Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 17, 2014	2013_220111_0023	000627, 000836, 000837	Follow up

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

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

CARESSANT CARE ON MCLAUGHLIN ROAD
114 McLaughlin Road, LINDSAY, ON, K9V-6L1

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): Dec.12 & 17, 2013

This follow up inspection was completed with inspector #555.
The follow up inspection was completed concurrently with two critical incidents (log# 000836 & 000837).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Food Service Manager, Dietary Aide (DA), Activity Director, One Registered Nurse (RN), two Personal Support Workers (PSW),and two residents.

During the course of the inspection, the inspector(s) observed two residents, observed two meals, reviewed health records of two residents, reviewed five employee files, reviewed the homes investigations, reviewed staff training records on Prevention of Abuse, and reviewed the homes safety plan-resident policy.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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

Findings/Faits saillants :

1. The licensee has failed to protect resident's from abuse by anyone and ensure that the resident's are not neglected by the licensee or staff[s.19].

Under O. Reg. 79/10, s. 5 "neglect" means 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.

Related to log#000836:

A Critical Incident (CI) was received by the Director for a resident injury resulting in transfer to hospital. The CI indicated Resident #1 slid from a mechanical lift and fell to floor resulting in pain.

Review of the homes investigation and review of the health care record for Resident #1 indicated:
- a complaint letter was received by the home from a staff member after the incident indicating staff to resident neglect,
- the resident was unable to stand, was transferred using a mechanical lift, and then slipped from the sling resulting in a fall,
-the resident complained of pain and requested to go to hospital for assessment but was not transferred to hospital for a period of 7 hours post fall,
-there was no documented assessment of the resident post fall,
-the resident did not receive any analgesic for a period of 7 hours despite complaints of pain,
-the resident was left unattended on the floor post fall,
-the homes investigation concluded that staff involved in the incident had "neglect of care".

The licensee failed to protect the resident from neglect due to the the pattern of inaction of failing to provide the resident with the treatment, care, services or assistance required for health, safety and well-being.

2. Related to log # 000837:

A CI was received by the Director for an incident of witnessed staff to resident neglect. A staff member witnessed another staff member remove a meal for Resident #2 without providing assistance with the meal, resulting in the resident not receiving the meal. The staff member indicated it was the second time this staff member was witnessed not providing assistance with feeding Resident #2.

Review of the homes investigation and interview of staff into the incident of witnessed staff to resident neglect indicated:
- the complaint letter regarding the incident was not submitted to the home for a period of two days.
- the homes investigation confirmed the staff member reported that this was the second witnessed incident of staff to resident neglect but the first incident was not

reported and no indication when the first incident actually occurred.

A Compliance Order for LTCHA, 2007, s.19 was issued previously on June 28, 2013 under inspection # 2013_220111_0009. [s. 19.]

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. 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, s. 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, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 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, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. Related to log# 000836:

A Critical Incident (CI)was submitted to the Director for "an injury resulting in transfer to hospital".

Review of the progress notes of Resident #1, the homes investigation, and interviews of staff indicated the home had reasonable grounds to suspect staff to resident neglect of Resident#1 but the CI was not reported as "neglect". The CI was also not amended to reflect this.(555)

2. Related to log # 000837:

A critical incident report (CI) was received by the Director for an incident of witnessed staff to resident neglect. The CI indicated Resident#2 did not receive assistance with nutrition and did not receive a meal as a result. The CI also indicated it was the second incident by the same staff member towards the same resident not providing assistance with nutrition. The CI did not indicate when the first incident occurred.

Review of the homes investigation into the incident of witnessed staff to resident neglect indicated the incident actually occurred two days before it was reported. The homes investigation also indicated it was the second witnessed incident by the same staff member towards the same resident. There was no indication the first incident was reported or when the first incident actually occurred.

A Compliance order was previously issued for O.Reg.79/10, s.24(1) on June 28, 2013 under inspection # 2013_220111_009. [s. 24. (1)]

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. Related to log# 000836:

A Critical Incident (CI) was submitted to the Director for an injury resulting in transfer to hospital. The CI indicated Resident #1 complained of pain after sustaining a fall from a mechanical lift and was transferred to hospital for assessment.

Review of the homes investigation and review of the health care record for Resident #1 indicated the home had reasonable grounds to suspect staff to resident neglect but there was no documented evidence that the police were notified.(555)

The licensee was issued non-compliance for O.Reg. 79/10, s.98 on January 25, 2012 under inspection #2012_043157_0004 and on October 23, 2013 under inspection # 2013_220111_0017. [s. 98.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1. Related to log# 000836:

The license has failed to ensure that the written plan of care provided clear direction to staff and others who provide direct care to the resident related to transferring.

Review of Resident #1 progress notes and the homes investigation indicated the resident was transferred in a sit-to-stand mechanical lift despite being unable to stand and resulted in a fall and pain.

Review of the plan of care for Resident #1 related to transferring and mobility indicated:
- the resident required extensive assistance,used a cane to assist with transferring,one staff to boost the resident up from a sitting position to a standing position,used 1 bed rail(left)to assist with positioning self in and out of bed,staff to provide weight-bearing support positioning side to side,resident to transfer and change positions slowly,and "staff to use the sit-to-stand lift on better days".

The plan of care did not define "better days" and it was unclear why a sit-to stand lift would be used if the resident was having "better days". [s.6.(1)(c)]

2. Related to log # 000837:

A CI was submitted to the Director for an incident of witnessed staff to resident neglect. The CI indicated a staff member witnessed another staff member not provide assistance to Resident#2 with eating resulting in not receiving the meal. The same staff member reported that it was the second witnessed incident by the same staff member towards the same resident.

Review of the plan of care for Resident #2 related to eating indicated the resident requires extensive assistance x1 staff to physically feed resident at meals, as the resident often becomes confused and will not eat.

The resident was not provided assistance and encouragement required to eat and drink as indicated in the plan. [s.6.(7)]

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 all residents receive nutrition and hydration according to the residents plan of care, to be implemented voluntarily.

WN #5: 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. Related to log #000836:

A CI was submitted to the Director for an injury resulting in transfer to hospital.The CI indicated Resident #1 fell to the floor during a transfer with a mechanical lift resulting in pain.

Review of the progress notes of Resident #1 and review of the homes investigation indicated at the time of the transfer, the resident was unable to weight bear and the staff used a mechanical lift that required the resident to be able to weight bear.

The licensee failed to ensure staff used safe transferring and positioning devices when assisting the resident with toileting(555). [s. 36.]

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 all staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. Related to log #000627:

The licensee failed to ensure that a written complaint made to the licensee concerning the care of a resident was provided a response within 10 business days.

Review of a written complaint from the POA(Power of Attorney) of Resident #3 indicated concerns of staff to resident neglect related to toileting and occurred on two different occasions by the same staff member.

Review of the homes response to POA indicated the home completed an investigation but the response was not provided for greater than 30 days. [s.101.(1)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 all complaints received by the licensee are provided a response within 10 business days, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Related to log # 000836:

Under O. Reg 79/10 s. 48 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury".

Review of home's policy "Safety Plan - Resident" indicated in Part C-Post Fall Management:
-initiate head injury routine and assess the resident's level of consciousness and any potential injury associated with the fall
- notify the attending physician and ensure immediate treatment after the fall
-review fall prevention interventions and modify plan of care as indicated

Review of the Resident's #1 health record had no documented evidence that the homes policy was complied with when the resident sustained a fall as:
-no indication Head Injury Routine was initiated;
-the Physician was not notified to ensure immediate treatment;
-the plan of care was not reviewed or modified for fall prevention interventions as indicated[s.8.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Related to log #000836:

Interview of the Administrator indicated staff are to complete a "Post Fall Investigation" (Appendix D) after a resident has fallen.

Review of the health care record of Resident #1 had no documented evidence of a "Post Fall Investigation" completed after the resident fell(555). [s.49.(2)]

Issued on this 30th day of January, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2013_220111_0023
Log No. / Registre no:	000627, 000836, 000837
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 17, 2014
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE ON MCLAUGHLIN ROAD 114 McLaughlin Road, LINDSAY, ON, K9V-6L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paul Ludgate

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2013_220111_0009, CO #004;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

The licensee shall prepare, implement and submit a plan to ensure that all residents are protected from neglect by anyone.

This plan shall include:
-that all staff are re-trained on the homes policy on the definition of abuse and prevention of abuse,
-how the home will ensure that immediate actions are taken by all staff when there is an alleged, suspected, or witnessed incident of abuse of a resident by anyone, and
-measures that will be put in place to monitor staff to ensure that staff are complying with the homes policy specifically of "Prevention of Abuse".

This plan is to be submitted electronically to Lynda.Brown2@ontario.ca by January 28, 2014.

Grounds / Motifs :

1. 1. The licensee has failed to protect resident's from abuse by anyone and ensure that the resident's are not neglected by the licensee or staff[s.19].

Under O. Reg. 79/10, s. 5 "neglect" means 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.

Related to log#000836:

A Critical Incident (CI) was received by the Director for a resident injury resulting

in transfer to hospital. The CI indicated Resident #1 slid from a mechanical lift and fell to floor resulting in pain.

Review of the homes investigation and review of the health care record for Resident #1 indicated:
- a complaint letter was received by the home from a staff member after the incident indicating staff to resident neglect,
- the resident was unable to stand, was transferred using a mechanical lift, and then slipped from the sling resulting in a fall,
-the resident complained of pain and requested to go to hospital for assessment but was not transferred to hospital for a period of 7 hours post fall,
-there was no documented assessment of the resident post fall,
-the resident did not receive any analgesic for a period of 7 hours despite complaints of pain,
-the resident was left unattended on the floor post fall,
-the homes investigation concluded that staff involved in the incident had "neglect of care".

The licensee failed to protect the resident from neglect due to the the pattern of inaction of failing to provide the resident with the treatment, care, services or assistance required for health, safety and well-being.

2. Related to log # 000837:

A CI was received by the Director for an incident of witnessed staff to resident neglect. A staff member witnessed another staff member remove a meal for Resident #2 without providing assistance with the meal, resulting in the resident not receiving the meal. The staff member indicated it was the second time this staff member was witnessed not providing assistance with feeding Resident #2.

Review of the homes investigation and interview of staff into the incident of witnessed staff to resident neglect indicated:
- the complaint letter regarding the incident was not submitted to the home for a period of two days.
- the homes investigation confirmed the staff member reported that this was the second witnessed incident of staff to resident neglect but the first incident was not reported and no indication when the first incident actually occurred.

A Compliance Order for LTCHA, 2007, s.19 was issued previously on June 28,

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

2013 under inspection # 2013_220111_0009. [s. 19.] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 17, 2014

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

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. 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 or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to describe how the Licensee will achieve and sustain compliance with the requirements to report to the Director immediately.
This plan is to include:
- that when there are reasonable grounds to suspect abuse of resident by anyone, or any other reporting requirement under s.24(1) of the LTCHA that it is immediately reported.
-a re-training plan on immediate reporting requirements
-how the Licensee will monitor the reporting requirements to ensure that staff comply with the home's policy on "Prevention of Abuse" and reporting requirements.

This plan is to be submitted electronically to Lynda.Brown2@ontario.ca by January 30, 2013.

Grounds / Motifs :

1. 1. Related to log# 000836:

A Critical Incident (CI)was submitted to the Director for "an injury resulting in transfer to hospital".

Review of the progress notes of Resident #1, the homes investigation, and interviews of staff indicated the home had reasonable grounds to suspect staff to resident neglect of Resident#1 but the CI was not reported as "neglect". The CI was also not amended to reflect this.(555)

2. Related to log # 000837:

A critical incident report (CI) was received by the Director for an incident of witnessed staff to resident neglect. The CI indicated Resident#2 did not receive assistance with nutrition and did not receive a meal as a result. The CI also indicated it was the second incident by the same staff member towards the same resident not providing assistance with nutrition. The CI did not indicate when the first incident occurred.

Review of the homes investigation into the incident of witnessed staff to resident neglect indicated the incident actually occurred two days before it was reported. The homes investigation also indicated it was the second witnessed incident by the same staff member towards the same resident. There was no indication the first incident was reported or when the first incident actually occurred.

A Compliance order was previously issued for O.Reg.79/10, s.24(1) on June 28, 2013 under inspection # 2013_220111_009. [s. 24. (1)](111) (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 30, 2014

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to indicate how the licensee 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.

This plan is to be submitted to Lynda Brown electronically via email to Lynda.Brown2@ontario.ca by January 28, 2013.

Grounds / Motifs :

1. 1. Related to log# 000836:

A Critical Incident (CI) was submitted to the Director for an injury resulting in transfer to hospital. The CI indicated Resident #1 complained of pain after sustaining a fall from a mechanical lift and was transferred to hospital for assessment.

Review of the homes investigation and review of the health care record for Resident #1 indicated the home had reasonable grounds to suspect staff to resident neglect but there was no documented evidence that the police were notified.(555)

The licensee was issued non-compliance for O.Reg. 79/10, s.98 on January 25, 2012 under inspection #2012_043157_0004 and on October 23, 2013 under inspection # 2013_220111_0017. [s. 98.] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 17, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 17th day of January, 2014

Signature of Inspector / Signature de l'inspecteur : L Brown

Name of Inspector / Nom de l'inspecteur : LYNDA BROWN

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