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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 12, 2015	2015_396103_0012	O-001431-14	Critical Incident System

Licensee/Titulaire de permis

2109577 ONTARIO LIMITED
195 Forum Drive Unit 617 MISSISSAUGA ON L4Z 3M5

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

2109577 ONTARIO LIMITED O/A ARBOUR HEIGHTS
564 Tanner Drive KINGSTON ON K7M 0C3

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

DARLENE MURPHY (103)

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): February 9-11, 2015

The following logs were included with this inspection: O-001431-14 and O-001628-15.

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Dietitian, the Director of Care (DOC) and the Administrator.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 by not following the home's zero tolerance of abuse policy.

Resident #1 is a cognitively intact resident. On a designated date, Resident #1 approached RPN S#100 and reported having problems involving PSW S#107 during the previous night. Resident #1 described that S#107 would answer the call bell and then inform the resident she couldn't assist them at that time and on one occasion did not return for over an hour. Resident #1 described having been incontinent on two occasions during that night because they didn't receive the toileting assistance required. Resident #1 also reported that at one point during the night, S#107 pulled on the resident so hard and so quickly that the resident fell onto the floor.

RPN S#100 was interviewed and stated the resident was very upset. She stated Resident #1 at times requires increased assistance due to their designated diagnosis. S#100 provided reassurance to the resident and stated she would follow up. S#100 reported the information to RN S#101 who in turn immediately reported the allegations to DOC #103.

The DOC was interviewed and stated she was informed of the allegations late in the evening on the designated date and believed she had enough cause to suspect abuse or improper care at that time. The DOC stated she was aware the staff member accused of the allegations was due to start the night shift and directed the RN to reassign this staff member to another resident home area. The DOC stated normally the staff member would be immediately suspended from work, but given the fact the staff member's shift was to start imminently she decided to allow the staff member to work. The DOC further stated the staff member was placed off work following that night shift pending the home's investigation into the allegations.

The Administrator was interviewed and stated in order to protect all residents from abuse, staff members are to be immediately suspended with pay pending a full investigation into the allegations. The Administrator stated that it would have been in keeping with the home's procedures to send the staff member home, advising them an investigation was underway and to expect to be contacted by the DOC the next day.

The DOC advised this inspector that the Director (Ministry of Health and Long Term Care-MOHLTC) was first informed of the allegations of abuse/improper care the following day when a critical incident report was submitted. The DOC stated at the time of this incident, she was unaware allegations of abuse and neglect needed to be immediately reported to MOHLTC.

The home's zero tolerance of abuse policy, ADM-VI-06, states under "Mandatory Reporting to the MOHLTC", 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:
-improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident,
-abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

Additionally, the DOC confirmed that she had asked the RN to obtain a statement from the staff member involved in the allegation. The RN was interviewed and confirmed she approached the staff member several times throughout the night shift but the staff member stated she would contact the DOC the following day. A written statement was not provided until eight days following the alleged incident.

The home's zero tolerance of abuse policy, ADM-VI-06, under Procedures-"Staff member alleged to have caused the abuse or neglect", states document the details as soon as possible including dates, times and witnesses.

The Administrator confirmed the home should have contacted the staff member to obtain the written statement in a more timely manner.

The home's compliance history was reviewed for the past three years:
In December 2014, the home was issued a Written notification (WN) and a Voluntary Plan of Correction (VPC) for failing to comply with the LTCHA, 2007 s. 24 (failure to immediately report instances of alleged abuse to the Director) and a WN for failing to comply with LTCHA, 2007 s. 23 (1) (failing to immediately investigate an allegation of abuse/neglect).

In October 2012, the home was issued a WN and a VPC for failing to comply with LTCHA, 2007 s. 23 (2) (failure to report to the Director the results of every investigation into allegations of abuse/neglect).

In January 2012, the home was issued a WN for failing to comply with O. Regs 79/10 s. 96 (written policy of abuse) and a WN for failing to comply with LTCHA, 2007 s. 20 (failing to comply with the zero tolerance of abuse policy).

The home has demonstrated ongoing non compliance related to abuse reporting and

compliance with the home's zero tolerance of abuse policy. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure policies set out under the Fall Prevention Program as required under O. Regs 79/10 s. 49 were complied with. O. Regs 79/10 s. 49 (2) states, when a resident has fallen, the resident is assessed and a post fall assessment is conducted.

On a designated date, during the night shift, Resident #1 reported PSW S#107 pulled so hard and so quickly that the resident fell out of bed and onto the floor. The resident stated they waited on the floor until S#107 called for another staff member to assist in returning the resident to bed.

PSW S#102 was interviewed and stated she was working as a float on the identified date. She recalled receiving a call from S#107 requesting her assistance in changing the resident's bed. The staff member stated when she arrived in the resident room a few minutes later, the resident was sitting on the floor beside the bed with their back against the bed. The staff member stated she assisted S#107 to return the resident to bed. The staff member went on to say that it wasn't until the following day that she learned the resident had not been assessed by a registered staff member prior to their moving the

resident back into bed. S#102 stated it is the home's policy to have a registered staff member assess all resident's who have fallen prior to them being moved. S#102 stated because she was not directly responsible for Resident #1 that night, she assumed the registered staff had already assessed the resident prior to her arriving to the room.

RN S#101 was interviewed and confirmed she was working on the identified night shift. She stated that she had not been advised of Resident #1's fall. Upon being made aware of the fall on the following evening, S#101 stated she completed a post fall assessment of Resident #1 and did not find any injuries.

The home's Fall Prevention and Management Program policy, RCSM-E-115 was reviewed. The policy defines a fall as any unintentional change in position where the resident ends up on the floor, ground or other lower level.

Under "Fall and Post Fall Assessment and Management", the policy indicates, when a resident has fallen, the resident will be assessed regarding the nature of the fall and associated consequences, the cause of the fall and the post-fall care management needs. The Person witnessing the fall shall not move the resident until a full head to toe assessment has been conducted and appropriate action determined.

According to the DOC, PSW S#107 was unclear as to why she did not follow the protocol of reporting the fall to a registered staff member. S#107 did receive disciplinary actions as a result which included reviewing the home's fall policy. [s. 8. (1) (a),s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence.

Resident #1 was interviewed and had full recall of the events that occurred during the identified night shift.

Resident #1 stated that during that night, he/she had rang the call bell on at least two occasions. The resident described that S#107 would answer the bell and then say she couldn't assist the resident at that time and on one occasion did not return for over an hour. Resident #1 described having been incontinent on two occasions during that night because they didn't receive the toileting assistance required. The resident described feeling embarrassed and stated other staff have no problem providing the required assistance.

RPN #100 was interviewed and recalled the resident was upset while telling her the details of the previous night. She stated Resident #1 at times requires increased assistance due to the identified diagnosis. S#100 provided reassurance to the resident and stated she would follow up. S#100 also stated this resident tends to require more assistance with care during the night shift.

PSW #102 was interviewed and stated she knows the resident well. The staff member stated on nights, the resident sometimes requires assistance with repositioning and toileting. The PSW went on to say that the resident is able to ring for assistance and that it is uncommon for the resident to be incontinent when provided the assistance required.

PSW S#107 was disciplined for failing to provide the resident with the required assistance for toileting. [s. 51. (2) (c)]

Issued on this 12th day of February, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2015_396103_0012
Log No. / Registre no:	O-001431-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 12, 2015
Licensee / Titulaire de permis :	2109577 ONTARIO LIMITED 195 Forum Drive, Unit 617, MISSISSAUGA, ON, L4Z-3M5
LTC Home / Foyer de SLD :	2109577 ONTARIO LIMITED O/A ARBOUR HEIGHTS 564 Tanner Drive, KINGSTON, ON, K7M-0C3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To 2109577 ONTARIO LIMITED, 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. 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 :

The licensee is hereby ordered to ensure the home's abuse policy, ADM-VI-06 is followed for every alleged, suspected or witnessed incident of resident abuse or neglect.

The licensee shall ensure a monthly monitoring system is in place to audit the home's reporting of and investigation into each incident of alleged resident abuse or neglect to determine compliance with the abuse policy.

The licensee will develop and implement a system to address and re-educate, if deemed appropriate, staff and managers when the abuse policy is not complied with.

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse by not following the home's zero tolerance of abuse policy.

Resident #1 is a cognitively intact resident. On a designated date, Resident #1 approached RPN S#100 and reported having problems involving PSW S#107 during the previous night. Resident #1 described that S#107 would answer the call bell and then inform the resident she couldn't assist them at that time and on one occasion did not return for over an hour. Resident #1 described having been incontinent on two occasions during that night because they didn't receive the toileting assistance required. Resident #1 also reported that at one point during the night, S#107 pulled on the resident so hard and so quickly that the resident fell onto the floor.

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In January 2012, the home was issued a WN for failing to comply with O. Regs 79/10 s. 96 (written policy of abuse) and a WN for failing to comply with LTCHA, 2007 s. 20 (failing to comply with the zero tolerance of abuse policy).

The home has demonstrated ongoing non compliance related to abuse reporting and compliance with the home's zero tolerance of abuse policy. [s. 19. (1)]

(103)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 26, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 12th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DARLENE MURPHY

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