



**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**

Public Copy/Copie du public

**Name of Inspector (ID #) /
Nom de l'inspecteur (No) :** MARGOT BURNS-PROUTY (106)

**Inspection No. /
No de l'inspection :** 2013_211106_0015

**Log No. /
Registre no:** 623,659,452,213,172

**Type of Inspection /
Genre d'inspection:** Critical Incident System

**Report Date(s) /
Date(s) du Rapport :** Aug 23, 2013

**Licensee /
Titulaire de permis :** BOARD OF MANAGEMENT OF THE DISTRICT OF
NIPISSING EAST
400 Olive St., NORTH BAY, ON, P1B-6J4

**LTC Home /
Foyer de SLD :** CASSELLHOLME
400 OLIVE STREET, NORTH BAY, ON, P1B-6J4

**Name of Administrator /
Nom de l'administratrice
ou de l'administrateur :** BRENDA LOUBERT

To BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST, you are hereby required to comply with the following order(s) by the date(s) set out below:



**Ministry of Health and
Long-Term Care**

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Order(s) of the Inspector
Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

Order # /
Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 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 of harm occurred reports their suspicion and the information upon which it was based to the Director immediately.

Grounds / Motifs :



**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
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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

1. Two Voluntary Plans of Correction under LTCHA 2007, S. O. 2007, c. 8, s. 24 (1) 2, have previously been issued in November 2011 during inspection # 2011_054133_0028 and in April 2012 during inspection #2012_051106_0011. (106)

2. A Critical Incident System report submitted to the Ministry of Health and Long-Term Care indicates, a staff member observed in a surveillance monitor, resident #003 being abused, this was not reported to the Director for 17 days. The Licensee failed to 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 of harm occurred reported their suspicion and the information upon which it was based to the Director immediately. (106)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Sep 12, 2013



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

Order # /

Order Type /

Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 96. 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.

Order / Ordre :

The licensee shall ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected and contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents

Grounds / Motifs :



**Ministry of Health and
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Order(s) of the Inspector
Pursuant to section 153 and/or
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**Ministère de la Santé et
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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

1. One Voluntary Plan of Correction under O. Reg. 79/10, s. 96 (a) has previously been issued in April 2012 during inspection #2012_051106_0011. (106)
2. On June 25, 2013, inspector asked staff member #S-100 for and was provided with the home's abuse policies. The policies were reviewed and they do not contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. (106)
3. On June 25, 2013, inspector asked staff member #S-100 for and was provided with the home's abuse policies. The policies were reviewed and they do not contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents. (106)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Sep 12, 2013



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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



**Ministry of Health and
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Ordre(s) de l'inspecteur
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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.



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Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
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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, 11^e 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.



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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 23rd day of August, 2013

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur :

MARGOT BURNS-PROUTY

Service Area Office /

Bureau régional de services : Sudbury Service Area Office



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection 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**

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 23, 2013	2013_211106_0015	623,659,452 ,213,172	Critical Incident System

Licensee/Titulaire de permis

**BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST
400 Olive St., NORTH BAY, ON, P1B-6J4**

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

**CASELLHOLME
400 OLIVE STREET, NORTH BAY, ON, P1B-6J4**

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

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 24, 25, 26, 2013

The following logs were reviewed as part of this Critical Incident inspection:

Log # S-000623-12, S-000659-12, S-000452-12, S-000213-13, S-000172-12

Concurrent inspections completed during this inspection: 2013_211106_0014

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Environmental Services Manager (ESM), Manager of Housekeeping and Laundry, Laundry Workers, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal support Workers (PSW), Residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Dignity, Choice and Privacy

Falls Prevention

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 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. A Critical Incident System report submitted to the Ministry of Health and Long-Term Care indicates, a staff member observed in a surveillance monitor, resident #003 being abused, this was not reported to the Director for 17 days. The Licensee failed to 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 of harm occurred reported their suspicion and the information upon which it was based to the Director immediately. [s. 24. (1)]

2. Two Voluntary Plans of Correction under LTCHA 2007, S. O. 2007, c. 8, s. 24 (1) 2, have previously been issued in November 2011 during inspection # 2011_054133_0028 and in April 2012 during inspection #2012_051106_0011. [s. 24. (1)]

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 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. On June 25, 2013, inspector asked staff member #S-100 for and was provided with the home's abuse policies. The policies were reviewed and they do not contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. [s. 96. (a)]
 2. One Voluntary Plan of Correction under O. Reg. 79/10, s. 96 (a) has previously been issued in April 2012 during inspection #2012_051106_0011. [s. 96. (a)]
 3. On June 25, 2013, inspector asked staff member #S-100 for and was provided with the home's abuse policies. The policies were reviewed and they do not contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents. [s. 96. (b)]

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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

- i. kept closed and locked,**
- ii. equipped with a door access control system that is kept on at all times, and**
- iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,**

- A. is connected to the resident-staff communication and response system, or**
- B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).**

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents. O. Reg. 79/10, s. 9. (1).

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency. O. Reg. 79/10, s. 9. (1).

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Findings/Faits saillants :

1. On June 24 and 25, 2013, inspector found the door near the 1st floor main dining room to be unlocked and residents could gain access to outside areas that were not secure. Inspector was able to walk out the door and access nearby parking lots and streets. The licensee failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terrace, or doors that residents do not have access to must be, kept closed and locked. [s. 9. (1) 1. i.]



Ministry of Health and
Long-Term Care

Ministère de la Santé et des
Soins de longue durée

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

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

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 doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terrace, or doors that residents do not have access to, are kept closed and locked, specifically the door to the outside near the main floor dining room, to be implemented voluntarily.

**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act
Specifically failed to comply with the following:**

- s. 23. (1) Every licensee of a long-term care home shall ensure that,**
- (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
 - (i) abuse of a resident by anyone,**
 - (ii) neglect of a resident by the licensee or staff, or**
 - (iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
 - (b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
 - (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

Findings/Faits saillants :



1. Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care indicates a staff member observed in a surveillance monitor, resident #003 being abused. On June 25, 2013, inspector requested staff member #S-100 to provide the home's documentation regarding the investigation into witnessed incident of abuse. The information given to the inspector including, a copy of the CIS report, three emails from staff member #S-100 to Staff member #S-101, # S-102 and # S-103, and 4 digital print outs from the surveillance monitor system, did not support that the licensee had undertaken an actual investigation into the incident. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse, that the licensee knows of, or that is reported to the licensee, is immediately investigated. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of abuse, that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

- 1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding. O. Reg. 79/10, s. 107 (1).**
 - 2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).**
 - 3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).**
 - 4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).**
 - 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).**
 - 6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).**
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Findings/Faits saillants :

1. A CIS report submitted to the Ministry of Health and Long-Term Care indicates that resident # 005 went missing from the home, sustained injury and was brought to the North Bay Regional Health Centre for assessment. The home did not notify the Director for 2 days that the resident was missing and sustained and injury. The licensee failed to ensure that the Director is immediately informed, in as much detail as is possible when a resident returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.

A CIS report submitted to the Ministry of Health and Long-Term Care indicates, resident # 004 was missing from the home for greater than 3 hours. The home did not notify the Director that resident # 004 was missing for more than 3 hours, ^{until} ~~at~~ 3 days later. The licensee failed to ensure that the Director is immediately informed, in as much detail as is possible when a resident is missing for three hours or more. [s. 107. (1)]



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

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 Director is immediately informed, in as much detail as is possible when a resident returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing and when a resident is missing for three hours or more, to be implemented voluntarily.

Issued on this 10th day of September, 2013

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

A handwritten signature in black ink, appearing to be "M. J. P.", written within a rectangular box.