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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Apr 24, 2013;	2013_168202_0002 (A1) (Appeal\Dir#: #20)	T-360-12	Follow up

Licensee/Titulaire de permis

SPECIALTY CARE INC
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

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

BLOOMINGTON COVE
13621 Ninth Line, Stouffville, ON, L4A-7X3

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

VALERIE JOHNSTON (202) - (A1)(Appeal\Dir#: #20)

Amended Inspection Summary/Résumé de l'inspection modifié

Note: This report has been revised to reflect a decision of the Director on a review of the Inspector's orders. The Director's review was completed on March 14, 2013. The Director's order is attached to this report.

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 prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 24 day of April 2013 (A1)(Appeal\Dir#: #20)

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

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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection/ Genre d'inspection
Apr 24, 2013;	2013_168202_0002 (A1) (Appeal/Dir# #20)	T-360-12	Follow up

Licensee/Titulaire de permis

SPECIALTY CARE INC
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

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

BLOOMINGTON COVE
13621 Ninth Line, Stouffville, ON, L4A-7X3

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

VALERIE JOHNSTON (202) - (A1)(Appeal/Dir# #20)

Amended Inspection Summary/Résumé de l'inspection modifié

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 prévue le Loi de 2007 les foyers de soins de longue durée

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 04, 07, 08, 09, 10, 11, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Nurse Practitioner, Registered Nursing Staff, Food Service Workers, Personal Support Workers, Residents

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, home policies related to Abuse and Neglect, Transferring and Positioning of residents

The following Inspection Protocols were used during this inspection:

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 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 failed to ensure that an identified resident is protected from physical and verbal abuse by staff. [s.19.(1)]

An interview with Personal Support Worker A (PSWA) revealed that on October 24, 2012 at 11:50 hours witnessed Personal Support Worker B (PSWB) slap resident #002 on the hand and state, "don't touch my breast, I will tell your wife". An interview with an identified Dietary Aide (DA) revealed in an interview that on October 24, 2012 at 11:50 hours heard a 'slap' and (PSWB) state "don't you touch my breast, I will tell your wife". An interview with (PSWB) revealed that on October 24, 2012 at 11:50 he/she moved resident #002's hand down from his/her left breast and state,"do not touch me, I will tell your wife".

An interview with (PSWA) revealed that the witnessed slap and verbal exchange on October 24, 2012 at 11:50 hours was reported to a member of the Housekeeping staff and an identified Registered staff member at 13:00 hours. An interview with the (DA) indicated that the slap and verbal exchange heard on October 24, 2012 at 11:50 hours was reported to an identified Food Service Worker at 13:30 hours.

An interview with the Director of Care (DOC) indicated that the witnessed slap and verbal exchange was reported by (PSWA) on October 24, 2012 at 13:40 hours and investigation commenced. The DOC revealed in an interview that (PSWB) was interviewed on October 24, 2012 at 14:00 hours and placed on Administrative leave pending results of the investigation. The DOC confirmed in an interview that the police, resident's SDM and the Director under the LTCHA were not notified.

A review of resident #002's clinical records for October 24, 2012 revealed that at 12:51 hours resident #002 had been agitated hitting staff and shaking fists at staff. On October 24, 2012 at 21:52 hours a skin assessment note written by an identified Registered Practical Nurse (RPN) revealed that resident #002 had bruises scattered on both forearms and hands measuring Lt forearm; 3cm x2.5, 2 cm x2cm, 1.5cm x1cm, Lt Hand;1cm x0.5cm, Rt forearm; 2cm x2cm, 2cm x2cm, 3cm x3cm, 1 cm x1cm, 1 cm x1cm, Rt hand; 2cm x1.5cm, 2 cmx1cm. An interview with the RPN indicated that resident #002 was found with increased bruising during the evening shift on October 24, 2012 prompting a skin assessment.

An interview with the DOC indicated that on October 30, 2012, (PSWB) was notified of his/her return to work. [s. 19. (1)]

Additional Required Actions:

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

(A1)(Appeal/Dir# #20)
The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe repositioning techniques when assisting residents. [s.36.]

Resident #001's plan of care directs staff to provide total assistance for all transferring and positioning and requires a tilt wheelchair for ambulation. Staff interviews revealed that on May 11, 2012 at 12:00 hours resident #001 was found in the dining room, sitting upright in his/her tilt wheelchair holding both hands toward chest with blood on the floor. The Nurse Practitioner indicated in an interview that resident #001's left fifth finger tip measuring 0.5 cm x1.0 cm was found between the pinch bars of the wheelchair's tilting mechanism after the wheelchair was tilted back in a reclined position. Resident #001 was immediately sent to hospital for further assessment and possible reattachment of left fifth finger digit.

An interview with the Director of Care and the Nurse Practitioner indicated that the laceration to resident #001's left fifth digit had occurred when resident #001 was tilted upright from a reclined position by staff. The Director of Care revealed in an interview that resident #001's hands were positioned outside the frame of the tilt wheelchair prior to repositioning causing resident #001's left fifth finger digit to become trapped and lacerated within the frame of the chair. [s. 36.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk to harm to the resident is immediately reported to the Director. [s.24.(1)2].

On October 24, 2012 at 13:40 hours an identified Personal Support Worker A (PSWA) reported to the Director of Care an incident of witnessed physical and verbal abuse by an identified Personal Support Worker B (PSWB) to resident #002.

An interview with the Director of Care (DOC) indicated that the witnessed incident of physical and verbal abuse reported on October 24, 2012 at 13:40 hours was not reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk to harm to the resident is immediately reported to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff receive training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to resident, prior to performing their responsibilities. [s.76(2)4].

Staff were interviewed during the course of this inspection on January 04,07,08,09,10 and 11, 2013 from all departments in the home. Staff interviews revealed that they were unaware of mandatory reporting under section 24 of the Act and had not received training. A review of the home's 'Jumpstart Preventing Abuse' educational program does not include training on mandatory reporting under section 24 of the Act. [s. 76. (2) 4.]

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 staff receive training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to residents, prior to performing their responsibilities, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse of the resident. [s.97.(1)(b)]

On October 24, 2012 at 13:40 hours an identified Personal Support Worker A (PSWA) reported to the Director of Care an incident of witnessed physical and verbal abuse by an identified Personal Support Worker B (PSWB) toward resident #002. An interview with the DOC confirmed that resident #002's SDM was not notified of the witnessed incident of physical and verbal abuse. [s. 97. (1) (b)]

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 resident's SDM and any other person specified by the resident are notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse of the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents contain an explanation of the duty under section 24 of the Act to make mandatory reports. [s.20. (d)]

The home's Abuse and Neglect of a Resident-Actual or Suspected, Policy #VI-G-10.00 revised October 2012 does not contain an explanation of the duty under section 24 of the Act to make mandatory reports. [s. 20. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff including the training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care. [s.96. (e) (i)].

The home's Abuse and Neglect of a Resident-Actual or Suspected, Policy #VI-G-10.00 revised October 2012 does not identify the training and retraining requirements for all staff including the training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care. [s. 96. (e)]

Issued on this 24 day of April 2013 (A1)(Appeal/Dir# #20)

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : VALERIE JOHNSTON (202) - (A1)(Appeal/Dir# #20)

Inspection No. / No de l'inspection : 2013_168202_0002 (A1)(Appeal/Dir# #20)

Appeal/Dir# / Appel/Dir#: #20 (A1)

Log No. / Registre no. : T-360-12 (A1)(Appeal/Dir# #20)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Apr 24, 2013;(A1)(Appeal/Dir# #20)

Licensee / Titulaire de permis : SPECIALTY CARE INC
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

LTC Home / Foyer de SLD : BLOOMINGTON COVE
13621 Ninth Line, Stouffville, ON, L4A-7X3

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

Ministère 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 Administrator / Nom de l'administratrice ou de l'administrateur : JANET IWASZCZENKO

To SPECIALTY CARE INC, 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) (b)

Linked to Existing Order / Lien vers ordre existant: 2011_080189_0028, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

(A1)(Appeal/Dir# #20)
The licensee shall:
a)Amend the licensees policy to promote zero tolerance of abuse and neglect of residents to ensure it provides all of the requirements in s. 20(2) of the LTCHA, including 20(2)(d) in that it shall contain an explanation of the duty under section 24 to make mandatory reports;
b)Provide a plan to the Director, for approval by the Director, identifying when all staff and volunteers within the homes that the licensee either owns or operates will receive training on any changes to the licensees policy to promote zero tolerance of abuse and neglect of residents, including the duty under section 24 to make mandatory reports.
c)Ensure that the licensee has a policy and a process to ensure the residents substitute decision-maker, if any, and any other person specified by the resident is notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the residents health or well-being; and are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.
d)Provide a plan to the Director with timelines to provide training to staff responsible for investigating incidents of alleged abuse or neglect so that the staff responsible are able to establish an atmosphere that encourages and supports staff in providing information in a manner that would not have the effect of potentially discouraging that reporting.

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

Ministère 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

Grounds / Motifs :

(A1)(Appeal/Dir# #20)
1. 1) The DOC did not establish an environment during the interviews with the witnesses to the alleged incident that contributed to ensuring the witnesses were comfortable and supported in bringing forward the information about what they had heard or witnessed.
2) The DOC did not report the alleged abuse to the Director under the LTCHA.
3) The policy of Specialty Care for Abuse and Neglect of a Resident-Actual or Suspected, fails to include an explanation of the Duty to report under section 24 of the Act.
4) Training provided to staff in the home does not provide for the explanation to report under section 24 of the Act and as a result staff only understood their obligation to report as reporting to their Charge Nurse.
5) The licensee failed to inform the substitute decision maker of the alleged abuse as required under s. 79 (1) of O.Reg 79 10. (202)

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

Apr 30, 2013(A1) (Appeal/Dir#: #20)

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2011_080189_0025, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff use safe repositioning techniques when assisting resident #001. Plan to be submitted to Valerie.Johnston@ontario.ca by February 04, 2013.

Grounds / Motifs :

1. The licensee failed to ensure that staff use safe repositioning techniques when assisting resident #001. [s.36.]

Resident #001's plan of care directs staff to provide total assistance for all transferring and positioning and requires a tilt wheelchair for ambulation. Staff interviews revealed that on May 11, 2012 at 12:00 hours resident #001 was found in the dining room, sitting upright in his/her tilt wheelchair holding both hands toward chest with blood on the floor. The Nurse Practitioner indicated in an interview that resident #001's left fifth finger tip measuring 0.5 cm x1.0 cm was found between the pinch bars of the wheelchair's tilting mechanism after the wheelchair was tilted back in a reclined position. Resident #001 was immediately sent to hospital for further assessment and possible reattachment of left fifth finger digit.

An interview with the Director of Care and the Nurse Practitioner indicated that the laceration to resident #001's left fifth digit had occurred when resident #001 was tilted upright from a reclined position by staff. The Director of Care revealed in an interview that resident #001's hands were positioned outside the frame of the tilt wheelchair prior to repositioning causing resident #001's left fifth finger digit to become trapped and lacerated within the frame of the chair. (202)

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

Feb 15, 2013

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

Ministère 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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 24 day of April 2013 (A1)(Appeal/Dir# #20)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : VALERIE JOHNSTON

Service Area Office / Bureau régional de services : Toronto