Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 29, 2019	2019_786744_0016 (A1) (Appeal\Dir#: DR #122)	007753-19	Complaint

Licensee/Titulaire de permis

St. Joseph's Health Centre of Sudbury
1140 South Bay Road SUDBURY ON P3E 0B6

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

St. Gabriel's Villa of Sudbury
4690 Municipal Road 15 Chelmsford ON P0M 1L0

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

Amended by STEVEN NACCARATO (744) - (A1)(Appeal\Dir#: DR #122)

Amended Inspection Summary/Résumé de l'inspection modifié

This report has been revised to reflect a decision of the Director on a review of the inspector's order. The Director's Review was completed on July 19, 2019. The order was revised to reflect the Director's Review.

Issued on this 29th day of July, 2019 (A1)(Appeal\Dir#: DR #122)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

Amended by STEVEN NACCARATO (744) - (A1)(Appeal/Dir# DR #122)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 13-17, 2019

The following intake was inspected during the Complaint inspection:

-One intake related to a complaint submitted to the Director regarding concerns about resident care and residents' rights

A Critical Incident Inspection #2019_752627_0008 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Interdisciplinary Team Members, Family Council member, residents and family members.

The inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Medication
Nutrition and Hydration

During the course of the original inspection, Non-Compliances were issued.

4 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	Légende 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

A complaint was submitted to the Director, regarding visitation restrictions, imposed by the home, between resident #001 and the complainant.

Inspector #627 interviewed the complainant who stated that the home had restricted their visitation with resident #001, whereby, they could only visit the home when resident #001's substitute decision maker (SDM) visited. The complainant stated that they had visited for a specified time frame and they assisted resident #001 with activities of daily living.

The complainant indicated that they felt they were no longer allowed to visit with the resident as they had advocated for the resident, by bringing forward concerns when they felt that care was not provided as per the resident's plan of care. The complainant indicated that they felt they had been restricted from visiting the home, after they forwarded concerns about incomplete care to the management of the home.

The complainant further stated that the home was very dissatisfied with them being an advocate for resident #001. The complainant further stated to the Inspector that they felt that resident #001's health condition was deteriorating. They further indicated that they were missing an opportunity to spend time with the resident which was decreasing resident #001's quality of life, as the resident should be allowed to visit with all their family members.

The complainant informed the Inspector that being placed on restricted visits was retaliation towards them for bringing forth care concerns and that the

Administrator was punishing them. The complainant indicated that the home had presented them (resident #001's family) with three choices; move resident #001 to another home, move resident #001 back home and care for them there, or conform to their directives. The complainant stated that they felt they had no choice but to agree to the home's directives as the resident was no longer able to be cared for in their home.

Inspector #744 reviewed the home's policy titled "Resident's Handbook- Resident Rights", (no revision date), which indicated that "Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference".

Inspector #744 reviewed correspondence written by the Administrator, which was addressed to resident #001's SDM, which outlined the home's concerns towards the complainant's role in the care of the resident and the complainant's conduct towards staff. Staff had reported feeling uncomfortable with the way the complainant portrayed their discontent with the care being provided. The letter also indicated that the complainant's excessive care of resident #001 was not helping, but rather harming the resident by interfering with their directives.

Inspector #744 reviewed additional correspondence from the Administrator to the complainant which indicated visitation restrictions including supervised visits only with resident #001's SDM.

Inspector #744 reviewed resident #001's progress notes, which indicated a discussion from Interdisciplinary Team Member #111 with the resident's family member and resident #001's SDM relating to the resident's condition. The family was made aware of an identified change in the resident's care level.

Inspector #744 and #627 interviewed resident #001's SDM who stated they had spoken to the Administrator to ask when the complainant could visit the resident without restrictions. The Administrator responded that the complainant could not visit unrestricted until a specified date, when the situation would be revisited. The SDM indicated in an interview with Inspector #744 that the complainant was very helpful with resident #001 and there were no issues with the complainant visiting resident #001 at any time.

Inspector #744 interviewed Interdisciplinary Team Member #110 who indicated that they believed that the residents' rights to receive visitors had not been

respected and that the complainant by not being present, was taking away from the quality of life from resident #001. They felt that resident #001 was used to seeing the complainant and liked their presence.

Inspector #744 and #627 interviewed the Administrator who stated that the complainant had their visits with resident #001 restricted as they had over stepped the boundaries with staff, and that they were not to be present with resident #001 during specified time frames. When asked by the Inspectors regarding the response to the SDM question of the complainant being able to visit without restrictions, the Administrator was unable to recall the SDMs request but provided meeting notes specific to other areas of concerns.

The Administrator stated that it was a culmination of things, that had lead to the visitation restrictions, and that after the Assistant Director of Care (ADOC), the DOC and themselves had spoken with staff, they wished that the complainant was not present with resident #001 during specified time frames. The Administrator stated that they recognized the progression of resident #001's health status and that they would review with the DOC, who would speak to staff and determine if and how the visitation rights would be altered, and communicate the following to resident #001's SDM. [s. 3. (1) 14.]

Additional Required Actions:

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

(A1)(Appeal/Dir# DR #122)
The following order(s) have been amended: CO# 001

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A complaint was submitted to the Director, regarding alleged concerns that staff were not providing appropriate care for resident #001.

Inspector #744 reviewed the home's policy titled "Careplanning" dated September 29, 2003, which stated that Interprofessional team members shall provide care to the resident as set out in the plan.

Inspector #744 reviewed resident #001's current care plan, which indicated that a specified intervention was to be used by staff when providing care.

Inspector #744 observed care being provided to resident #001 by Interdisciplinary Team Member #101 and #113. Interdisciplinary Team Member #101 asked Interdisciplinary Team Member #113 if there was the specified intervention available for resident #001, to which Interdisciplinary Team Member #113 replied "nope, I think it's on backorder". Resident #001 was cared for without the specified intervention. Resident #001 cried out in pain during care. Interdisciplinary Team Member #101 and #113 questioned each other as to why resident #001 was in more pain and mentioned that they will report the increased pain to the registered staff.

In an interview with Inspector #744, Interdisciplinary Team Member #101 indicated that the specified intervention was in resident #001's care plan and was used to prevent pain when providing a specific type of care. Interdisciplinary Team Member #101 stated that the specific intervention should have been used before care was preformed to reduce pain but that it was too late to retrieve the intervention because both Interdisciplinary Team Members were already in resident #001's room.

Inspector #744 interviewed Interdisciplinary Team Member #113 who indicated

that the specified intervention should be retrieved from registered staff before performing care on resident #001. Interdisciplinary Team Member #113 stated that the specified intervention listed in the care plan would help to reduce pain. It was also mentioned that Interdisciplinary Team Member #113 chose to "let it go" and not use the specified intervention because it was a "once in a lifetime occurrence" that the specified intervention was missing in resident #001's room.

In an interview with Inspector #744, Interdisciplinary Team Member #112 stated that the specified intervention was in resident #001's care plan because it was important to maintain the resident's health status. Interdisciplinary Team Member #112 stated that a staff member would notify them when more of the specified intervention was required and the intervention was available at the home.

Inspector #744 interviewed the DOC who acknowledged that the specified intervention was to be used during care. The DOC indicated that staff should have followed the care plan and that "following the care plan can sometimes be missed in the real world when there are many patients to see." [s. 6. (7)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

A complaint was submitted to the Director, regarding concerns with resident #001's care.

Inspector #627 interviewed the complainant who stated that they were not satisfied with the care provided by the home's staff and emailed a complaint outlining concerns of resident #001 to the Administrator and the DOC.

Inspector #744 reviewed the home's policy titled "Complaints, Concerns, and Suggestions Process" dated September 11, 2010, which stated that "Immediately upon receiving a written compliant concerning the care of a resident or operation of the long-term care home the Administrator or delegate will forward it to the Centralized Intake, Assessment and Triage Team (CIATT) of the Ministry of Health, Long Term Care".

Inspector #627 and Inspector #744 interviewed the DOC who acknowledged that the email sent to them from the complainant was not reported to the Ministry as "it was not a valid complaint" and that "staff had provided care and did not have to be investigated".

Inspector #627 and Inspector #744 interviewed the Administrator who acknowledged that the complainant's email was not submitted to the Ministry because this email was not taken as a complaint as there was no risk to resident #001 during the provision of care. [s. 22. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 65. No interference by licensee
A licensee of a long-term care home,
(a) shall not interfere with the meetings or operation of the Residents' Council or the Family Council;
(b) shall not prevent a member of the Residents' Council or Family Council from entering the long-term care home to attend a meeting of the Council or to perform any functions as a member of the Council and shall not otherwise hinder, obstruct or interfere with such a member carrying out those functions;
(c) shall not prevent a Residents' Council assistant or a Family Council assistant from entering the long-term care home to carry out his or her duties or otherwise hinder, obstruct or interfere with such an assistant carrying out those duties; and
(d) shall ensure that no staff member, including the Administrator or other person involved in the management or operation of the home, does anything that the licensee is forbidden to do under clauses (a) to (c). 2007, c. 8, s. 65.

Findings/Faits saillants :

1. The licensee has failed to ensure that a member of the Family Council was not prevented from entering the home to attend a meeting of the Council.

A complaint was submitted to the Director, regarding care and residents' rights concerns towards resident #001.

Inspector #627 interviewed the complainant who stated that they had been restricted from visiting the home, unless accompanied by resident #001's SDM. They further stated that they no longer attended the Family Council meetings as they were not to be on the property unless accompanied by resident #001's SDM.

Inspector #627 reviewed a written letter from the Administrator to the complainant, which indicated "Your visits to the home must be supervised by [resident #001's SDM]".

During a further interview with Inspector #627, the complainant stated they had asked the Administrator about attending the Family Council meetings, to which the Administrator had answered that they were only allowed on the premises if resident #001's SDM was with them. As resident #001's SDM had not been a member of the Family Council and had not wished to participate, they were unable to attend the Family Council meetings.

Inspector #627 interviewed a Family Council member, who stated that the complainant was a member of the Family Council and attended the Family Council meetings; however, they had not attended as they were not allowed in the home (where the meetings were held), unless accompanied by resident #001s SDM.

Inspector #627 interviewed the DOC who acknowledged that the complainant was not to enter the building without resident #001's SDM present, however, they had not thought or been asked about attending the Family Council meeting.

Inspector #744 interviewed the Administrator who stated that they did not recall the complainant asking specifically about attending the Family Council meetings; however, if they had asked, they would have been informed that they were only to attend a Family Council meeting, if resident #001's SDM was in the home. [s. 65. (b)]

Issued on this 29th day of July, 2019 (A1)(Appeal/Dir# DR #122)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	Amended by STEVEN NACCARATO (744) - (A1) (Appeal/Dir# DR #122)
Inspection No. / No de l’inspection :	2019_786744_0016 (A1)(Appeal/Dir# DR #122)
Appeal/Dir# / Appel/Dir#:	DR #122 (A1)
Log No. / No de registre :	007753-19 (A1)(Appeal/Dir# DR #122)
Type of Inspection / Genre d’inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 29, 2019(A1)(Appeal/Dir# DR #122)
Licensee / Titulaire de permis :	St. Joseph's Health Centre of Sudbury 1140 South Bay Road, SUDBURY, ON, P3E-0B6
LTC Home / Foyer de SLD :	St. Gabriel's Villa of Sudbury 4690 Municipal Road 15, Chelmsford, ON, P0M-1L0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Ray Ingriselli

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To St. Joseph's Health Centre of Sudbury, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or

another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

(A1)(Appeal/Dir# DR #122)
The licensee must be compliant with Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.3 (1) 14.

Specifically, the licensee must:
a) Ensure that the rights of all residents are fully respected and promoted by allowing all family members and visitors to visit the resident without interference and restrictions.
b) Develop and implement strategies to deal with potentially threatening conduct by visitors while upholding a resident's personal rights to receive visitors without interference or restrictions. Strategies may include, but not limited to, establishing cooperative role behaviours for family and friends, informing the visitor of the behaviour changes that he or she needs to make, recommending that the visitor have a support person present during visits with a resident, limiting the care that the visitor is providing the resident; attending regular meetings with the interdisciplinary team related to specific issues, continue its attempts to resolve the issue and evaluate the appropriateness of mitigation strategies etc….
c) The Licensee will ensure a support person, chosen by the visitor, is permitted to be in attendance at each meeting.

The Order must be complied with by August 15, 2019.

Grounds / Motifs :

1. The licensee has failed to ensure that every resident had the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

A complaint was submitted to the Director, regarding visitation restrictions, imposed by the home, between resident #001 and the complainant.

Inspector #627 interviewed the complainant who stated that the home had restricted their visitation with resident #001, whereby, they could only visit the home when resident #001's substitute decision maker (SDM) visited. The complainant stated that they had visited for a specified time frame and they assisted resident #001 with activities of daily living.

The complainant indicated that they felt they were no longer allowed to visit with the resident as they had advocated for the resident, by bringing forward concerns when they felt that care was not provided as per the resident's plan of care. The complainant indicated that they felt they had been restricted from visiting the home, after they forwarded concerns about incomplete care to the management of the home.

The complainant further stated that the home was very dissatisfied with them being an advocate for resident #001. The complainant further stated to the Inspector that they felt that resident #001's health condition was deteriorating. They further indicated that they were missing an opportunity to spend time with the resident which was decreasing resident #001's quality of life, as the resident should be allowed to visit with all their family members.

The complainant informed the Inspector that being placed on restricted visits was retaliation towards them for bringing forth care concerns and that the Administrator was punishing them. The complainant indicated that the home had presented them (resident #001's family) with three choices; move resident #001 to another home, move resident #001 back home and care for them there, or conform to their directives. The complainant stated that they felt they had no choice but to agree to the home's directives as the resident was no longer able to be cared for in their home.

Inspector #744 reviewed the home's policy titled "Resident's Handbook- Resident Rights", (no revision date), which indicated that "Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference".

Inspector #744 reviewed correspondence written by the Administrator, which was addressed to resident #001's SDM, which outlined the home's concerns towards the complainant's role in the care of the resident and the complainant's conduct towards staff. Staff had reported feeling uncomfortable with the way the complainant portrayed their discontent with the care being provided. The letter also indicated that the complainant's excessive care of resident #001 was not helping, but rather harming the resident by interfering with their directives.

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complainant which indicated visitation restrictions including supervised visits only with resident #001's SDM.

Inspector #744 reviewed resident #001's progress notes, which indicated a discussion from Interdisciplinary Team Member #111 with the resident's family member and resident #001's SDM relating to the resident's condition. The family was made aware of an identified change in the resident's care level.

Inspector #744 and #627 interviewed resident #001's SDM who stated they had spoken to the Administrator to ask when the complainant could visit the resident without restrictions. The Administrator responded that the complainant could not visit unrestricted until a specified date, when the situation would be revisited. The SDM indicated in an interview with Inspector #744 that the complainant was very helpful with resident #001 and there were no issues with the complainant visiting resident #001 at any time.

Inspector #744 interviewed Interdisciplinary Team Member #110 who indicated that they believed that the residents' rights to receive visitors had not been respected and that the complainant by not being present, was taking away from the quality of life from resident #001. They felt that resident #001 was used to seeing the complainant and liked their presence.

Inspector #744 and #627 interviewed the Administrator who stated that the complainant had their visits with resident #001 restricted as they had over stepped the boundaries with staff, and that they were not to be present with resident #001 during specified time frames. When asked by the Inspectors regarding the response to the SDM question of the complainant being able to visit without restrictions, the Administrator was unable to recall the SDMs request but provided meeting notes specific to other areas of concerns.

The Administrator stated that it was a culmination of things, that had lead to the visitation restrictions, and that after the Assistant Director of Care (ADOC), the DOC and themselves had spoken with staff, they wished that the complainant was not present with resident #001 during specified time frames. The Administrator stated that they recognized the progression of resident #001's health status and that they would review with the DOC, who would speak to staff and determine if and how the visitation rights would be altered, and communicate the following to resident #001's

SDM.

The severity of this issue was determined to be a level 2 as there was minimal harm to the resident. The scope of the issue was a level 1 as the issue was determined to be isolated. The home had a level 3 compliance history as they had on-going non-compliance with this section of the LTCHA that included:

-Written notification (WN) issued December 2018 (2018_3655679_0032)

(744)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 15, 2019(A1) (Appeal/Dir#: DR #122)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 29th day of July, 2019 (A1)(Appeal/Dir# DR #122)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by STEVEN NACCARATO (744) - (A1) (Appeal/Dir# DR #122)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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