her in an identified common area with resident #042 and it appeared resident #042 was demonstrating a specified responsive behaviour toward resident #049. The progress note further revealed that resident #049 was spoken to by RPN #132 and stated he/she was becoming uncomfortable. In an interview, resident #049 stated that he/she did not recall the incident.

Review of resident #044's health records revealed he/she was admitted to the home with an identified medical diagnosis. Review of resident #044's MDS assessment revealed cognitive impairment and memory recall ability. Review of resident #044's progress notes revealed that on an identified date, resident #044 stated resident #042 had demonstrated a specified responsive behaviour toward him/her when leaving a program. The progress note further revealed that resident #044 indicated he/she was not frightened by the incident and had had responded in an identified manner toward resident #042. In an interview, resident #044 stated that he/she recalled an incident with resident #042 in which resident #042 demonstrated specified responsive behaviours toward him/her. Resident #044 stated that when #042 would pass by his/her room he/she would ring the call bell and that resident #042 was often warned to stay away.

Review of resident #043's health records revealed she was admitted to the home with an

identified medical diagnosis. Review of resident #043's MDS assessment revealed cognitive impairment and memory problems. Review of resident #043's progress notes revealed an incident on an identified date, in which resident #042 had demonstrated identified responsive behaviours toward resident #043. When interviewed by RPN #130 resident #043 did not recall the incident, or appear upset. Resident #043 was not able to be interviewed at the time of inspection.

In an interview, associate nurse manager (ANM) #134 who was the coordinator for the responsive behaviour program stated that resident #042 exhibited identified responsive behaviours toward co-residents. ANM #134 defined abuse of a resident and indicated certain activities between residents require consent. ANM #134 was not aware how residents were assessed for their capacity to consent. ANM #134 stated that if resident #042 had demonstrated the above mentioned responsive behaviours toward residents #043, #044, #045, #046 and #047 without their consent it would be considered abuse.

In an interview, the DON stated that when an incident of witnessed, alleged or suspected abuse of a resident the home would look at the resident's capacity to consent. The DON further stated that the home assessed capacity to consent by looking at the resident's CPS score, and resident ability to make an informed decision. The DON stated no formal capacity assessments were being conducted as part of the protocol in the home. The DON acknowledged that residents #043, #044, #045, #046 and #047 did not have the capacity to consent based on their respective CPS scores. The DON acknowledged that the actions of resident #042 towards residents #043, #044, #045, #046 and #047 were considered to be abuse by the definition and the resident's lack of capacity to consent. In these cases the DON acknowledged that residents #043, #044, #045, #046 and #047 were not protected from abuse by resident #042.

The severity of this noncompliance was potential for actual harm. The scope of the noncompliance was widespread as five residents were affected. A review of the home's compliance history revealed two compliance orders had been previously issued related to LCTHA, 2007, S.O. 2007, c.8, s. 19. (1). Compliance order CO #001 was served on October 6, 2017, under inspection report 2017_414110_0007 with a compliance due date of November 17, 2017. Compliance order CO #001 was served on February 23, 2017, under inspection report 2016_414110_0008 with a compliance due date of February 23, 2017, and was compiled on June 9, 2017. As a result of ongoing noncompliance with LCTHA, 2007, S.O. 2007, c.8, s. 19. (1) a compliance order is warranted. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A CIR was submitted to the MOHLTC on an identified date. Review of the CIR revealed that on the previous day, a PSW witnessed resident #042 demonstrating an identified responsive behaviour toward co-resident #043. An amendment to the CIR submitted three weeks following the CIR, revealed that there were other incidents of a similar nature involving resident #042 spanning a three month period leading up to the incident reported in the CIR.

Review of resident #042's progress notes revealed the following incidents in which it was witnessed, alleged or suspected that resident #042 had demonstrated specified responsive behaviours toward co-residents:

- On an identified date, resident #048 reported to RPN #132 that he/she witnessed resident #042 demonstrating specified responsive behaviours toward co-resident #047 in a common area;
- Two weeks following the first above mentioned incident, a PSW reported RPN #132 that resident #042 was found in a common area with resident #046. Resident #042 and #046 were engaged in a specified responsive behaviour; and
- Ten weeks after the first incident, resident #044 reported that resident #042 had demonstrated a specified responsive behaviour toward him/her when leaving a program.

Review of the MOHLTC Critical Incident System database failed to reveal a CIR for the incidents of witnessed, alleged or suspected abuse of residents on the three above mentioned dates.

In an interview, ANM #134 stated that he/she had become aware of the first above mentioned witnessed incident, but was not sure when it was reported to him/her. A progress note by ANM #134 in resident #042's electronic health record indicated that a meeting with staff was held by ANM #134 three days following the incident, to discuss the behaviour of resident #042 and strategies to manage the behaviours. ANM #134 stated this incident was not reported immediately to the Director. ANM #134 stated that he/she had become aware of the allegations of abuse of resident #044 on the above mentioned identified date, and did not report to the Director as he/she investigated and it was not a witnessed incident. ANM #134 acknowledged that allegations of abuse of a resident are expected to be reported immediately to the Director.

In an interview, NM #135 stated that it is the expectation of the home for staff to report any witnessed, alleged or suspected abuse of a resident to the nurse managers or DON, and the management would complete the CIR. NM #135 further stated that he/she had become aware of the incident of witnessed abuse of resident #046 that occurred on the above mentioned date, though was not sure when he/she became aware. NM #125 stated that he/she was not sure if the incident was immediately reported to the Director.

In an interview, the DON stated that it was the responsibility of the nurse managers to complete the CIR with help of the unit staff for any witnessed, alleged or suspected incidents of abuse of a resident. The DON acknowledged that the three above mentioned incidents were considered abuse of a resident and that they were not immediately reported to the Director.

The severity of this noncompliance was identified as potential for actual harm and the

scope was identified as a pattern. A review of the home's compliance history revealed previous noncompliance was issued related to LCTHA, 2007, S.O. 2007, c.8, s. 24. (1) as a Written Notification (WN) under inspection reports #2017_414110_0007 and #2016_414110_0008. As a result of the severity, scope and compliance history related to LCTHA, 2007, S.O. 2007, c.8, s. 24. (1) a compliance order is warranted. [s. 24. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with 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 the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A CIR was submitted to the MOHLTC on an identified date. Review of the CIR revealed that on the previous day, a PSW witnessed resident #042 demonstrating an identified responsive behaviour toward co-resident #043. An amendment to the CIR submitted three weeks following the CIR, revealed that there were other incidents of a similar nature involving resident #042 spanning a three month period leading up to the incident reported in the CIR.

Review of the home's policy titled "Abuse and Neglect Policy" policy number P-10, with a review date of March 17, 2017, revealed that all staff of the home are required to make reports to the home when there is reasonable grounds to suspect abuse of a resident by anyone has occurred or may occur. The home's policy states that it is also the duty of the staff member to report these incidents to the Director.

Review of resident #042’s electronic health records revealed a progress note documenting an incident on an identified date, in which resident #042 was witnessed by a PSW demonstrating a specified responsive behaviour toward resident #045. The progress note was written by RPN #133 and indicated the behaviour constituted abuse. The progress note did not indicate to whom RPN #133 reported the incident of witnessed abuse.

In an interview, RPN #133 stated that if receiving a report of abuse of a resident he/she would report to management about the incident. RPN #133 further stated that any witnessed or alleged abuse needs to be reported right away. RPN #133 stated he/she did not recall who the incident was reported to but would have reported to the nurse manager.

In interviews, ANM #134 and nurse manager (NM) #135 stated that they did not recall receiving a report from RPN #133 related to the incident of witnessed abuse of resident #045. ANM #124 and NM #135 stated it was the expectation of the home for staff to report immediately to the nurse managers any witnessed, alleged or suspected resident abuse. [s. 20. (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 with ensuring that the written policy to promote zero tolerance of abuse and neglect of residents is complied with,, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

During an interview with RPN #106 on an identified home area, he/she indicated PSW staff are able to apply topical medicated creams as the registered staff provide education and monitoring. RPN #106 further stated the topical medication creams are stored in a treatment cart in the clean utility room and the PSW staff had keys to access the room but not to the treatment cart. RPN #106 and inspector observed the clean utility room, the inspector observed the door to the clean utility room was locked and the treatment cart inside the room was unlocked. RPN #106 indicated the treatment cart is left

unlocked as the PSW staff do not have a key to the treatment cart and housekeeping/maintenance staff have access to the clean utility room in order to clean and stock supplies in the room. The RPN confirmed anyone who has access to the clean utility room has access to the topical medication creams.

Interviews conducted with PSW #109 and Housekeeper #110 indicated they work on the above mentioned identified home area and have access to the clean utility room. The PSW stated he/she enters the room to retrieve topical medicated cream treatments and the treatment cart is left unlocked as the PSWs do not have keys to unlock the treatment cart. The Housekeeper indicated he/she comes in the room to fill soap and other housekeeping supplies. The PSW and Housekeeping staff acknowledged the treatment cart is often left unlocked and they both had access to topical medicated creams.

As non-compliance was identified, the inspector expanded the sample to two additional home areas.

Interviews conducted with PSW #111, PSW #104, and Housekeeper #112 and #113, indicated they had access to the clean utility room. The PSWs stated they enter the room to retrieve topical cream treatments and that the treatment cart is left unlocked on occasion as the PSWs do not have keys to unlock the treatment cart. The Housekeeping staff stated they come in the room to fill housekeeping supplies. The PSW and Housekeeping staff acknowledged if the treatment cart is often left unlocked they both had access to topical medicated creams.

An interview with ANM #114 indicated it was the home's expectation that treatment carts are locked when not in use and nursing staff provide the PSW staff with the topical medicated cream treatments and lock the cart. ANM #114 acknowledged that the housekeeping and maintenance staff do have access to the clean utility room and would have access to the topical medicated cream when the treatment carts are unlocked. [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that steps are taken to ensure the security of the drug supply including restricting access to areas where drugs are stored to persons who may dispense, prescribe or administer drugs in the home and the administrator,, to be implemented voluntarily.

Issued on this 9th day of January, 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) :	ADAM DICKEY (643), SHIHANA RUMZI (604)
Inspection No. / No de l'inspection :	2017_420643_0022
Log No. / No de registre :	025044-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 4, 2018
Licensee / Titulaire de permis :	MILL CREEK CARE CENTRE 286 Hurst Drive, BARRIE, ON, L4N-0Z3
LTC Home / Foyer de SLD :	MILL CREEK CARE CENTRE 286 Hurst Drive, BARRIE, ON, L4N-0Z3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Althea Bess

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

Order / Ordre :

Upon receipt of this compliance order the licensee shall:

1. Ensure that direct care staff perform checks of all fall prevention safety devices as set out in resident #001 and all other applicable residents' plans of care as specified in the plan; and
2. Develop an auditing system to ensure that all fall prevention safety devices used in the home are functioning and in working order.

Grounds / Motifs :

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

The home submitted a Critical Incident System report (CIR) to the Ministry of Health and Long-Term Care (MOHLTC). Review of the CIR revealed an incident that caused an injury to a resident for which the resident is taken to hospital and which resulted in a significant change in the resident's health status related to a fall. The CIR indicated on an identified date, a Personal Support Worker (PSW) heard a sound, when he/she entered the room they found the resident on the floor. The PSW called for help, and the resident was noted to have sustained suspected injuries. The resident was turned and assessed, a specified injury was identified and the resident was transferred to hospital for further assessment.The CIS indicated the resident has had an identified number of falls within one quarter.

A review of resident #004's fall history was carried out for the above mentioned quarter, an identified number of fall incidents were documented. Resident #004 did not sustain any significant injuries from the prior falls until the incident

reported in the CIR, in which he/she sustained identified injury and was transferred to hospital for further assessment.

A review of resident #004's written plans of care for the identified quarter was carried out. The written plans of care consisted of a focus related to risk of falls, characterized by history of falls/injury, and multiple fall risk factors. The plans of care indicated interventions for falls risk included an identified safety device to be applied while resident #004 is in bed and check every shift to ensure the device is functioning.

A review of resident #004's progress notes was carried out. A progress note from an identified date indicated writer went into resident room and saw that resident #004 was laying on the floor beside his/her bed. Resident #004 was assessed, no pain or new injuries were noted. The progress note further indicated that the batteries in the above mentioned safety device were loose and the device was not functioning and did not alert staff as intended. A progress note on the date of the CIR indicated resident #004 had a fall at an identified time, the assigned PSW and writer were in another resident room when the PSW had overheard a noise. PSW checked on resident #004 and found the resident laying on the floor with identified suspected injury. The progress note indicated the identified safety device was in place.

An interview conducted with PSW #126 confirmed he/she worked the shift at the date and time of the incident reported in the CIR, on resident #004's home area. PSW #126 stated it was the home's expectation that the PSW carryout safety and personal care rounds when arriving for the identified shift. PSW #126 further stated that as a part of the safety checks any fall prevention safety devices are to be checked to ensure they are functioning. The PSW indicated resident #004 has had multiple falls and has an identified safety device which he/she is to check at the beginning and end of his/her shift as a fall prevention intervention. The PSW indicated he/she is expected to check the identified safety device by disconnecting it and observing a beep indicating the device is in working order. The PSW acknowledged that he/she did not disconnect resident #004's identified safety device, only observed the light flashing on the device, and resident #004 had a fall that shift. PSW #126 stated he/she did not follow the set plan of care for fall interventions for resident #004.

Interviews conducted with the home's Director of Nursing (DON) who stated it was the homes expectation that the staff follow and provide the set plan of care

to all residents in the home. The DOC stated all staff including PSWs are expected to carryout fall safety rounds on high risk residents when they arrive for their shift which includes checking all safety devices to ensure they are functioning. The DOC indicated all staff are educated on how to check the safety devices on orientation. The DOC stated he/she was aware of resident #004's fall, and the resident was transferred to hospital for further assessment as the resident sustained an identified injury. The DOC indicated the home carried out an investigation and the outcome was that PSW #126 did not carry out proper safety checks on resident #004's identified safety device as indicated in the plan of care.

The severity of this noncompliance was identified as actual harm to the resident. The scope of the noncompliance was identified as isolated as it was limited to one resident. A review of the home's compliance history revealed noncompliance was issued related to LCTHA, 2007, S.O. 2007, c.8, s. 6. (7) and compliance order CO #002 was served on October 6, 2017, under inspection report #2017_414110_0007 with a compliance due date of November 17, 2017. A previous compliance order CO #001 was served February 18, 2016, under inspection report #2015_168202_0026 with a compliance due date of May 27, 2016. As a result of previous noncompliance related to LCTHA, 2007, S.O. 2007, c.8, s. 6. (7) with previous compliance orders being issued a compliance order is warranted. (604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 02, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

Upon receipt of this compliance order the licensee shall:

1. Protect residents from abuse from resident #042;
2. Reassess resident #042's behaviours and implement strategies to prevent further incidents of resident to resident abuse; and
3. Ensure that all staff are aware of resident #042's responsive behaviours and interventions developed to prevent abuse of co-residents.

Grounds / Motifs :

1. The Licensee has failed to protect residents from abuse.

A CIR was submitted to the MOHLTC on an identified date. Review of the CIR revealed that on the previous day, a PSW witnessed resident #042 demonstrating an identified responsive behaviour toward co-resident #043. An amendment to the CIR submitted three weeks following the CIR, revealed that there were other incidents of a similar nature involving resident #042 spanning a three month period leading up to the incident reported in the CIR.

Review of resident #042's health records revealed that he/she was admitted to the home with identified medical diagnoses. Review of resident #042's Minimum Data Set (MDS) assessment from revealed cognitive impairment and impaired memory.

Review of resident #042's progress notes revealed the following incidents of resident #042 demonstrating responsive behaviours toward co-residents:
- On an identified date, resident #048 reported to RPN #132 that he/she witnessed resident #042 demonstrating identified responsive behaviours toward

co-resident #047 in a common area;
- Three days later, it was reported that resident #042 was found demonstrating identified responsive behaviours toward co-resident #045;
- Two weeks following the first above mentioned incident, a PSW reported RPN #132 that resident #042 was found in a common area with resident #046. Resident #042 and #046 were engaged in a specified responsive behaviour;
- Seven weeks after the first incident, a PSW reported to RPN #132 that resident appeared to be demonstrating an identified responsive behaviour toward co-resident #049 in a common area;
- Ten weeks after the first incident, resident #044 reported that resident #042 had demonstrated a specified responsive behaviour toward him/her when leaving a program;
- Ten weeks following the first incident, resident #042 was witnessed by RPN #133 demonstrating an identified responsive behaviour toward co-resident #043; and
- 12 weeks following the first incident, a PSW reported witnessing resident #042 demonstrating a specified responsive behaviour toward co-resident #043.

In an interview, resident #042 stated that he/she did not recall any of the above mentioned incidents in which he/she demonstrated responsive behaviours toward any of the co-residents. When asked, resident #042 acknowledged that it would be wrong to demonstrate the above mentioned responsive behaviours toward co-residents.

In interviews, PSWs #125, #128, #129 and #131 stated that resident #042 was known to exhibit specified responsive behaviours, toward co-residents and staff members. PSW #125 stated that resident #042 knows which residents are vulnerable, and has targeted residents #043, #044 and #047. PSW #125 further stated he/she had witnessed resident #042 demonstrating specified responsive behaviours toward resident #043 and resident #045. PSW #128 stated that resident #042 targeted residents #047, #043 and had once targeted resident #044. PSW #131 stated that resident #042 had targeted residents #043, #047 and #049, and that the co-residents were unable to prevent the behaviours from taking place which upset PSW #131. PSWs #125, #128, #129 and #131 stated that interventions were in place to manage resident #042's behaviours.

In an interview with RPN #130, he/she stated that resident #042 exhibited identified responsive behaviours, toward co-residents and staff. RPN #130 stated that resident #042 targeted residents #043, #044, #047 and #049. RPN

#130 further stated that resident #042's behaviours were being managed by specified non-pharmacological interventions and a specified medication. In an interview, RPN #132 stated that he/she thought resident #042 knew what he/she was doing was wrong as he would look to see if staff members were watching. RPN #132 further stated that resident #042 had targeted residents #043 and #047.

Review of resident #047's health records revealed he/she was admitted to the home with identified medical diagnoses. Review of resident #047's MDS assessment revealed he/she was cognitively impaired and had memory problems. Review of resident #047's progress notes revealed that on an identified date, resident #048 had reported resident #042 was demonstrating identified responsive behaviours toward co-resident #047. The progress note further revealed that when asked about the incident resident #047 did not recall it occurring. In an interview, resident #047 did not know who resident #042 was, and did not recall the incident.

In an interview, resident #048 stated that he/she had witnessed resident #042 demonstrating identified responsive behaviours toward co-resident #047 in a common area. Resident #048 stated that resident #042 had been trying to bring co-residents into his/her room and seemed to target residents #043 and #047, and has intervened in the past stating that he/she felt the other residents needed to be protected. Review of resident #048's health records indicated intact cognition.

Review of resident #045's health records revealed he/she was admitted to the home with identified diagnoses. Review of resident #045's MDS assessment indicated cognitive impairment and memory problems. Review of resident #045's progress notes indicate that on an identified date, resident #042 had demonstrated identified responsive behaviours toward him/her, and appeared fine and had no issues following the incident. Resident #045 was not able to appropriately answer questions and was not able to be interviewed.

Review of resident #046's health records revealed she was admitted to the home with identified medical diagnoses. Review of resident #046's MDS assessment revealed he/she had cognitive impairment and memory problems. Review of resident #046's progress notes revealed a witnessed incident on an identified date, in which resident #042 demonstrated specified responsive behaviours toward resident #046. Resident #046 was not able to appropriately

answer questions and was not able to be interviewed.

Review of resident #049's health records indicated that he/she was admitted to the home with an identified medical diagnosis. Review of resident #049's MDS assessment revealed he/she had mild cognitive impairment and had some ability to recall. Review of resident #049's progress notes revealed that on an identified date, a PSW observed him/her in an identified common area with resident #042 and it appeared resident #042 was demonstrating a specified responsive behaviour toward resident #049. The progress note further revealed that resident #049 was spoken to by RPN #132 and stated he/she was becoming uncomfortable. In an interview, resident #049 stated that he/she did not recall the incident.

Review of resident #044's health records revealed he/she was admitted to the home with an identified medical diagnosis. Review of resident #044's MDS assessment revealed cognitive impairment and memory recall ability. Review of resident #044's progress notes revealed that on an identified date, resident #044 stated resident #042 had demonstrated a specified responsive behaviour toward him/her when leaving a program. The progress note further revealed that resident #044 indicated he/she was not frightened by the incident and had had responded in an identified manner toward resident #042. In an interview, resident #044 stated that he/she recalled an incident with resident #042 in which resident #042 demonstrated specified responsive behaviours toward him/her. Resident #044 stated that when #042 would pass by his/her room he/she would ring the call bell and that resident #042 was often warned to stay away.

Review of resident #043's health records revealed she was admitted to the home with an identified medical diagnosis. Review of resident #043's MDS assessment revealed cognitive impairment and memory problems. Review of resident #043's progress notes revealed an incident on an identified date, in which resident #042 had demonstrated identified responsive behaviours toward resident #043. When interviewed by RPN #130 resident #043 did not recall the incident, or appear upset. Resident #043 was not able to be interviewed at the time of inspection.

In an interview, associate nurse manager (ANM) #134 who was the coordinator for the responsive behaviour program stated that resident #042 exhibited identified responsive behaviours toward co-residents. ANM #134 defined abuse of a resident and indicated certain activities between residents require consent.

ANM #134 was not aware how residents were assessed for their capacity to consent. ANM #134 stated that if resident #042 had demonstrated the above mentioned responsive behaviours toward residents #043, #044, #045, #046 and #047 without their consent it would be considered abuse.

In an interview, the DON stated that when an incident of witnessed, alleged or suspected abuse of a resident the home would look at the resident's capacity to consent. The DON further stated that the home assessed capacity to consent by looking at the resident's CPS score, and resident ability to make an informed decision. The DON stated no formal capacity assessments were being conducted as part of the protocol in the home. The DON acknowledged that residents #043, #044, #045, #046 and #047 did not have the capacity to consent based on their respective CPS scores. The DON acknowledged that the actions of resident #042 towards residents #043, #044, #045, #046 and #047 were considered to be abuse by the definition and the resident's lack of capacity to consent. In these cases the DON acknowledged that residents #043, #044, #045, #046 and #047 were not protected from abuse by resident #042.

The severity of this noncompliance was potential for actual harm. The scope of the noncompliance was widespread as five residents were affected. A review of the home's compliance history revealed two compliance orders had been previously issued related to LCTHA, 2007, S.O. 2007, c.8, s. 19. (1). Compliance order CO #001 was served on October 6, 2017, under inspection report 2017_414110_0007 with a compliance due date of November 17, 2017. Compliance order CO #001 was served on February 23, 2017, under inspection report 2016_414110_0008 with a compliance due date of February 23, 2017, and was compiled on June 9, 2017. As a result of ongoing noncompliance with LCTHA, 2007, S.O. 2007, c.8, s. 19. (1) a compliance order is warranted. (643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 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 : 003

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

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 :

Upon receipt of this compliance order the license shall prepare, submit and implement a plan to ensure compliance with LTCHA, 2007, S.O. 2007, c.8, s. 24. (1). The plan should include but not be limited to:

1. Education to all management level employees responsible for completing Critical Incident System reports on the forms of abuse and neglect of residents which are to be reported immediately to the Director;
2. Education to all staff regarding the duty under LTCHA, 2007, S.O. 2007, c.8, s. 24. (1) to report suspected abuse or neglect of a resident; and
3. Maintain a record of education provided and date staff receive education.

Please submit the plan no later than January 18, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A CIR was submitted to the MOHLTC on an identified date. Review of the CIR

revealed that on the previous day, a PSW witnessed resident #042 demonstrating an identified responsive behaviour toward co-resident #043. An amendment to the CIR submitted three weeks following the CIR, revealed that there were other incidents of a similar nature involving resident #042 spanning a three month period leading up to the incident reported in the CIR.

Review of resident #042's progress notes revealed the following incidents in which it was witnessed, alleged or suspected that resident #042 had demonstrated specified responsive behaviours toward co-residents:
- On an identified date, resident #048 reported to RPN #132 that he/she witnessed resident #042 demonstrating specified responsive behaviours toward co-resident #047 in a common area;
- Two weeks following the first above mentioned incident, a PSW reported RPN #132 that resident #042 was found in a common area with resident #046. Resident #042 and #046 were engaged in a specified responsive behaviour; and
- Ten weeks after the first incident, resident #044 reported that resident #042 had demonstrated a specified responsive behaviour toward him/her when leaving a program.

Review of the MOHLTC Critical Incident System database failed to reveal a CIR for the incidents of witnessed, alleged or suspected abuse of residents on the three above mentioned dates.

In an interview, ANM #134 stated that he/she had become aware of the first above mentioned witnessed incident, but was not sure when it was reported to him/her. A progress note by ANM #134 in resident #042's electronic health record indicated that a meeting with staff was held by ANM #134 three days following the incident, to discuss the behaviour of resident #042 and strategies to manage the behaviours. ANM #134 stated this incident was not reported immediately to the Director. ANM #134 stated that he/she had become aware of the allegations of abuse of resident #044 on the above mentioned identified date, and did not report to the Director as he/she investigated and it was not a witnessed incident. ANM #134 acknowledged that allegations of abuse of a resident are expected to be reported immediately to the Director.

In an interview, NM #135 stated that it is the expectation of the home for staff to report any witnessed, alleged or suspected abuse of a resident to the nurse managers or DON, and the management would complete the CIR. NM #135 further stated that he/she had become aware of the incident of witnessed abuse

of resident #046 that occurred on the above mentioned date, though was not sure when he/she became aware. NM #125 stated that he/she was not sure if the incident was immediately reported to the Director.

In an interview, the DON stated that it was the responsibility of the nurse managers to complete the CIR with help of the unit staff for any witnessed, alleged or suspected incidents of abuse of a resident. The DON acknowledged that the three above mentioned incidents were considered abuse of a resident and that they were not immediately reported to the Director.

The severity of this noncompliance was identified as potential for actual harm and the scope was identified as a pattern. A review of the home's compliance history revealed previous noncompliance was issued related to LCTHA, 2007, S.O. 2007, c.8, s. 24. (1) as a Written Notification (WN) under inspection reports #2017_414110_0007 and #2016_414110_0008. As a result of the severity, scope and compliance history related to LCTHA, 2007, S.O. 2007, c.8, s. 24. (1) a compliance order is warranted. (643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 27, 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 4th day of January, 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 : Adam Dickey

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