Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 30, 2020	2019_752627_0025	023000-19, 023062-19, 023155-19, 000117-20	Complaint

Licensee/Titulaire de permis

Board of Management for the District of Parry Sound West
21 Belvedere Avenue PARRY SOUND ON P2A 2A2

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

Belvedere Heights
21 Belvedere Avenue PARRY SOUND ON P2A 2A2

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

SYLVIE BYRNES (627), SHELLEY MURPHY (684), STEVEN NACCARATO (744)

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): December 16-20, 2019, and January 8-9, 2020. Additional off-site activities were completed on December 23, 27, 30-31, 2019, January 3 and 6-7, 2020.

The following intakes, which were complaints submitted to the Director, were inspected during this Complaint inspection:

- One intake regarding care and repositioning of residents, and care delivery concerns regarding a Registered Nurse;
- One intake regarding repositioning and care of residents; and,
- One intake regarding an allegation of retaliation.

A Follow Up inspection, #2019_752627_0026 and a Critical Incident System inspection, #2019_752627_0027, were completed concurrently during this inspection.

PLEASE NOTE: written notifications and compliance orders related to LTCHA, 2007, s 20 (1) and s 24 (1), identified in the Critical Incident System (CIS) inspection, have been issued in this Complaint inspection report.

During the course of the inspection, the inspector(s) spoke with the previous Chief Executive Officer (CEO), current CEO, previous Director of Care (DOC), Physician, Nurse Practitioner (NP), Nurse Managers (NM), Program Coordinators (PCs), Information Technologist (IT), Union President, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff, residents and family members.

The Inspectors also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents, policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

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

- **3 WN(s)**
- **1 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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.
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, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:

A) Two complaints were submitted to the Director regarding care concerns toward resident #009. The complaint reports indicated that Registered Nurse (RN) #105 had told Personal Support Worker (PSW) #104 and Registered Practical Nurse (RPN) #118 to provide the resident with interventions and medications, in a manner inconsistent with what had been ordered by the Physician.

Inspector #627 reviewed resident #009's archived chart which documented the resident's health status and indicated the care, the treatments and medications resident #009 was to receive.

Inspector #627 reviewed the home's policy titled "Critical Incident Reporting", #NR G 501, ADM 2001, effective date, July 2017, which indicated that "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 was based to the

Director:
- Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident".

Inspector #627 reviewed the Ministry of Long Term Care's online reporting portal and could not identify a CIS report for the above incident.

Inspector #627 interviewed PSW #104 who stated that RN #105 had told them they would provide treatments and medications in a manner that may be harmful to resident #009. PSW #104 verbalized to the Inspector that they had immediately notified Chief Executive Officer (CEO) #100.

Inspector #627 interviewed RPN #118 who stated that resident #009 had returned from the hospital with a change to their health status. RPN #118 stated that RN #105 had approached them and told them to provide treatments and medications in a manner that may be harmful to resident #009 and that they had refused. RPN #118 further stated they felt this was incompetent care.

Inspector #627 interviewed RN #105. The Inspector asked RN #105 if they had directed staff to provide resident #009 with a specific treatment and medications to which RN #105 replied “yes, this was the physician’s order”.

Inspector #627 interviewed RN #123 who stated that the approach of RN #105, to provide treatments and medications in a manner that may be harmful to resident #009 was incompetent care and should have been reported.

Inspector #627 interviewed the Nurse Practitioner (NP) who, after reviewing the Physician's orders for the resident, stated RN #105, providing treatment and medications in the alleged manner was not appropriate.

Inspector #627 interviewed Physician #125 who stated that they remembered the incident with RN #105 and that they were “quite surprised by [their] actions, which was totally inappropriate, and not what I had told [them] to do”.

Inspector #627 interviewed Program Coordinator (PC) #122 who stated they had not spoken with RN #105; however, providing treatments and medications in a manner that may be harmful to resident #009 was not competent care, if that was the intent of RN #105.

Inspector #627 interviewed CEO #100. Inspector #627 asked CEO #100 if they felt this was incompetent care and if they had reported the incident to the Ministry. CEO #100 stated that they had not reported the incident to the Ministry and that this had been difficult, but "incompetence was a strong statement" and had RN #105 proceeded as alleged, they would have reported them to the Ministry.

B) A Critical Incident Report (CIS) was submitted to the Director on a specific date, for an incident of neglect, which had occurred three days prior. The CIS report indicated that while reviewing documentation, Director of Care (DOC) #101 had discovered flow sheets for three residents (resident #010, #011 and #012). The documentation indicated that the three residents were not provided with care for an entire shift.

Inspector #627 reviewed the home's policy titled "Critical Incident Reporting", #NR G 501, ADM 2001, effective date, July 2017, which indicated that "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 was based to the Director: Neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Inspector #684 interviewed CEO #100 regarding the CIS report submitted on a specific date. CEO #100 acknowledged that the report was submitted late.

2. A CIS report was submitted to the Director for neglect of resident #001 and #007 by staff, that occurred on a specified date.

During a review of the home's investigation notes for the critical incident that occurred on a specific date, Inspector #684 noted a letter addressed to PSW #110 regarding another incident involving PSW #110 which occurred on another date. The letter stated, "you neglected to provide care to a resident."

Inspector #684 reviewed the online reporting portal for the Ministry of Long-Term Care (MLTC) and noted that the incident which occurred on another date was not reported to the Director.

Inspector #684 reviewed the home's policy "Prevention of Abuse and Neglect Zero Tolerance", policy number PER-2300, effective October 2015, which stated "Belvedere Heights is mandated to make reports to the Director (Ministry of Health) on the following:

a) Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. b) Abuse of a resident by anyone or neglect of a resident by the Home or staff that has resulted in harm or a risk of harm to the resident".

Inspector #684 interviewed DOC #101 regarding the process for reporting abuse/neglect. DOC #101 stated “When abuse/neglect was suspected, we placed the person on suspension pending investigation, made sure the resident was safe, if after hours, called the after-hours CIS line and if the incident occurred during business hours, I start the CIS”.

Inspector #684 reviewed the investigation file with DOC #101, making note of the letter addressed to PSW #110 regarding an incident which occurred on another date. Inspector #684 asked DOC #101, was this resident neglected, to which DOC #101 replied “Yes, I probably should have submitted a [CIS report]”.

Additional Required Actions:

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

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

The licensee has failed to ensure that the home’s written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A) A CIS report was submitted to the Director on a specific date, regarding neglect of residents #010, #011 and #012. The CIS report indicated that documentation indicated that the three residents had not been provided with care on another specific date, for an

entire shift.

Inspector #627 reviewed the specific documentation which indicated that the aforementioned residents had not been provided with care for an entire shift due time constraint, when a new routine was implemented in the home.

Inspector #684 reviewed the home's policy titled "Critical Incident Reporting", policy number: NR G 501, ADM 2001, effective date July 2017, which described neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well being of one or more residents. Belvedere Heights has a resident centered, zero tolerance policy for abuse and neglect".

In separate interviews with PSW #103 and #104, they confirmed to Inspector #627 that residents #010, #011 and #012 had not been provided with care, due to a new routine in the home, which had caused time constraints. The PSWs stated that they had reported to DOC #101 that the above-mentioned residents had not been provided with care due to time constraints multiple times, and during a meeting on a specific date, after the shift.

In separate interviews with PSW #103 and #104, they both acknowledged that resident #010, #011 and #012 had not been provided with care throughout the shift. Both PSWs stated that they had made DOC #101 aware multiple times throughout the day of their inability to provide care to the aforementioned residents due to time constraints. DOC #101 denied being told throughout the day that PSW #103 and #104 were unable to provide care to three residents; however, it remains that residents #010, #011 and #012 were not provided with care.

B) Ontario Regulations (O.Reg.) 79/10, of the Long-Term Care Homes Act (LTCHA), 2007, defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

Two complaints were submitted to the Director regarding care concerns from by RN #105 to resident #009. Please see WN #1, item #1, for details.

During an interview with Inspector #627, RPN #118 stated that during a meal service, on a specific date, they had observed RN #105 lean on the dining room table where resident

#009 was sitting with three other residents and tell them something that seemed to upset the resident. RPN #118 stated that they had verbally reported the incident to CEO #100, when they had returned to the unit. CEO #100 had instructed them (RPN #118) to keep an eye on things, as they did not trust RN #105.

Inspector #627 reviewed the home's policy titled "Prevention of Abuse and Neglect -Zero Tolerance", #PER_2300, effective date October 2015, which defined emotional abuse as "any threatening, intimidating or humiliating gestures, actions, behaviours or remarks that were performed by anyone other than a resident" and that the home had "a resident centered, zero tolerance of abuse and neglect" .

Inspector #627 interviewed resident #014, who was resident #009's tablemate during meals, and had been present during the specific meal service. Resident #014 stated that the comments had upset resident #009 and that the nurse should not have said those things.

Inspector #627 interviewed PSW #104 who stated that they were in the dining room, during the specific meal service. PSW #104 stated that they could not overhear what was said, but that resident #009 had looked scared and a little shocked.

Inspector #627 interviewed RN #105 and asked them if they had told resident #009 something that had upset them, to which RN #105 replied that resident #009 knew about what they had told them already; "it was written everywhere".

Inspector #627 interviewed DOC #101 who stated that RN #105 had admitted to speaking with the resident in the dining room and that RN #105 should have chosen their words better.

Inspector #627 interviewed CEO #100 who stated that this had not been reported to them, and that they felt this was "not promoting resident's rights to have their information kept private and not emotional abuse".

2. A CIS report was submitted by the home to the Director on a specific date, which described care concerns towards resident #001 and #007, by PSW #110.

Inspector #684 reviewed the home's investigation file and noted an email from RPN #106 which indicated that they worked with PSW #110 on the specific date, describing their concern regarding the care provided by PSW #110 to resident #001. Inspector #684

noted a second email from RPN #106, dated one day later, regarding a second incident that occurred involving PSW #110. This incident was regarding PSW #110's provision of care towards resident #007.

Inspector #684 interviewed RPN #106 who informed the Inspector that suspected abuse/neglect was to be reported immediately. Together RPN#106 and Inspector #684 reviewed the two emails that RPN #106 submitted to DOC #101 and CEO #100. RPN #106 stated that it was a busy day on the specified day, and that they had documented the incidents and sent the emails to DOC #101 the following day, and that they "absolutely should have sent the email on [the specific date]".

Inspector #684 reviewed the home's policy titled "Critical Incident Reporting", policy number: NR G 501, ADM 2001, effective date July 2017, which stated "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".

Inspector #684 reviewed the home's policy titled "Prevention of Abuse and Neglect Zero Tolerance", policy number PER-2300, effective date October 2015, which stated "Belvedere Heights is mandated to make reports to the Director (Ministry of Health) on the following: 1)Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident, 2) Abuse of a resident by anyone or neglect of a resident by the Home or staff that has resulted in harm or a risk of harm to the resident".

Inspector #684 interviewed who acknowledged that this incident of abuse was reported late to both themselves and DOC #101.

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 O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal office.

Two complaints were submitted to the Director regarding care concerns toward resident #009, by RN #105. Please see WN #1, item #1 for details.

Inspector #627 reviewed the home's policy titled "Prevention of Abuse and Neglect: Zero Tolerance", policy # PER-2300, effective date October 2015, which directed to "immediately notify Police of any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence".

Inspector #627 interviewed CEO #100 who acknowledged that they had not called the police; "In that moment, it is not how I evaluated the situation". [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

Issued on this 30th day of January, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SYLVIE BYRNES (627), SHELLEY MURPHY (684), STEVEN NACCARATO (744)
Inspection No. / No de l'inspection :	2019_752627_0025
Log No. / No de registre :	023000-19, 023062-19, 023155-19, 000117-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 30, 2020
Licensee / Titulaire de permis :	Board of Management for the District of Parry Sound West 21 Belvedere Avenue, PARRY SOUND, ON, P2A-2A2
LTC Home / Foyer de SLD :	Belvedere Heights 21 Belvedere Avenue, PARRY SOUND, ON, P2A-2A2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kami Johnson

Ontario

Ministry of Long-Term Care

Ministère 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 Board of Management for the District of Parry Sound West, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 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. 24. Reporting certain matters to Director

Order / Ordre :

The licensee must be compliant with s. 24 (1) of the Long-Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee must:

1. Ensure that 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 was based to the Director:
i) Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident;
ii) 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;
iii) Unlawful conduct that resulted in harm or a risk of harm to a resident;
iv) Misuse or misappropriation of a resident's money; and,
v) Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:

A) Two complaints were submitted to the Director regarding care concerns toward resident #009. The complaint reports indicated that Registered Nurse (RN) #105 had told Personal Support Worker (PSW) #104 and Registered Practical Nurse (RPN) #118 to provide the resident with interventions and medications, in a manner inconsistent with what had been ordered by the

Physician.

Inspector #627 reviewed resident #009's archived chart which documented the resident's health status and indicated the care, the treatments and medications resident #009 was to receive.

Inspector #627 reviewed the home's policy titled "Critical Incident Reporting", #NR G 501, ADM 2001, effective date, July 2017, which indicated that "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 was based to the Director:
- Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident".

Inspector #627 reviewed the Ministry of Health's online reporting portal and could not identify a CIS report for the above incident.

Inspector #627 interviewed PSW #104 who stated that RN #105 had told them they would provide treatments and medications in a manner that may be harmful to resident #009. PSW #104 verbalized to the Inspector that they had immediately notified Chief Executive Officer (CEO) #100.

Inspector #627 interviewed RPN #118 who stated that resident #009 had returned from the hospital with a change to their health status. RPN #118 stated that RN #105 had approached them and told them to provide treatments and medications in a manner that may be harmful to resident #009 and that they had refused. RPN #118 further stated they felt this was incompetent care.

Inspector #627 interviewed RN #105. The Inspector asked RN #105 if they had directed staff to provide resident #009 with a specific treatment and medications to which RN #105 replied "yes, this was the physician's order".

Inspector #627 interviewed RN #123 who stated that the approach of RN #105, to provide treatments and medications in a manner that may be harmful to resident #009 was incompetent care and should have been reported.

Inspector #627 interviewed the Nurse Practitioner (NP) who, after reviewing the

Physician's order for the resident, stated RN #105, providing treatment and medications in the manner alleged was not appropriate.

Inspector #627 interviewed Physician #125 who stated that they remembered the incident with RN #105 and that they were "quite surprised by [their] actions, which was totally inappropriate, and not what I had told [them] to do".

Inspector #627 interviewed Program Coordinator (PC) #122 who stated they had not spoken with RN #105; however, providing treatments and medications in a manner that may be harmful to resident #009 was not competent care, if that was the intent of RN #105.

Inspector #627 interviewed CEO #100. Inspector #627 asked CEO #100 if they felt this was incompetent care and if they had reported the incident to the Ministry. CEO #100 stated that they had not reported the incident to the Ministry and that this had been difficult, but "incompetence was a strong statement" and had RN #105 proceeded as alleged, they would have reported them to the Ministry.

B) A Critical Incident Report (CIS) was submitted to the Director on a specific date, for an incident of neglect, which had occurred three days prior. The CIS report indicated that while reviewing documentation, Director of Care (DOC) #101 had discovered flow sheets for three residents (resident #010, #011 and #012). The documentation indicated that the three residents were not provided with care for an entire shift.

Inspector #627 reviewed the home's policy titled "Critical Incident Reporting", #NR G 501, ADM 2001, effective date, July 2017, which indicated that "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 was based to the Director: Neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Inspector #684 interviewed CEO #100 regarding the CIS report submitted on a specific date. CEO #100 acknowledged that the report was submitted late. (627)

2. A CIS report was submitted to the Director for neglect of resident #001 and

#007 by staff, that occurred on a specified date.

During a review of the home's investigation notes for the critical incident that occurred on a specific date, Inspector #684 noted a letter addressed to PSW #110 regarding another incident involving PSW #110 which occurred on another date. The letter stated, "you neglected to provide care to a resident."

Inspector #684 reviewed the online reporting portal for the Ministry of Long-Term Care (MLTC) and noted that the incident which occurred on another date was not reported to the Director.

Inspector #684 reviewed the home's policy "Prevention of Abuse and Neglect Zero Tolerance", policy number PER-2300, effective October 2015, which stated "Belvedere Heights is mandated to make reports to the Director (Ministry of Health) on the following: a) Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. b) Abuse of a resident by anyone or neglect of a resident by the Home or staff that has resulted in harm or a risk of harm to the resident".

Inspector #684 interviewed DOC #101 regarding the process for reporting abuse/neglect. DOC #101 stated "When abuse/neglect was suspected, we placed the person on suspension pending investigation, made sure the resident was safe, if after hours, called the after-hours CIS line and if the incident occurred during business hours, I start the CIS".

Inspector #684 reviewed the investigation file with DOC #101, making note of the letter addressed to PSW #110 regarding an incident which occurred on another date. Inspector #684 asked DOC #101, was this resident neglected, to which DOC #101 replied "Yes, I probably should have submitted a [CIS report]".

The severity of the issue was determined to be a level two, as there was minimal harm or risk of harm to the residents. The scope of the issue was a level three as it was widespread. The home had previous non-compliance in this area of the legislation which included:
Voluntary Plan of Correction (VPC), in March 2018, from inspection report 2019_657681_0027; and,
Written Notification (WN), in August 2019, from inspection report

Ontario

Ministry of Long-Term Care

Ministère 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

2019_786744_0025. (627)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Feb 13, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 # / No d'ordre : 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. 20. Policy to promote zero tolerance

Order / Ordre :

The licensee must be compliant with s. 20. (1) of the Long Term Care Homes Act (LTCHA) 2007.

Specifically, the licensee must:

1) Implement and document a system to monitor a staff member to ensure that all residents receive competent care. The monitoring system shall be provided to the Inspector upon request.
2) Ensure that the home's policy titled "Prevention of Abuse and Neglect-Zero Tolerance", #PER-2300, effective date October 2015, or any policy related to prevention of abuse and neglect, is complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A) A CIS report was submitted to the Director on a specific date, regarding neglect of residents #010, #011 and #012. The CIS report indicated that documentation indicated that the three residents had not been provided with care on another specific date, for an entire shift.

Inspector #627 reviewed the specific documentation which indicated that the aforementioned residents had not been provided with care for an entire shift due time constraint, when a new routine was implemented in the home.

Inspector #684 reviewed the home's policy titled "Critical Incident Reporting", policy number: NR G 501, ADM 2001, effective date July 2017, which described neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a

pattern of inaction that jeopardizes the health, safety or well being of one or more residents. Belvedere Heights has a resident centered, zero tolerance policy for abuse and neglect".

In separate interviews with PSW #103 and #104, they confirmed to Inspector #627 that residents #010, #011 and #012 had not been provided with care, due to a new routine in the home, which had caused time constraints. The PSWs stated that they had reported to DOC #101 that the above-mentioned residents had not been provided with care due to time constraints multiple times, and during a meeting on a specific date, after the shift.

In separate interviews with PSW #103 and #104, they both acknowledged that resident #010, #011 and #012 had not been provided with care throughout the shift. Both PSWs stated that they had made DOC #101 aware multiple times throughout the day of their inability to provide care to the aforementioned residents due to time constraints. DOC #101 denied being told throughout the day that PSW #103 and #104 were unable to provide care to three residents; however, it remains that residents #010, #011 and #012 were not provided with care.

B) Ontario Regulations (O.Reg.) 79/10, of the Long-Term Care Homes Act (LTCHA), 2007, defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

Two complaints were submitted to the Director regarding care concerns from by RN #105 to resident #009. Please see WN #1, item #1, for details.

During an interview with Inspector #627, RPN #118 stated that during a meal service, on a specific date, they had observed RN #105 lean on the dining room table where resident #009 was sitting with three other residents and tell them something that seemed to upset the resident. RPN #118 stated that they had verbally reported the incident to CEO #100, when they had returned to the unit. CEO #100 had instructed them (RPN #118) to keep an eye on things, as they did not trust RN #105.

Inspector #627 reviewed the home's policy titled "Prevention of Abuse and Neglect -Zero Tolerance", #PER_2300, effective date October 2015, which defined emotional abuse as "any threatening, intimidating or humiliating gestures, actions, behaviours or remarks that were performed by anyone other than a resident" and that the home had "a resident centered, zero tolerance of abuse and neglect" .

Inspector #627 interviewed resident #014, who was resident #009's tablemate during meals, and had been present during the specific meal service. Resident #014 stated that the comments had upset resident #009 and that the nurse should not have said those things.

Inspector #627 interviewed PSW #104 who stated that they were in the dining room, during the specific meal service. PSW #104 stated that they could not overhear what was said, but that resident #009 had looked scared and a little shocked".

Inspector #627 interviewed RN #105 and asked them if they had told resident #009 something that had upset them, to which RN #105 replied that resident #009 knew about what they had told them already; it was written everywhere".

Inspector #627 interviewed DOC #101 who stated that RN #105 had admitted to speaking with the resident in the dining room and that RN #105 should have chosen their words better.

Inspector #627 interviewed CEO #100 who stated that this had not been reported to them, and that they felt this was "not promoting resident's rights to have their information kept private and not emotional abuse". (627)

2. 2. A CIS report was submitted by the home to the Director on a specific date, which described care concerns towards resident #001 and #007, by PSW #110.

Inspector #684 reviewed the home's investigation file and noted an email from RPN #106 which indicated that they worked with PSW #110 on the specific date, describing their concern regarding the care provided by PSW #110 to resident #001. Inspector #684 noted a second email from RPN #106, dated one day later, regarding a second incident that occurred involving PSW #110. This

incident was regarding PSW #110's provision of care towards resident #007.

Inspector #684 interviewed RPN #106 who informed the Inspector that suspected abuse/neglect was to be reported immediately. Together RPN#106 and Inspector #684 reviewed the two emails that RPN #106 submitted to DOC #101 and CEO #100. RPN #106 stated that it was a busy day on the specified day, and that they had documented the incidents and sent the emails to DOC #101 the following day, and that they "absolutely should have sent the email on [the specific date).

Inspector #684 reviewed the home's policy titled "Critical Incident Reporting", policy number: NR G 501, ADM 2001, effective date July 2017, which stated "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".

Inspector #684 reviewed the home's policy titled "Prevention of Abuse and Neglect Zero Tolerance", policy number PER-2300, effective date October 2015, which stated "Belvedere Heights is mandated to make reports to the Director (Ministry of Health) on the following: 1)Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident, 2) Abuse of a resident by anyone or neglect of a resident by the Home or staff that has resulted in harm or a risk of harm to the resident".

Inspector #684 interviewed who acknowledged that this incident of abuse was reported late to both themselves and DOC #101.

The severity of the issue was determined to be a level two as there was minimal harm or minimal risk to the residents. The scope of the issue was a level three which indicated that the issue was widespread. The home had a level 3, which indicated previous non-compliance to the same subsection of the legislation that included:
- Compliance Order (CO), March 2019, from inspection report #2019_615609_0010;
- Voluntary Plan of Correction (VPC), September 2018, from inspection report #2018_615638_0005; and,
- VPC March 2018, from Inspection report 2018_615638_0005.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

(627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 13, 2020

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 Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 30th day of January, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sylvie Byrnes

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