Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 29, 2017	2017_655679_0013	024207-17	Resident Quality Inspection

Licensee/Titulaire de permis

North Shore Health Network
525 Causley Street P.O. Box 970 BLIND RIVER ON P0R 1B0

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

North Shore Health Network - LTC Unit
525 CAUSLEY STREET P. O. BOX 970 BLIND RIVER ON P0R 1B0

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

MICHELLE BERARDI (679), SHELLEY MURPHY (684)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 6-10, 2017.

Additional logs inspected during this RQI included:

-Two Critical Incidents the home submitted to the Director regarding resident to resident abuse; and
-One Follow-Up log regarding compliance order #001, issued during inspection #2016_283542_0007, regarding s. 15 (1), bed rail assessments.

During the course of the inspection, the inspector(s) spoke with the Chief Nursing Executive (CNE), Registered Nurse Manager, Resident Assessment Instrument (RAI) Coordinator, Education and Safety Coordinator, Behavioural Supports Ontario (BSO) staff, Registered Practical Nurse (RPNs), Maintenance staff, Personal Support Workers (PSWs), family members and residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, as well as reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2016_283542_0007	684

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 ensure that all residents were protected from abuse by anyone.

A) Inspector #679 reviewed two Critical Incident (CI) reports submitted to the Director by the home on two separate dates. The CI reports described two allegations of resident to resident abuse that occurred towards resident #002 by resident #001.

A review of the electronic records identified that resident #001 was a visitor to the home until a specific date in which they became a resident of the home.

Inspector reviewed resident #001's progress notes. The review of the electronic progress notes for resident #001 (while they were a visitor to the home) revealed four incidents related to responsive behaviours towards resident #002.

Inspector reviewed resident #001's progress notes. The review of the electronic progress notes for resident #001 (post admission to the home) revealed three incidents related to responsive behaviours towards resident #002.

In addition to the notes outlined above, Inspector #679 identified two occasions in which resident #001 displayed responsive behaviours towards other residents of the home.

A review of the electronic care plans for resident #002 revealed no focus or interventions to protect resident #002 from resident #001's responsive behaviours until a specific date.

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

Non-compliance related to s. 20 (1), of the LTCHA, 2007, was identified. Refer to WN #2, contained within this report for further detail.

In an interview with BSO RPN #112 they indicated that resident #001 exhibited responsive behaviours in the past. RPN #112 indicated that resident #001 targeted resident #002. Further, BSO RPN #112 identified that information regarding a resident's behaviours would be located in the residents care plan.

In an interview with the Nurse Manager, they indicated that they were unable to locate that there was any focus or interventions in the care plan for resident #002 prior to a specific date. Further, they confirmed that the behaviours should have been something

inputted into the care plan, and that it was an oversight.

In conclusion, the licensee failed to ensure that the home's policy to promote zero tolerance of abuse was complied with and failed to report any suspected/alleged abuse to the Director. Further, the home failed to implement interventions to protect resident #002 from the above stated instances of resident #001's responsive behaviours.

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 :

1. The licensee has failed to ensure that the policy promoting zero tolerance of abuse and neglect was complied with.

A) Inspector #679 reviewed a Critical Incident (CI) report submitted by the home to the Director for an incident of resident to resident abuse. The CI report indicated that resident #001 was found performing an inappropriate action towards resident #002.

A review of the CI report indicated that the incident occurred on a specific date; however, it was not reported until the following day, when the Nurse Manager was made aware.

B) Inspector #679 reviewed a CI report submitted to the Director for an incident of resident to resident abuse. The CI report indicated that resident #001 was found performing an inappropriate action towards resident #002.

A review of the CI report indicated that the incident occurred on a specific date, however,

it was not reported until the following day when the Nurse Manager was made aware.

In an interview with the Nurse Manager they identified that they were unsure if the failure to report was stemming from the RPN's working in the home or the charge nurses who worked in the adjoining hospital.

C) Inspector #679 reviewed the electronic progress notes for resident #001 and observed three incidents in which resident #001 performed inappropriate actions towards resident #002.

Inspector #679 reviewed the Ministry of Health and Long-Term Care's online reporting portal and was unable to identify that a CI report was submitted for any of the incidents outlined in the progress notes.

A review of the policy entitled "Abuse Policy" last revised August 2017, identified that "any person that witnesses or suspects abuse of a resident/patient must report the incident to the Manager or designate immediately". Further, the policy indicated that the manager will "complete a Ministry of Health and Long Term Care Critical Incident report of abuse as per the Long Term care Act 2007".

According to s. 24 (1) of the Long Term Care Homes Act, 2007, any person who has reasonable grounds to suspect that the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 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.

In an interview with RPN #104 they identified that any type of abuse was to be reported immediately to either the Nurse Manager or the Registered Nurse (RN) in charge.

In an interview with the Nurse Manager they identified that instances of abuse were to be reported immediately. Further, they identified that both CI reports were submitted to the Director one day late, and that a report was not submitted to the Director for the incidents outlined in the progress notes.

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. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, reported to the resident, the resident’s substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident’s attending physician or the registered nurse in he extended class attending the resident and pharmacy service provider.

On November 9, 2017, Inspector #684 completed a review of the medication incidents which occurred in the home over a one year period. Inspector #684 reviewed two separate medication error reports. Neither form indicated that the Substitute Decision Maker (SDM) was notified of the error.

Inspector #684 reviewed the electronic Point Click Care documentation for each medication incident and was unable to identify any indication that an error occurred or that the SDM was notified of the error.

Inspector #684 reviewed the "Medication Incident Report Form Guideline for Completion" policy and procedure dated July 2010 and the "Medication Standards" policy, last revised in October 2009. Neither policy indicated that staff were to notify the SDM of medication error incidents. Further, Inspector #684 reviewed the home's policy titled "Medication Incident and Error Management" provided by the Nurse Manager. The bottom of the policy indicated that this was a Draft policy. The draft policy did not indicate that a SDM was to be contacted when an error occurred.

In an interview with Inspector #684, RPN #104 identified that they would notify the SDM if an adverse reaction/change in condition occurred as a result of the error. Further, RPN #104 stated that if they were to notify the SDM of an error, they would document a note in Point Click Care.

Inspector #684 interviewed the Chief Nursing Executive (CNE), who confirmed that the policy did not indicate that staff were to contact the SDM when a medication error occurred.

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 ensuring that every medication incident involving a resident and every adverse drug reaction is reported to the resident and the resident's substitute decision-maker, if any, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring in the case of new items.

Inspector #684 observed the following used and unlabelled items:

- In the shower rooms: two bars of hand soap, two bottles of shampoo and conditioner, three razors, and one stick of deodorant; and,
- In the tub room: two sticks of deodorant, one bar of soap, one bottle of shampoo and conditioner, and a razor.

Inspector #679 reviewed the policy entitled "Admission Procedure LTC" last revised February 2011. The policy did not indicate that all resident belongings were to be labelled upon admission and upon acquiring thereafter.

In an interview with Inspector #684 on November 10, 2017, PSW #113 identified that when new resident items were brought into the facility they were to be labelled.

In an interview with Inspector #684 on November 10, 2017, the Nurse Manager indicated that all residents personal belongings were to be labelled.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's condition was reassessed and the effectiveness of the restraining was evaluated by a registered nursing staff at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Resident #004 was identified as having a potential restraint through a resident observation.

On November 7, 2017, Inspector #679 observed resident #004 with a potential restraint in place.

A review of the electronic care plan identified under the heading "Restraint" that the resident used a particular device.

Inspector #679 reviewed the "Restraint Record" for resident #004 and identified that on a number of occasions, registered staff did not document that the resident's condition was reassessed nor that the effectiveness of the restraint was evaluated.

A review of the home's policy entitled "Restraint/ PASD Policy" last revised July 2013, identified that the nurse or PSW would monitor the resident every hour for safety, proper positioning, and response to the restraint. The policy further indicated that the nurse or PSW would record on the restraint flow sheet the hourly monitoring of the patient/restraint for the response to the restraint, safety, and proper positioning.

In an interview with Inspector #679, RPN #104 identified that PSWs and RPNs were to document the resident's restraint use on the "Restraint Record" in the residents paper chart. Further, RPN #104 identified that all boxes on the Restraint Record should have been filled out.

In an interview with the Nurse Manager on November 8, 2017, they identified that staff were to chart on the Restraint Record each shift and that staff were to check on the resident every hour. Further, the Nurse Manager identified that registered staff were to document on each shift and that this was not done for resident #004.

2. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were documented; all assessment, reassessment and monitoring, including the resident`s response.

Resident #004 was identified as having a potential restraint through a resident observation.

On November 7, 2017, Inspector #679 observed resident #004 with a potential restraint in place.

A review of the electronic care plan, identified under the heading "Restraint" that the resident used a specific device.

Inspector #679 reviewed the "Restraint Record" for resident #004 and identified that on a number of occasions, the assessment, reassessment and monitoring of the restraint was not documented:

A review of the homes policy entitled "Restraint/ PASD Policy" last revised July 2013, identified that the nurse or PSW would monitor the resident every hour for safety, proper positioning, and response to the restraint. The policy further indicated that the nurse or PSW would record on the restraint flow sheet the hourly monitoring of the

patient/restraint for the response to the restraint, safety, and proper positioning.

In an interview with Inspector #679 on November 8, 2017, RPN #104 identified that PSWs and RPNs were to document the resident's restraint use on the "Restraint Record" in the residents paper chart.

In an interview with the Nurse Manager on November 8, 2017, they identified that staff were to chart on the Restraint Record each shift and that staff were to check on the resident every hour. Inspector #679 and the Nurse Manager reviewed the documentation, and identified that this was not done for resident #004.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared.
O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that once in every calendar year an evaluation to determine the effectiveness of the policy, and to identify what changes and improvements were required to minimize restraining and ensure that restraining was done in accordance with the Act and Regulation was completed.

On November 7, 2017, resident #004 and resident #006 were identified as having a potential restraints through a resident observation.

Inspector #679 reviewed the homes policy entitled "Restraint/ PASD Policy" which was last revised in July 2013.

In an interview with the Nurse Manager on November 8, 2017, they identified that the home did not conduct an evaluation to determine the effectiveness of the policy, nor identify what changes and improvements were required to minimize restraining. Further, the Nurse Manager indicated that the policy was last revised in July 2013. [s. 113. (b)]

Issued on this 16th day of January, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MICHELLE BERARDI (679), SHELLEY MURPHY (684)
Inspection No. / No de l'inspection :	2017_655679_0013
Log No. / No de registre :	024207-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 29, 2017
Licensee / Titulaire de permis :	North Shore Health Network 525 Causley Street, P.O. Box 970, BLIND RIVER, ON, P0R-1B0
LTC Home / Foyer de SLD :	North Shore Health Network - LTC Unit 525 CAUSLEY STREET, P. O. BOX970, BLIND RIVER, ON, P0R-1B0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	GASTON LAVIGNE

To North Shore Health Network, 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 shall ensure that all residents are protected from abuse by anyone.

Grounds / Motifs :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone.

A) Inspector #679 reviewed two Critical Incident (CI) reports submitted to the Director by the home on two separate dates. The CI reports described two allegations of resident to resident abuse that occurred towards resident #002 by resident #001.

A review of the electronic records identified that resident #001 was a visitor to the home until a specific date in which they became a resident of the home.

Inspector reviewed resident #001's progress notes. The review of the electronic progress notes for resident #001 (while they were a visitor to the home) revealed four incidents related to responsive behaviours towards resident #002.

Inspector reviewed resident #001's progress notes. The review of the electronic progress notes for resident #001 (post admission to the home) revealed three incidents related to responsive behaviours towards resident #002.

In addition to the notes outlined above, Inspector #679 identified two occasions in which resident #001 displayed responsive behaviours towards other residents of the home.

A review of the electronic care plans for resident #002 revealed no focus or

interventions to protect resident #002 from resident #001's responsive behaviours until a specific date.

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

Non-compliance related to s. 20 (1), of the LTCHA, 2007, was identified. Refer to WN #2, contained within this report for further detail.

In an interview with BSO RPN #112 they indicated that resident #001 exhibited responsive behaviours in the past. RPN #112 indicated that resident #001 targeted resident #002. Further, BSO RPN #112 identified that information regarding a resident's behaviours would be located in the residents care plan.

In an interview with the Nurse Manager, they indicated that they were unable to locate that there was any focus or interventions in the care plan for resident #002 prior to a specific date. Further, they confirmed that the behaviours should have been something inputted into the care plan, and that it was an oversight.

In conclusion, the licensee failed to ensure that the home's policy to promote zero tolerance of abuse was complied with and failed to report any suspected/alleged abuse to the Director. Further, the home failed to implement interventions to protect resident #002 from the above stated instances of resident #001's responsive behaviours.

The decision to issue this compliance order was based on the scope, which was determined to be a pattern, the compliance history which indicated that although non-compliance was not issued under this portion of the legislation, previous non-compliance was issued to the home, and the severity which was deemed to be potential for actual harm.
(679)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 12, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the policy promoting zero tolerance of abuse and neglect is complied with, specifically ensuring that any instances of abuse are reported immediately as per the Long Term Care Home's Act, 2007.

Grounds / Motifs :

1. The licensee has failed to ensure that the policy promoting zero tolerance of abuse and neglect was complied with.

A) Inspector #679 reviewed a Critical Incident (CI) report submitted by the home to the Director for an incident of resident to resident abuse. The CI report indicated that resident #001 was found performing an inappropriate action towards resident #002.

A review of the CI report indicated that the incident occurred on a specific date; however, it was not reported until the following day, when the Nurse Manager was made aware.

B) Inspector #679 reviewed CI report submitted to the Director for an incident of resident to resident abuse. The CI report indicated that resident #001 was found performing an inappropriate action towards resident #002.

A review of the CI report indicated that the incident occurred on a specific date, however, it was not reported until the following date when the Nurse Manager was made aware.

In an interview with the Nurse Manager they identified that they were unsure if the failure to report was stemming from the RPN's working in the home or the charge nurses who worked in the adjoining hospital.

C) Inspector #679 reviewed the electronic progress notes for resident #001 and observed three incidents in which resident #001 performed inappropriate actions towards resident #002.

Inspector #679 reviewed the Ministry of Health and Long-Term Care's online reporting portal and was unable to identify that a CI report was submitted for any of the incidents outlined in the progress notes.

A review of the policy entitled "Abuse Policy" last revised August 2017, identified that "any person that witnesses or suspects abuse of a resident/patient must report the incident to the Manager or designate immediately". Further, the policy indicated that the manager will "complete a Ministry of Health and Long Term Care Critical Incident report of abuse as per the Long Term care Act 2007".

According to s. 24 (1) of the Long Term Care Homes Act, 2007, any person who has reasonable grounds to suspect that the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 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.

In an interview with RPN #104 they identified that any type of abuse was to be reported immediately to either the Nurse Manager or the Registered Nurse (RN) in charge.

In an interview with the Nurse Manager they identified that instances of abuse were to be reported immediately. Further, they identified that both CI reports were submitted to the Director one day late, and that a report was not submitted to the Director for the incidents outlined in the progress notes.

The decision to issue this compliance order was based on the scope, which was determined to be a pattern, the compliance history which indicated that although non-compliance was not issued under this portion of the legislation, previous non-compliance was issued to the home, and the severity which was deemed to be potential for actual harm. (679)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 12, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
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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 December, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Michelle Berardi

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