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

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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
Jan 30, 2015;	2014_280541_0035 (A1)	O-001065-14	Resident Quality Inspection

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road 3rd Floor PICKERING ON L1V 1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

AMBER MOASE (541) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

CO #006 date for compliance amended to February 9, 2015 at request of Long-Term Care Home.

Issued on this 30 day of January 2015 (A1)

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

Original report signed by the inspector.

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AMBER MOASE (541) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): October 27-31 and November 3-7, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Director of Quality Nursing (DQN), the Environmental Services Manager (ESM), Resident Care Area Managers, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aides, Housekeepers, the Presidents of both Resident and Family Councils, Families and Residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

23 WN(s)
8 VPC(s)
6 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. Related to log #O-000903-14 for Resident #48:

The licensee failed to comply with O.Reg.79/10, s.101 (1)1 by not ensuring 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:
• has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and

• where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately investigated

The Action Line was contacted on a specified date by Complainant #75 voicing concerns relating to Hot Weather Temperature. The complainant indicated having had contacted the Administrator 6 days prior as to excessive temperatures within the home. The Administrator, during an interview on November 03, 2014, indicated receiving a written (email) complaint from Complainant #75 on a specified date; details of the complaint were as follows:

- Complainant indicated visiting a family member (a resident of the home) on several occasions; while sitting in the dining room assisting resident observed sweat pouring of the faces of kitchen and nursing staff, as well as off the faces of many of the residents. Complainant indicated during the same observation, resident's faces being flushed. The written complaint indicated the temperatures in the dining room were oppressively hot and quite unbearable.

The Administrator provided further email correspondence written by Complainant #75 on three other dates requesting a meeting with the Administrator and Resident Care Area Manager to discuss excessive hot temperatures and other concerns. The Administrator did comment that a meeting with the complainant occurred on a specified date, but agreed the meeting and or communication was twenty days following the initial complaint.

According to the Meeting Minutes, on a specified date, the response provided by the Administrator to the Complainant, surrounding excessive temperature within the home, was 'everything that could be done was being done'.

The Administrator indicated that an investigation relating to complainants concerns was not completed as the home was doing everything possible to control the home's heating and cooling.

The Environmental Services Manager (ESM), on a specified date, indicated no awareness of this complaint with regards to excessive temperatures within the home. [s. 101. (1) 1.]

2. The licensee failed to comply with O. Reg. 79/10, s. 101 (2), as it relates to a verbal complaint made by complainant #76 and Residents #07, 53 and 08 by not ensuring that a documented record is kept in the home that includes:

(a) the nature of each verbal complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

Related to Log #O-001184-14, for Resident #42:

Complainant #76 contacted the ActionLine on a specified date voicing a concern as to the temperature in the home and its effect on complainant's loved one. Family indicated that concerns have been voiced to the Director of Care (DOC) and the home has not done anything about the concern.

The Director of Care indicated that a call was received by Complainant #76 regarding the heat once sometime last month. The DOC indicated a Client Feedback Form had not been completed as the call was not taken as a complaint but a concern. The DOC indicated that the home is sometimes warmer than usual but the heating system is older and difficult to regulate.

The Administrator and Environmental Services Manager indicated no awareness of this family's complaint.

Relating to Residents #07 and #53:

Residents #07 and #53 indicated reporting complaints to the management and or nursing staff, relating to a) their room being cold, especially the washroom and; b) that two residents across the hall cry all night long. Residents indicated these are long standing complaints without resolution. Residents indicated they have stopped voicing concern as their complaints go unheard. It was also noted that the vent in bathroom has been covered with cardboard and masking tape; On a specified date residents indicated staff had covered the vent.

The ESM indicated that Residents #07 and #53 frequently complain of their rooms being cold but when investigated the ESM finds the window open; ESM indicated no awareness of the vent in the room being covered with cardboard and masking tape.

Staff # 102, who works on the resident home area where Resident #07 and #53 resides, indicated being aware of the resident's concerns about the two residents crying or frequently calling out, indicating the (responsive) behaviour is normal for the residents.

The DOC indicated no awareness of the complaints by Resident #07 and #53 re: residents crying all night, but did indicate the concern would be addressed with Resident Care Area Manager.

Relating to Resident #08:

Resident #08 indicated voicing several complaints to the management team during a care conference on a specified date; resident indicated voicing the following complaints, a) the drapes in the resident's room had not been cleaned in over two years, b) when resident rings call bell for assistance, staff enter the room, cancel the call bell and indicate they will get someone to assist; resident indicated staff rarely return; and c) referred to an incident where resident asked for assistance in returning to room and staff shouted I'm busy helping residents on a specified unit, I'm not assigned to your unit, you will need to ask someone else to assist you. A progress note in resident #08's health record indicated that Staff #124 completed a Client Feedback Form following the conference.

The DOC indicated no awareness of Resident #08's concerns which were voiced at the annual care conference held on a specified date, despite Staff #124 indicating in the progress notes that a Client Feedback Form had been completed. Both the Director of Care and Director of Quality had no record to a form being completed. The Director of Quality indicated that Staff #124 can not recall if a form had been completed.

A review of the home's Client Feedback Forms 2014 binder (complaints log) for a 4 month period failed to provide any supporting documentation that the complaints voiced by Resident #07, 08, 53 and Complainant #76 were recorded on the Client Feedback Forms as indicated in the home's policy (Complaint Handling Process, ADM-QUA-100) nor is there any supporting records indicating the management of the home responded to the complainants.

The home's policy, Complaint Handling Process (ADM-QUA-100) directs that a Client Feedback Log is to be completed by any person receiving a concern or complaint. The policy communicates that it is the responsibility of the person receiving a concern

or complaint to document the information on the Client Feedback Log Form, if follow up is required; identifying actions taken or recommended actions and names of persons accountable for these actions. The completed form is to be submitted to the Administrator.

The policy indicates that resident, family and visitor concerns are to be addressed promptly in an efficient manner and that client satisfaction is evidenced.

The Administrator indicated not being aware of any of the above concerns, despite resident's and family indicating concerns were voiced to the management team and asked that inspector addresses these concerns to others on the management team. [s. 101. (2)]

3. The licensee failed to comply with O. Reg. 79/10, s. 101 (3), by not ensuring that complaints received are reviewed and analyzed for trends at least quarterly and that the results of the review and analysis are taken into account in determining what improvements are required in the home.

The Administrator indicated, in an interview on November 03, 2014, that the Admission's Coordinator tracks all complaints and completes trending and analysis; the Administrator indicated that trending and analysis of complaints is completed but was unsure how often and commented complaints are to be reviewed at quarterly Leadership meetings but this has not been consistently occurring over the past year.

The Admission's Coordinator indicated being recently assigned the role of grouping complaints into categories (e.g. communication, lost money, clothing or property, resident issues, food issues, etc.) but indicated the management team has not yet utilized the information to determine trends occurring nor has information been used in determining improvements required in the home. The Admission's Coordinator indicated that this is a new process for the home and has not been completed on a quarterly basis.

The home's policy, Complaint Handling Process-Client Feedback Log (ADM-QUA-100) directs that the Administrator will complete the Client Feedback Log Summary Log on a monthly basis and will provide a summary of all Client Feedback Logs for the previous month to the Leadership/Partnership Team.

The policy further directs that the client feedback summary (monthly) is to be utilized for identifying trends, risk problems, and recommendations. [s. 101. (3)]

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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 229 (4), by not ensuring that staff participate in the implementation of the infection prevention and control program.

The following observations were made:

- Staff #117 was observed, on a specified date, cleaning a specified room; staff was observed not wearing personal protective equipment (PPE), despite signage on the door indicating Contact Isolation/Precautions. Staff #117 indicated being told by Registered Nursing Staff that PPE's were not required. It is noted that this is a shared resident room.

- Staff #118 was observed, on a specified date, cleaning room a specified room; staff was observed not wearing personal protective equipment (PPE), despite signage on the door indicating Contact Isolation/Precautions. During this same observation, Staff #118 had the housekeeping cart inside of the room. Staff indicated that the residents residing in the room were not contagious and that PPE's were not required when cleaning the room. It is noted that this is a shared resident room.

- On a specified date, two nursing staff were observed caring for a resident in bed, in a

specified room; staff were not seen wearing personal protective equipment (PPE), despite signage on the indicating Contact Isolation/Precautions.

The home's policy, Isolation - Daily Cleaning (HKG D-10-05) directs that the Housekeeping Aide is to gown and glove at entrance of isolation rooms prior to cleaning.

The ESM indicated that Housekeeping Staff are to wear personal protective equipment (gown, gloves, ect.) at all times when cleaning rooms with signage indicating Contact Precautions /Isolation or any other infection precautionary signs. The DOC and ESM confirmed that the Registered Nursing staff had provided improper direction to the staff regarding the PPE.

The ESM confirmed that both Staff #117 and #118 had annual education specific to infection control, which included cleaning and disinfection and additional precautions / use of PPE's; training was completed May and June 2014.

The DOC, who is the lead for infection control, indicated that staff providing direct resident care and/or housekeeping staff cleaning resident rooms are to wear the indicated PPE when any resident is designated as being in isolation or infection precautions. The DOC further indicated that housekeeping carts are not to be in resident rooms, but are to be in the hallway outside the room.

Other Observations on a specified date:

- Staff #105, who was working Linden Home Area, was observed administering medications during the noon medication pass; staff was observed administering medications to three residents, including once administering insulin without performing hand hygiene before or after any of the three residents.

- Staff #124, who was working Maple Resident Home Area, was observed administering medications during the noon medication pass; staff was observed administering medications to three residents without performing hand hygiene before or after any of the three residents.

The DOC indicated that all staff are provided infection control education upon hire and annually; education includes, 4 Moments of Hand Hygiene. The DOC indicated it is the expectation that all staff perform hand hygiene before and after contact with all residents. [s. 229. (4)]

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Residents #8, #15, #30, #29, #42, #16, #50, #57, #55 are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Emotional Abuse Definition
Under O.Reg.79/10, s.2(1)(a) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Related to Resident #8
During stage one of the RQI:
-Interview of Resident #8 (by Inspector # 554) stated they "had a confrontation with a staff member, and at the time, I hurt my arm, had to use manual chair, and they left me in the dining room. I asked staff member "Can you take me back? I had to ask several times". Staff responded "I'm looking after Maple not Birch, get someone else."
Review of the progress notes for Resident #8 indicated during the care conference on a specified date, the home was notified of the resident's concern of neglect of care

and indicated a "client feedback form was completed" at that time. There was no documented evidence a "client feedback form" was completed at that time or an investigation into the allegation completed. A "Client Feedback" form was provided to the inspector by the DQN indicating Resident #8 had been re-interviewed and identified the staff member involved in the allegation of staff to resident neglect as PSW #136 but the staff member had not yet been interviewed. Review of the staff schedule for PSW#136 indicated the PSW worked 6 evening shifts since the home becoming aware of the incident.

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures states:
- If an employee(s) is involved, immediately notify of the pending investigation requiring alleviation from duty pending completion of the investigation, including reporting requirements to the Director (MOHLTC) and local police authorities.
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation
-the Registered staff will report the alleged, actual, or suspected abuse to the Administrator, General Manager, Director of Care, Wellness Coordinator, and or designate, local police authorities, and the Director (MOHLTC).
- registered nursing staff and the person discovering the abuse shall prepare a written incident report. The report shall include: what occurred, when it occurred, who was involved, names of witnesses, where it occurred, what was observed and heard. The report shall be submitted to the Administrator, Director of Care and or designate.

Related to Resident #29
- Resident #29 stated during an interview on a specified date that "I had an earache and reported it to the RPN who told me the doctor would be in tomorrow to assess. The following day I saw the physician but he did not come to see me. A week later, the physician came in to see me and I stated I still have the earache and the physician said very loudly and abruptly to me "do you realize people die here". I just wanted my ear ache dealt with but I didn't like that." On a specified date the Administrator was notified of the allegation of physician to resident emotional abuse towards Resident #29. Review of the homes investigation indicated on a "client feedback log", dated the day the home became aware of the incident, the resident was interviewed and confirmed what was reported to the inspector. The form indicated under further action: "speak to Dr." to be completed by Administrator and DOC. There was no indication the physician was interviewed as of 7 days later and the physician had been in the home on 4 occasions since the home becoming aware of the incident.

There was no documented evidence that when the allegations of staff to resident abuse/neglect for Residents #8 and #29 were reported to the Administrator on the dates specified, that the Administrator completed the resident incident report as indicated in the home's policy as "the person discovering the abuse". The progress notes and plan of care were not updated regarding the allegations, as well as interventions to prevent recurrence and no indication that the substitute decision makers of the residents were notified of the allegations.

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures states:
- registered nursing staff and the person discovering the abuse shall prepare a written incident report. The report shall include: what occurred, when it occurred, who was involved, names of witnesses, where it occurred, what was observed and heard. The report shall be submitted to the Administrator, Director of Care and or designate.
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation
-the Registered staff will immediately notify the Resident's substitute decision maker, if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident

The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA, 2007 s. 23.(1)a 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 (Refer to WN#16)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

Verbal Abuse Definiton
Under O.Reg.79/10, s.2(1) (a) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense

of well-being, dignity or self-worth, that is made by anyone other than a resident.

Related to Resident #15
-Interview of Resident #15 on a specified date "a staff member yells at him/her and is rude". The Administrator was notified of the allegation on October 30, 2014. The DQN indicated becoming aware of the allegation of staff to resident abuse on approximately 3 days later and initiated the investigation 2 days afterwards using the "client feedback forms". The DQN was not aware a "Resident Incident Report" was to be completed for allegations of abuse instead of a "Client Feedback Form". Review of the "client feedback form" provided by the DQN on a specified date indicated that PSW #134 was the alleged staff member involved in the incident and was to be interviewed by the DOC. The DQN indicated only the resident had been interviewed regarding the allegations. There was no indication that any of the staff had been interviewed or notified of the allegation or any other actions taken 4 days after the allegation was reported to the home by the Inspector. Review of the staff schedule indicated that PSW#134 had worked day shift on three occasions since the home becoming aware of the incident.

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation.
-The Registered Staff and the person discovering the abuse shall prepare a written incident report. All documentation of an alleged, actual, or suspected abuse incident will use descriptive and precise language free from opinion and conjecture. The report shall contain the following information and shall be submitted to the Administrator, General Manager, Director of Care, Wellness Coordinator and/or designate: what occurred, when it occurred, who was involved (including the names of witnesses or those who were in the vicinity when it occurred), what was observed/heard, written statements from witnesses including information pertaining to the incident.
-the Registered staff will immediately notify the Resident's substitute decision maker, if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident.
The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)

- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

Related to Resident #30
-Interview of Resident #30 stated "a couple of weeks ago, a staff member was yelling at me in the morning when they were washing my face but I don't know their name". On a specified date the Administrator was notified of the allegation of staff to resident verbal abuse towards Resident #30. Review of the health care records for Resident #30 had no documented evidence that the SDM, or any other person specified by the resident were notified of an alleged incident of verbal abuse. Review of the "Client Feedback" form provided by the DQN indicated 5 days after the home becoming aware of the incident, the resident was interviewed by the DQN and indicated PSW #137 was the staff member allegedly involved in staff to resident verbal abuse. The form indicated staff member had not yet been interviewed regarding the allegation. Review of the PSW schedule indicated that PSW #137 worked day shift on 5 occasions since the home becoming aware of the incident.

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation.
-The Registered staff will immediately notify the Resident's substitute decision maker, if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident.
The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

There was no documented evidence that when the allegations of staff to resident abuse/neglect for Residents #15 and #30 that were reported to the Administrator on

specified dates, that the Administrator completed the resident incident report as indicated in the home's policy as "the person discovering the abuse" . The progress notes and plan of care were not updated regarding the allegations, as well as interventions to prevent recurrence and no indication that the substitute decision makers of the residents were notified of the allegations.

Related to Resident #16:
The home's former Director of Care, submitted a Critical Incident Report on a specified date. The CI details an incident of Staff to Resident (verbal) abuse, which was said to have occurred 2 days earlier; details of the incident are as follows:
- Staff #119 was asked by Resident #16 to make resident's bed; Resident #16 called staff 'a lazy bitch'. Staff #119 responded 'I'm not a bitch, you are the bitch'.
The allegation of Staff to Resident (verbal) abuse was reported by the Registered Practical Nurse (#124) to the Resident Care Area Manager (RCAM #123), who was the supervisor in the home during the incident which occurred.
According to the CI report, the RCAM contacted the Director of Care of the incident. The incident of Staff to Resident Verbal Abuse was not reported to the Director within the time line required under legislation.

A review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- the Administrator, Director of Care and or designate will immediately report the incident to the Director (MOHLTC) and local police authorities.

The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA 2007 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: 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. (Refer to WN #17)

Related to Log #O-000584-14 for Resident #50
A critical incident, submitted, by the home's former Director of Care, on a specified date describes an incident of alleged Staff to Resident (verbal/physical) abuse reported to have occurred 1 day earlier.

Details of the CI are as follows: According to a Critical Incident Report Resident #52 reported hearing a staff member yelling at Resident #50 in the hallway sometime during the night; Resident #52 reports hearing staff yell at Resident #50 to go back to bed and then reports hearing a slapping sound followed by a yelping sound from Resident #50. According to the CI report, Resident #52 reported the incident to family; in turn, Resident #52's family reported the incident of verbal/physical abuse to Resident Care Area Manager (RCAM #123).

Director of Care indicated that Resident #52 has since deceased but was cognitively well when the incident was reported.
The current DOC indicated that there were three staff (a Registered Practical Nurse and two Personal Support Workers) assigned to work the night shift, on Resident #50 and #52's home area, on the date in question. The DOC indicated not being involved with the staff interviews, and deferred further comments to the Director of Quality Nursing (DQN). The DQN stated that he and the former Director of Nursing interviewed the three staff as to the allegation of Abuse; Director of Quality indicated Staff #120, 121 and #122 were not interviewed as to the allegations until 7 and 8 days after becoming aware of the incident.
A review of the home's Staffing Assignment Schedule for a specified period, indicated that Staff #120, 121 and #122 worked shifts following the allegation and prior to being interviewed by the licensee or its designate on dates indicated above.

The Director of Quality could not comment as to why there was a delay in investigating the incident of alleged Staff to Resident Abuse. The Director of Quality commented the investigation as to the allegation of abuse was completed on a specified date and findings were inconclusive.
The Director of Quality indicated that the practice of the home is to immediately investigate all allegations of suspected or witness abuse and that during the investigation, staff alleged to be involved are normally placed on a leave of absence pending the outcome of the investigation.
The DOC and Director of Quality both indicated the allegation of abuse (verbal/physical) was not reported to the police. The Director of Quality, who was present during the investigation of the abuse, indicated the incident was not reported to the police as Resident #50 was assessed by registered nursing staff and found to have had no visible injuries nor could resident recall the incident.

A review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- Immediately remove the persons allegedly or suspected of inflicting abuse from the

immediate area and any resident home area, pending further investigation.
The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- O. Reg 79/10 r. 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 (Refer to WN #23)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

Related to Resident #42
Complainant #76 contacted the home on a specified date and time, to report that Resident #42 had asked a staff member to turn off the television, as remote control was not within resident's reach; complainant indicated that a staff member stated, to the resident, "I'm not your bloody slave". Complainant indicated being concerned as to the way his/her loved one is being treated in the home when family is not around.
Resident #42, during an interview on a specified date, indicated feeling belittled by the comment of staff; resident further commented 'I can't wait to get out of this place'.
Complainant #76 stated the concern surrounding verbal abuse was brought to the attention of Registered Practical Nurse #148, who was the Charge Nurse, working on Resident Home Area that day.
Staff #148 commented during an interview on a specified date, that the allegation of verbal abuse was brought to the attention of the Registered Nurse Supervisor, who was in charge of the home, on the date of the incident.
Staff #148 indicated that MOHLTC was not contacted as to the allegation of verbal abuse, as that is not staff's role, but a supervisor's job.

Resident Care Area Manager (#145) indicated awareness of the allegation but commented such was not reported to Director. The DOC indicated no awareness of Complainant #76's allegation of verbal abuse. The Administrator indicated that all staff are to report allegations of Abuse. The RCAM #145 stated during an interview on a specified date that the resident was not spoken to following the incident. Staff #148, RN supervisor and RCAM #145 all indicated they did not contact the resident's substitute decision maker following becoming aware of the incident. Staff #148 spoke

with only two of the three staff working on the day of the incident.

A review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- If an employee(s) is involved, immediately notify of the pending investigation requiring alleviation from duty pending completion of the investigation, including reporting requirements to the Director (MOHLTC) and local police authorities.
-The Registered Staff and the person discovering the abuse shall prepare a written incident report. All documentation of an alleged, actual, or suspected abuse incident will use descriptive and precise language free from opinion and conjecture. The report shall contain the following information and shall be submitted to the Administrator, General Manager, Director of Care, Wellness Coordinator and/or designate: what occurred, when it occurred, who was involved (including the names of witnesses or those who were in the vicinity when it occurred), what was observed/heard, written statements from witnesses including information pertaining to the incident.
-the Registered staff will immediately notify the Resident's substitute decision maker, if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident.
The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA 2007 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: 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. (Refer to WN #17)
As of November 6, 2014, the Director of Care was investigating the concern of Complainant #76.

O.Reg. 79/10, s.2(1)(b) defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff member.

Log #00051 related to resident #57:
Review of the progress notes for Resident #54 indicated:
-on a specified date Resident #54 was found in his/her room with door closed and

Resident #57 in the room. Staff removed Resident #57 from the room and Resident #54 followed them out of the room as well. Resident #54 then sat with Resident #57 at the nursing station and was observed with "his/her hands on Resident #57's private area and when the PSW attempted to separate them the resident hit the PSW on the hand" Resident #57 was taken to his/her room. Interview of the DOC indicated the incident was not reported to the Director.
Review of the current care plan for Resident #54 indicated the resident is diagnosed with Dementia, is independently mobile, and demonstrates specified responsive behaviors. Strategies to deal with the responsive behaviors are specified in the care plan.

The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA 2007 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: 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. (Refer to WN #17)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

Related to Resident #55
A Critical Incident Report (CIR) was submitted by the home on a specified date for a resident to resident sexual abuse incident that occurred on a specified date. The CIR indicated Resident #55 was seen walking with a PSW towards own room and "was crying uncontrollably". When CN ask resident why the resident was crying, the resident stated that Resident #54 was sitting on a chair across from him/her at the nursing station when Resident #54 reached over and placed his/her hand between the resident's legs, touching his/her private area and then touched his/her self. The CIR had no indication that police were called.
Review of the progress notes for Resident #54 from a specified date range indicated:
-on a specified date the resident was observed “displaying inappropriate sexual behaviour towards another resident”. The PSW observed the resident inappropriately touch another resident. There was no indication which resident and no documented

evidence of an investigation.
-on a specified date staff overheard voices in the residents room and when entered the room, found another resident laying in the resident's bed. The resident was distracted while staff removed the other resident from the room. There was no incident report completed and no indication who the other resident was.
-on a specified date the resident was found in his/her room with door closed and Resident #57 in the room. Staff removed Resident #57 from the room. The resident followed them out of the room and then sat with Resident #57 near nursing station. The resident was then observed inappropriately touching Resident #57 and when the PSW attempted to separate them the resident hit the PSW on the hand" Resident #57 was taken to his/her room. The POA of resident was not notified of incident.

Review of the homes investigations and interview of staff indicated there was no investigations completed related to witnessed or suspected incidents of sexual abuse that occurred on the identified dates.
Review of the progress notes for Resident #55 and Resident #54 on a specified date had no indication the police were notified. Interview of the DOC indicated that if it was not indicated on the CIR then they were not notified.

The licensee failed to comply with:
- O. Reg 79/10 r. 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 (Refer to WN #23)
- LTCHA, 2007 s. 23.(1)a 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 (Refer to WN #16)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

In addition to the individual incidents and the areas of non-compliance identified for the incidents involving Residents #8, #29, #15, #30, #16, #50, #42, #57, #55, the following was also identified:

The licensee failed to comply with O. Reg. 79/10, s. 101(2), as it relates to a verbal complaint made by complainant #8 by not ensuring that a documented record is kept

in the home that includes:
(a) the nature of each verbal complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant (As identified in WN #1)

The licensee failed to comply with LTCHA, 2007, s. 76(4), by not ensuring that all staff have received retraining annually relating to the following:
• The Residents' Bill of Rights
• The home's policy to promote zero tolerance of abuse and neglect of residents
• The duty to make mandatory reports under section 24
• The whistle-blowing protections (As identified in WN #19)

The licensee has failed to comply with 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, (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. (As identified in WN #21) [s. 19. (1)]

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. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:
1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 2007, c. 8, s. 91 (1).
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Findings/Faits saillants :

Related to Log #000146:

The licensee has failed to ensure that residents in preferred accommodation are not charged more than what can be charged for basic accommodation unless the preferred accommodation was provided under an agreement.

A complaint was received from the SDM of Resident #44 indicating on a specified date in 2012 the resident was transferred from a semi-private room to a private room and the SDM was not made aware of the transfer until after the resident was transferred. A review of the progress notes from a specified date range in 2012 for Resident #44 indicated the resident was transferred from one unit on a specified date in 2012 to another unit and there was no indication the SDM was notified.

The complaint submitted by the SDM of Resident #44 also indicated being overcharged for accommodations at a rate that was not agreed to in the admission agreement. Review of Resident #44's admission agreement indicated the resident was admitted into semi-private accommodation room/rate on a specified date in 2010. There were no other accommodation agreements in place.

Review of the resident's charges for accommodation indicated the resident was admitted on a specified date in 2010 at semi-private rate. The resident remained on semi-private rate (along with annual increases in July of each year) until a specified date in 2012 when the monthly accommodation charge was increased to private accommodation rate. The private rate was charged until a specified date in 2014 when the accommodation charge was changed to a basic accommodation rate. The SDM requested the funds be reimbursed.

Interview of the Administrative Assistant (AA) indicated she was given verbal direction by the previous DOC during a specific month of 2012 to change Resident #44's accommodation rate from semi-private to private rate as the resident was moved to a private room from a semi-private room. The AA indicated she did not complete a new accommodation agreement or contact the family regarding the new rate change. The AA indicated on a specified date in 2014 she received an email from the Administrator that the resident's rate was to be reduced to basic rate and the accommodation rate was changed. [s. 91. (1) 2.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 :

Related to Log #O-001255-13

The licensee has failed to ensure that staff use safe transferring techniques when assisting residents.

A Critical Incident indicated that on a specified date PSW #128 was getting Resident #46 dressed out of bed for lunch. Resident was sitting upright at side of bed. PSW #128 turned around to get wheelchair and Resident #46 fell forward onto the floor sustaining an injury that required sutures at hospital.

Review of Resident #46's plan of care related to transferring and Falls/Balance indicated the resident requires extensive assistance – two + persons physical assist and the resident's risk of falls is high related to history of falls, unsteadiness, and self transferring but too weak to do so.

Resident #46's progress notes were reviewed. On a specified date, RPN #131 documented that Resident #46 fell from bed and sustained an injury. The resident was unconscious for a few minutes.

On a specified date, interview with PSW #128 indicated at the time of the incident, PSW#128 assisted Resident #46 to dress up and sat him/her up at edge of bed. Resident's feet at the time were not entirely flat on the floor. PSW #128 was aware of resident's transfer status of 2 persons assist and was waiting for another staff member to help. The resident fell, while PSW #128 was reaching over to pull the wheelchair and could not prevent the resident from falling.

On a specified date, interview with DOC indicated at the time of the incident, a bang was heard from Resident #46's room and found Resident #46 on the floor. The DOC indicated that PSW #128 should have not left Resident #46 sitting at edge of bed as the resident could not maintain upright sitting position and requires two persons assist for transfer.

An internal investigation completed by the home confirmed that PSW #128 had failed to use safe transferring techniques when the resident was left sitting at the edge of bed, unsupported. [s. 36.]

Related to Log #O-000500-14

The licensee has failed to ensure that staff use safe transferring techniques when assisting residents

A Critical Incident indicated that on a specified date while PSW #127 and PSW #110 were transferring Resident #46 from bed to wheelchair using a mechanical lift, the resident fell out of the sling onto the floor approximately 4 feet to the ground, sustaining an injury.

Resident #46's progress notes were reviewed. On the date of the incident, RPN #124 documented that PSWs on Pine unit were transferring Resident #46 from the bed to the wheelchair using a mechanical lift. During the transfer, Resident # 46 fell from the sling and sustained a skin tear. Sling used for transfer was blue with red boarder (Arjohuntleigh Article Num MAA4100m-s). No visible deficit was noted on sling all four clips were present and intact.

On a specified date interview with PSW #127 indicated at the time of incident the left hook snapped and had no idea how that happened. PSW #127 was operating the lift when PSW #110 was coming around. The hook was not broken, it was just snapped. PSW #127 stated "I should pay more attention".
On November 6, 2014 interview with PSW #110 indicated at time of incident he/she was assisting staff #127 to transfer Resident #46. PSW #110 hooked up the left side and checked it and PSW #127 hooked up the other side. While Resident #46 was lifted, the left hook came off causing the resident to slide down and roll to the floor. PSW #110 was not guiding the resident when the resident fell. PSW #110 was coming around to direct the resident to the chair.

A written statement by PSW #110 on the date of the incident indicated that while helping a staff member to transfer Resident #46 from the bed to the wheelchair, the resident slid out of the sling onto the floor.

A written statement by PSW #127 on the date of the incident indicated that while getting Resident #46 up from bed with my partner, we used the full lift that we were supposed to use. When lifting the resident up, the sling at the left side snapped and the resident slid out of the sling and fell.

An interview with DOC on a specified date indicated that, she was called to unit and found Resident # 46 on the floor. The DOC confirmed that PSW #127 and PSW #110 did not follow policy of operating the mechanical lift to ensure the resident is safe during the transfer. One PSW forgot to clip his/her side of the sling and the other PSW started to operate the lift while his/her partner was not ready to guide and reassure the resident during the transfer.

An internal investigation completed on a specified date by the home concluded that PSW #127 and PSW #110 had performed an improper mechanical lift which resulted in injury to resident.

The staff failed to ensure the Resident's safety during transfer. [s. 36.]

Related to Log #O-001202-14

The licensee has failed to ensure that staff use safe transferring devices or techniques when assisting residents.

Resident #49's progress notes were reviewed. On a specified date, RPN #141 documented that 2 staff were transferring Resident #49 from bed to wheelchair by a full mechanical lift (ergo). During the transfer, the resident was on the sling up in the air over the wheelchair and the mechanical lift tilted entirely with the sling backward. The resident was over the wheelchair and landed on it, no injury was noted. Resident Care Manager (RCAM) and maintenance were notified and the lift was taken to be repaired.

On November 6, 2014 interview with RPN #141 indicated that on the date of the incident, two PSWs were transferring Resident #49 from bed to wheelchair when the whole lift tilted entirely backwards with the resident. The lift had a defect or a problem and could not tell what was wrong with the lift. RPN #141 indicated that the

expectation is that PSWs should have checked the lift before use. An out of order sign was placed on the lift after the incident.

During an interview with PSWs #108, #142 and #143 they indicated that lifts are checked if working properly before use. The lifts are checked for charged batteries, proper sling, make sure the lift is clean, check arms if moving up and down and legs moving in and out, check if lift is easy to move, check sling is clean and not damaged. If a problem noted the nurse is informed, requisition is completed on computer and out of order sign will be placed on lift.

On a specified date and time, interview with Environmental Services Manager (ESM) indicated that lifts are inspected on monthly basis for preventative maintenance. The lifts are checked for the up and down and legs for out and close. If the lift is defective it will be removed for repair.

Review of a note by maintenance staff #144 indicated that an Ergo lift was tagged out of service and removed for inspection by maintenance on the date of the incident, after the incident occurred. A note by ESM indicated that the lift was tagged out in the maintenance shop from the date of the incident and a request for inspection was sent to Arjohuntleigh 15 days later.

Review of Arjohuntleigh service call report indicated the Ergo lift Maple #3 serial number ERLI-1887 which was used on the date of the incident, was inspected and found that the legs were loose and not aligned properly. The lift was repaired and technician suggested the some parts of the lift to be replaced including: 1 braked caster, emergency stop switch, hanger bar cover and pin assembly. The recommended parts were replaced.

There is no documented evidence that the Ergo lift Maple #3 serial number ERLI-1887 was inspected to be in good repair and safe for use prior to the incident by maintenance staff or by PSW staff prior to use with Resident #49. There was no maintenance record of this lift prior to the date of the incident and there was no documentation the lift was checked monthly similar to other lifts in the home as it was not included in the assets inventory of the home. [s. 36.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

Related to Log #000551:

The licensee has failed to ensure that strategies were developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Review of the current care plan for Resident #54 indicated the resident is diagnosed with cognitive impairment, is independently mobile, and demonstrates specified responsive behaviours and specified strategies to manage the responsive behavior.

Review of the progress notes over a 6 month period for Resident #54 indicated on specified dates and times 4 incidents where Resident #54 inappropriately touched another resident, 2 incidents where another resident was found in Resident #54's room without staff being aware, 3 incidents where Resident #54 attempted to hit or touch another resident but was stopped by staff. On one specified date Resident #54's monitoring was decreased from every 15 minutes to every 1 hour monitoring.

Interview of PSW #140 by Inspector #541 indicated that they are not currently monitoring Resident #54 as "his/her behaviours have calmed down". Observation of the resident's room by Inspector #541 indicated the specified interventions in Resident #54's care plan were not in place.

Review of the progress notes for Resident #54 indicated the resident demonstrated inappropriate sexually touching and sexual comments to several residents and staff. The resident also wandered into other resident's rooms and other residents wandering into the resident's room. The resident also displayed verbal and physical aggression towards staff and residents. The resident was placed on every 15 minute checks following the second incident of resident to resident sexual abuse.

The current care plan for Resident #54 indicated that some of the specified strategies suggested were not effective, but still in use and some of the specified strategies were not consistently implemented. Some of the specified strategies identified were not clear as to when they would be implemented. Some of the specified strategies to prevent sexually inappropriate responsive behaviour were not implemented. [s. 53. (4) (b)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 006

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to privacy was respected and promoted in caring for his or her personal needs.

On a specified date(while walking by), Resident #41 was observed lying in bed with pants pulled down to knees exposing the resident's genitals. The door was completely open and no curtains pulled for privacy.
Interview of RPN #100 who was passing by indicated PSW #101 had left the resident prepped for the RPN to complete a catheter treatment. The RPN entered the resident room and informed the resident that the door would be closed until the RPN could return for privacy. [s. 3. (1) 8.]

2. The following was observed:

- On a specified date and time, a nursing staff member was observed providing incontinence care to Resident #03 in the washroom, the door to the washroom was open; this is a shared (ward) room. During this same observation, another resident was lying in a bed within the room and was able to visualize the washroom and care being provided to Resident #03.

- On a specified date and time, two nursing staff were observed providing care to Resident #42; the door to the room was open to the hallway.

The Director of Care indicated that the expectation is that when care is being provided the privacy and dignity of each resident is to be maintained. The DOC indicated that annual education is provided to all staff with respect to Resident's Bill of Rights. [s. 3. (1) 8.]

3. The licensee failed to ensure the residents right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Observation of medication pass on Linden unit with RPN #132 indicated after the medications were prepared, the medication packages were tossed in the garbage bin without personal health information altered or removed. Observation of medication pass on Birch unit and interview of RPN #124 indicated that the medication packages are tossed in the regular garbage bin without personal health information altered or removed. [s. 3. (1) 11.]

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 right to privacy is respected and promoted in caring for his or her personal needs; to ensure the residents right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act and to ensure that the resident's right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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. The licensee failed to ensure that the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care related to internal transfers.

A complaint was received from the SDM of Resident #44 indicating on a specified

date in 2012 the resident was transferred from a semi-private room to a private room and SDM was not made aware of the transfer until after the resident was transferred.

Review of the progress notes from a specific date range in 2012 for Resident #44 indicated the resident was transferred from one unit on a specified date in 2012 the Resident was transferred to another unit and there was no indication the SDM was notified. [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan related to falls risk.

Log # O-000075-14:

A Critical Incident indicated that on a date in 2014 Resident #48 was found on floor in his/her room bedside. The resident was assessed and sent to the Hospital where a fracture was confirmed. Resident #48 has high-low bed, bed and chair alarms. At the time of this fall, the alarm was not attached to resident. Falls mat was not on floor beside bed.

Review of Resident #48's plan of care related to Transferring, Falls/Balance and Aids to Daily Living indicated that the resident is at high risk of falling. The plan of care direct staff to:
- Transfer with one person when calm and two person assist when agitated.
- Use bed/chair alarm as resident may attempt to self transfer.
- Keep bed in lowest position, rail down.
- Fall mat on floor beside bed.

Review of progress notes and fall incident report related to Resident #48's fall on a specified date in 2014 indicated that:
- Resident #48 was transferring at time of fall.
- Alarm was not attached to resident. The alarm was attached to the bed.
- Falls mat was not beside the bed. The fall mat was kept behind dresser.

On November 4, 2014 interview with RPN #129 indicated that Resident #48 is at high risk of falling. Interventions in place for Resident #48 to prevent falls include close monitoring, use of alarm in wheelchair, use of bed alarm, bed in lowest position.

On November 4, 2014, interview with DOC indicated that at the time of the incident staff did not follow the plan of care for Resident #48 where an alarm was not attached

to the resident and falls mat was not placed at bedside while the resident was in bed. [s. 6. (7)]

3. Related to Log #O-001171014 for Resident #42:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan.

Complainant #76 contacted the ActionLine on a specified date indicating Resident #42's call bell is rarely in reach. Complainant indicated, during an interview, that resident calls the family almost daily to report call bell and other personal items.

The current written care plan for Resident #42, indicates the following:

Toileting / Continence Care:
- ensure call bell in reach
- do not leave unattended on the toilet

Falls Risk:
- ensure call bell in reach
- commonly used articles are to be within reach

Aids to Daily Living:
- ensure call bell, table and other personal items are within resident's reach at all times

The following observations were made on specified dates and times:
- over bed table containing drinking bottles was observed in front of the closet door; resident was in bed (table was out of resident's reach)
- resident was in washroom using the toilet, door was ajar, and call bell was not in reach of the resident; no staff were in attendance

Resident #42 indicated in an interview on specified dates that the call bell is often not within reach and as a result needs to call family to contact the home to ask staff to come to room to assist. Resident commented that staff do not remain in room when resident is on the toilet and further commented that when the call bell is rung to get off the toilet that staff takes a long time to respond.

Staff #146, who works on the care unit where Resident #42 resides, indicated being

unsure if resident is to be left alone on the toilet or not and was unsure of what personal items were to be within resident's reach; staff indicated not being the primary care provider for this resident.

Resident Care Area Manager (#145) indicated that staff are to respond to call bells as quickly as possible; RCAM indicated that Resident #42's television remote, drinking bottles are to be within resident's reach but stated 'sometimes people forget'.

Director of Care indicated that staff working resident home area's should be aware of resident care needs. [s. 6. (7)]

4. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #13 was observed on a specified date by Inspector #554 to be sitting in a wheelchair which was tilted. two specified dates Resident #13 was observed by Inspector #541 sitting in a wheelchair which was tilted.

PSW staff members #S113 and #S115 as well as RPN staff member #S114 stated Resident #13's wheelchair is tilted for comfort and is not used as a restraint. Staff member #S115 stated this information would be found in the resident's care plan. Resident #13's care plan was reviewed and there is no indication that the resident's wheelchair is to be tilted. Staff member #S116 stated that the Occupational Therapist (OT) would determine if the resident's wheelchair was to be tilted. After a review of Resident #13's progress notes staff member #S116 confirmed there was no documentation by the OT to reflect why the wheelchair for Resident #13 is tilted.

The plan of care for Resident #13 failed to specify the reported need for the wheelchair to be tilted. [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 the plan of care for Resident #13, #48 and #42 is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15(2)(a), by not ensuring that the home, furnishings and equipment are kept clean and sanitary.

The following observations were from October 27-31, 2014:

- Toilets: dark brownish black staining was visible at the base of the toilet bowl, along the sealant and on the flooring surrounding the toilet in resident washrooms in the following home areas - Birch Unit: # B5, B9, B18, B23, B24; Linden Unit: # L4, L7, L10, L16, L19; Maple Unit: #M1, M3; Pine Unit: # P9, P11

- Flooring: dark brownish black staining, dust and or debris was visible on flooring in resident rooms and/or resident washrooms in the following home areas - Linden Unit: #L4, L7, L9, L10, L16, L17, L19; Birch #B9, B23, B24; Maple Unit: #M1, M3, M6, M14; Cedar Unit #C8; Pine Unit: #P9, P11; the brownish black staining or debris was easily removable when scraped.

- Windows: visible cobwebs, dead bugs and white staining was seen on windows or on window sills in the following home areas - Linden Unit: #L7, L10; Birch Unit: #B4,

B5, Birch Hall (end window) and Maple Lounge

- Shower Stall: Birch/Maple Spa Room – yellowish/brown staining along shower wall tiles

- Tub (ARJO): Birch/Maple Spa Room was observed on October 27-28, 2014 to be visibly soiled with brownish specs of debris and hair; the inside surface of the tub was dry on both occasions. Personal Support Worker(s) indicated that this tub is used on a daily basis for resident care.

- Shower Chair(s): seat of chairs(2) had whitish film visible on seating area of chairs

- Privacy Curtains: soiled in Linden Unit room #L17

Staff #118 indicated that the dark staining on the floors was wax build up and that housekeeping staff did not have time to scrap floors during routine daily cleaning.

Staff #117 indicated that a thorough cleaning of the toilets inside and out are completed as part of the daily cleaning as well as both the resident rooms and washrooms are dry and wet cleaned daily.

The ESM indicated no awareness of the build-up of dust, debris and/or wax on flooring in hallways or in resident rooms. The ESM indicated there is a procedure in place to remove build up on flooring and housekeeping staff should be routinely cleaning these areas. The ESM further indicated that the windows in the home are cleaned by an external contracted service bi-annually and on an as-needed basis by housekeeping staff when observed to need cleaning.

The ESM indicated that there is an expectation that the home is kept clean and sanitary at all times.

Note: Several of the identified resident rooms above had signage on the door indicating contact isolation and/or precautions are in place due to resident(s) identified as having a antimicrobial resistant organism. [s. 15. (2) (a)]

2. The licensee failed to comply with LTCHA, 2007, s.15 (2)(c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following was observed:

- Flooring: was lifting, had seams split or visibly torn in the following home areas - Birch Unit: #B20; Linden Unit: #L4, L7, L19; Maple Unit: #M14 and in common areas on Maple (flooring overlooking atrium), Birch/Cedar foyer area (two areas), Birch – in front of the nursing station

- Walls in resident rooms and/or washrooms: scuffed (black marks), paint chipped, dry wall compound visible or damage seen in the following home areas - Linden Unit: #L9. L16, L17, L19; Maple Unit: #M1, M3, M6; Birch Unit: #B9, B14, B18, B23

- Walls in common areas: scuffed (black marks), paint chipped, dry wall compound visible or damage seen in hallways in Resident Home Areas on Maple (specifically outside of #M17) , Linden, Birch(outside of tub room door and inside foyer as you enter the room) / in tub room on Linden (ceiling, areas of steel encasement exposed)

- Wall Guard: loose or missing in Linden Unit: #L10, L16, L19; Birch Unit #B14

- Closet Doors: scuffed (black marks), bent, off track or doors missing in Linden Unit: #L4, L9, L10, L17, L19; Birch Unit: #B5; Maple Unit: #M1, M3

- Washroom Door: wooden door has a hole in Birch Unit: #B23

- Bed Rails: paint chipped in Linden Unit: #L9; Birch Unit:#B23

- Wall Phone Jack: has no cover in Birch Unit: #B23; Maple Unit: #M6; and Cedar Unit: #C6

- Ceiling: cracked and/or having visible water staining in the following areas – outside of Birch Lounge, inside of Birch Lounge, outside of rooms on Maple Unit: #M7; Linden Unit: #L12

- Door Frames: scuffed (black marks), paint chipped or visible damage in room(s) on Linden Unit: #L7, L9; Birch Unit: #B9, B18; Maple Unit: #M1, M3, M6; Pine Unit: #P9, P11

- Window Screens: loose or bent in on Maple Unit: #M3; Linden lounge

- Window Screens missing in room on Birch Unit: #B24; Maple Unit #M1

- Window 'foggy': Birch Unit: #B5, B24

- Towel Rack: missing, or broken in room(s) on Birch Unit: #B9; Pine Unit: #P25

- Over the Toilet Hand Rails: rusted, paint chipped, foam arms torn or visible damaged in rooms on Linden Unit: #L4, L7, L9

- Washroom vanity laminate: chipped in rooms on Linden Unit: #L9, L17; Maple Unit: #M3; Birch Unit #B23 (note: damaged areas are porous in nature, and pose an infection control risk)

- Bedside Tables or Dressers: laminate surface is chipped or damaged in rooms on Birch Unit: # B23 (note: damaged areas are porous in nature, and pose and infection control risk)

- Shower Hand Rails: rusted in one shower stall in the Maple/Birch Spa Room

- Nursing Stations: laminate surrounding desk area is chipped or damage on Resident Home Area Units – Maple and Linden (note: damaged areas are porous and pose an infection control risk)

- Bathroom Vent: covered with cardboard and masking tape – Linden Unit: #L17

Staff #133, 134 and 135 all indicated being aware of the home's policy regarding communicating to maintenance if repairs and or damage is observed in resident rooms and/or throughout the home; staff indicated that the maintenance requisitions are completed on-line through PM Works and through this system go directly to the ESM. Staff #133 indicated 'urgent' issues are called directly to ESM.

Environmental Services Manager (ESM) reviewed the PM Works system for the period of September 01, through to October 31, 2014 and indicated that there were over 700 maintenance requisitions for home maintenance and/or repairs forwarded by staff. A random sampling of PM Works was conducted (together with ESM and Inspector) and failed to identify maintenance deficiencies in rooms on Birch Unit #20, 23; Linden Unit #16, 17, 19; flooring issues (lifting, or torn areas).

The ESM communicated that PM Works (home's maintenance repair system) is reviewed by himself on a daily basis and priority repairs are communicated to

maintenance and/or housekeeping staff for completion; the system functions the best when all staff utilize the program and reports areas of concern. [s. 15. (2) (c)]

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 the home, furnishings and equipment are kept clean, sanitary, maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 16, by not ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The following observations were made:
- Birch Unit – the window at the end of the hall was observed to be opened approximately fifteen inches (~37cm); the screen on this same window was bent and loose. This window is located on the second floor of the home where residents reside. (October 27, 2014)

- Birch Unit – Room #B18A – the window was observed to be open approximately fifteen inches (~37cm). This window is located on the second floor of the home where residents reside. (October 28, 2014)

The two identified window issues (opening > 15cm) were brought to the attention of the Administrator on the dates indicated above; windows were attended to by the Environmental Services Manager and the issue(s) were resolved on October 27 and 28, 2014.

Observations by Inspector #541:
- Windows opening greater than fifteen centimeters were identified in resident washrooms in Room(s), Maple #4 and Pine #11

The ESM indicated that an AirCon system had been removed from the two windows on the Birch Unit and it was an oversight of the department in not replacing the locking system that controls the opening of the windows following removal of the units.

The Administrator, as well as the ESM had no knowledge of the windows opening greater than fifteen centimetres prior to such being brought to their attention. On November 7, 2014 the windows openings were adjusted to not open greater than 15 cm. [s. 16.]

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 window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. Related to Log #O-000903-14 for Resident #48:

The licensee failed to comply with LTCHA, 2007, s. 22 (1), by not ensuring that any written complaint received concerning the care of a resident or the operations of the home is immediately forwarded to the Director.

The Action Line was contacted on a specified date by Complainant #75 voicing concerns relating to Hot Weather Temperature. The complainant indicated having had contacted the Administrator 6 days prior as to excessive temperatures within the home, but had not received a response from the home's Administrator; complainant remained concerned not only for loved one but other residents residing in the home.

The Administrator, during an interview on November 03, 2014, indicated receiving a written (email) from the complainant on a specified date specific to home temperatures; Administrator stated that the written complaint had not been forwarded to the Ministry of Health and Long Term Care.

Administrator indicated being aware that all written complaints were to be forwarded to MOHLTC and could not comment as to why the complaint by Complainant #75 had not been forwarded. [s. 22. (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 any written complaint received concerning the care of a resident or the operations of the home is immediately forwarded to the Director, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 37 (1)(a), by not ensuring that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

The following observations were made:
- Birch Room #6 – a toothbrush was seen lying on the counter in a shared (semi)washroom; the item was unlabelled. There is signage on the door indicating contact isolation/precautions.
- Birch Room #9 – a toothbrush and a denture cup were seen lying on the washroom vanity in a shared (semi) washroom; these items were unlabelled.
- Birch Room #24 – used disposable razors (3), denture cup and a tooth brush were seen lying on the washroom vanity in a shared (semi) washroom; these items were unlabelled. This room has signage on door indicating contact isolation/precautions.
- Maple Room #1 – a toothbrush inside of a toothbrush holder was seen lying on the washroom vanity in a shared (ward) washroom; the items were unlabelled.
- Maple Room #3 – a toothbrush was seen lying on the washroom vanity in a shared (ward) washroom; the item was unlabelled.
- Maple/Birch Tub Room – a hairbrush (used, contains hair) was observed sitting on the counter top in the shower area of this room. This is a communal care area.

Staff #133, 134 and 135, all indicated that personal care items are to be labelled as to which resident supplies belong too.

The DOC indicated that all resident care and/or grooming supplies (personal care) are to be labelled for individual resident use. The DOC indicated that all staff should label items when it is observed that items have no names (in addition to new admission items and new supplies). [s. 37. (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 each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labeled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 86 (2)(b), by not ensuring there are measures in place to prevent the transmission of infections.

The following observations were made on specified dates:
- A soiled incontinence product was observed lying on the counter top in the Linden Tub Room; during this same observation, soiled washcloths, towels, incontinence bed pad and pyjamas were observed in a sink in this same room.
- A soiled incontinence product, washcloth and towels were observed lying on the floor in a specified room.
- A soiled incontinence product and clothing were observed on the floor in a specified room.

The DOC indicated that at no time is any soiled product(s) or clothing to be placed on the floors in any area.

Other observations:
- A urinal was observed sitting on the back of a toilet in the Maple/Birch tub room; during this same observation a bed pan was seen lying on the floor in this same area. Both items were unlabelled; this is a communal resident care area.
- A urinal was observed was observed sitting on the back of the toilet in the Maple

/Birch tub room, during this same observation a grey bed pan was seen lying across an open seat on the toilet. Both items were unlabelled; this is a communal resident care area.
- A urinary catheter draining bag and tubing were observed lying in a basin under a sink in the washroom, of a specified room; the urinary drainage bag was unlabeled and soiled. During this same observation, an unlabelled urinal was seen sitting on the back of the toilet; this is a shared basic resident room.
- A urinary catheter drainage bag and tubing was observed hanging on a towel bar next to towels in the washroom of a specified room; the urinary drainage bag was unlabeled and soiled. During this same observation, an unlabeled urinal was seen lying on the back of the toilet; this is a shared (semi) resident room.

The home's policy, Equipment Cleaning (RSL-SAF-080) directs that bedpans and urinals are to be labelled for individual resident use and to be stored in a designated area.

Staff #133, 134 and #135 all indicated being aware of the home's policy and confirmed the practice of the home is to ensure all that resident care items (e.g. bedpans and urinals) are labeled with resident's name; items are to be stored clean and in each resident's night stand. Staff #134 indicated that one resident in one specified room is independent in caring for own catheter and changing over the larger urinary drainage bag to a smaller one each morning. Staff #134 indicated it is the staff's responsibility to ensure the catheter equipment is stored appropriately.

The DOC indicated that all bedpans and urinals are to be labeled for individual resident use and are not to be stored in communal resident washrooms. The DOC indicated that residents in rooms two specified rooms are independent in catheter care and have been reminded numerous times to properly store equipment.

Note: There are numerous rooms within the home (all resident home areas) which have identified residents colonized with Antimicrobial Resistant Organisms; the DOC has provided confirmation that incidence of Health Care Worker transmission has been identified within the home. [s. 86. (2) (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 there are measures in place to prevent the transmission of infections, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. As part of the organized program of maintenance services under LTCHA, 207 s. 15 (1)(c), the licensee has failed to comply with O.Reg 79/10 s. 90(2)(a) in that they did not ensure mechanical lifts are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum.

Log #O-001202-14

On a specified date in 2014, staff #141 documented that 2 staff were transferring Resident #49 from bed to wheelchair by a full mechanical lift (ergo). During the transfer, the resident was on the sling up in the air over the wheelchair, all of a sudden the mechanical lift tilted entirely with the sling backward and the resident landed in the wheelchair. Resident Care Manager (RCAM) and maintenance were notified and lift was taken to be repaired.

On November 6, 2014 interview with RPN #141 indicated that on the date of the incident two PSWs were transferring Resident #49 from bed to wheelchair when the whole lift tilted entirely backwards with the resident. The lift had a defect or a problem and could not tell what was wrong with the lift.

On November 6, 2014 interview with Environmental Services Manager (ESM) indicated that lifts are inspected on monthly basis for preventative maintenance. The lifts are checked for the up and down and legs for out and close. If the lift is defective it will be removed for repair.

Review of a note by maintenance staff # indicated that an Ergo lift was tagged out of service and removed for inspection by maintenance on the date of the incident, after the incident. A note by ESM indicated that the lift was tagged out in the maintenance shop from the date of the incident and a request for inspection was sent to Arjohuntleigh on October 8, 2014.

Review of Arjohuntleigh service call report dated October 14, 2014 indicated the Ergo lift Maple #3 serial number ERLI-1887 was inspected and found that the legs were loose and not aligned properly. The lift was repaired and technician suggested the some parts of the lift to be replaced including: 1 braked caster, emergency stop switch, hanger bar cover and pin assembly. The recommended parts were replaced on October 23, 2014. Until the final repair was completed, the lift was kept in the maintenance shop.

Review of Monthly Lifting Devices Inspection records for specified dates indicated that all lifts were inspected and no problems noted. The lifting device labelled Ergo lift Maple #3 serial number ERLI-1887 was not included on the list of devices inspected.

The ESM indicated that the lifting device Ergo lift Maple #3 serial number ERLI-1887 was not listed in the home's assets list. The ESM could not confirm if the lift was inspected at all by maintenance staff as it was not included in the Monthly Lifting Devices Inspection list.

There is no documented evidence that the Ergo lift Maple #3 serial number ERLI-1887 was inspected to be in good repair and safe for use prior to the incident on a specified date. [s. 90. (2) (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 mechanical lifts are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum., to be implemented voluntarily.

WN #15: 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. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

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

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- If an employee(s) is involved, immediately notify of the pending investigation requiring alleviation from duty pending completion of the investigation, including reporting requirements to the Director (MOHLTC) and local police authorities.
-The Registered Staff and the person discovering the abuse shall prepare a written incident report. All documentation of an alleged, actual, or suspected abuse incident will use descriptive and precise language free from opinion and conjecture. The report shall contain the following information and shall be submitted to the Administrator, General Manager, Director of Care, Wellness Coordinator and/or designate: what occurred, when it occurred, who was involved (including the names of witnesses or those who were in the vicinity when it occurred), what was observed/heard, written statements from witnesses including information pertaining to the incident.
-the Registered staff will report the alleged, actual, or suspected abuse to the Administrator, General Manager, Director of Care, Wellness Coordinator, and or designate, local police authorities, and the Director (MOHLTC).
-the Registered staff will immediately notify the Resident's substitute decision maker, if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident.
-the Registered staff will update the plan of care and progress notes following the incident as appropriate, inclusive of measures to assess the Residents physical and /or psychosocial well-being post incident as well as interventions to prevent recurrences.

On a specified date the Administrator was notified by Inspector of a staff to resident emotional abuse towards Resident #29. The following day, the Administrator was notified by Inspector of three more reports of staff to resident verbal abuse or neglect towards Resident #8, #15 & #30 that were received during stage 1 of the Resident Quality Inspection. The Administrator indicated that the incidents would be investigated immediately.

Interview of the DOC by Inspector #554 indicated that all allegations of resident abuse involving nursing staff are forwarded to the Director of Quality Nursing (DQN) to complete the investigation.

The DQN indicated he was notified of the allegations of staff to resident abuse/neglect approximately two days prior and initiated the investigations for Resident #8, #15 &

#30 on a specified date using the client feedback forms. The DQN indicated that the Administrator had completed the "client feedback" form for Resident #29 and was on the Administrator's desk. The DQN was not aware a "Resident Incident Report" was to be completed for allegations of abuse instead of a "Client Feedback" form. Later in the day, the DQN provided the inspector with copies of "Client Feedback" forms" for 3 out of the 4(for Resident #8, 15, & #30) who reported allegations of staff to resident abuse/neglect. There was no indication that any of the staff had been interviewed or notified of the allegations (despite working during that time period) or any other actions taken 4 days after the allegations were reported to the home.

There was no documented evidence that when the allegations of staff to resident abuse/neglect for Resident #8, #15, #29 & #30 were reported to the Administrator on specified dates, that the Administrator completed the resident incident report as indicated in the home's policy as "the person discovering the abuse" . The progress notes and plan of care were not updated regarding the allegations, as well as interventions to prevent recurrence and no indication that the substitute decision makers of the residents were notified of the allegations. [s. 20. (1)]

2. Related to Log #O-001171-14 for Resident #42:

Complainant #76 contacted Registered Practical Nurse #148 on a specified date and reported an allegation of verbal abuse directed toward Resident #42 by a staff member.

Staff #148, who was the charge nurse on the unit, Registered Nurse Supervisor, who was in charge of the home on the date of the allegation and RCAM #145 who became aware of the allegation of verbal abuse on a specified date all failed to:
- provide support and reassurance to the resident affected. As per interview on November 7, 2014, RCAM indicated not speaking with the resident following becoming aware of the incident
- immediately report the allegation of verbal abuse to the MOHLTC
- complete an incident report including, what occurred, when it occurred, who was involved, names of witnesses, where it occurred, what was observed and heard, nor was the allegation or report of such submitted to the Administrator, Director of Care and or designate; staff indicated Registered Nursing Supervisor directed staff to place the family complaint in the progress notes
- contact Administrator, Director of Care or designate as to the allegation of verbal abuse. During interview with the RCAM on November 7, 2014, she indicated forgetting to advise the DOC of the allegation.

- did not meet with any staff working the day of the allegation, as indicated Staff #148 spoke with two of the staff working that day and staff felt allegation unfounded. RCAM indicated that there were at least three other staff working the day shift indicated.
- contact the Resident and/or substitute decision maker following becoming aware of the incident and/or awareness of the outcome.

As of November 06, 2014, the Director of Care was investigating the concern of Complainant #76.

2) Related to Log #O-000658-14 for Resident #16:

An incident of Staff to Resident Verbal Abuse occurred on a specified date; the personal support worker involved with the incident was placed on a leave pending the outcome of the investigation.

The Registered Practical Nurse (#124), who was the charge nurse on the unit at the time of the incident reported the verbal abuse to Registered Nurse (RCAM #125), who was in charge of the home during the day shift on the date of the incident.

According to CIATT, MOHLTC was not notified of the incident until the following day.

Staff #124 and Resident Care Area Manager #125 both failed to:
- immediately contact MOHLTC as to the incident of Staff to Resident verbal abuse as per the Home`s policy.

3) Related to Log #O-000584014 for Resident #50:

According to a Critical Incident Report submitted, by the home's former Director of Care, on a specified date in an incident of alleged Staff to Resident (verbal/physical) Abuse was reported to have occurred on one day earlier.

Details of the CI are as follows:
Resident #52 reported hearing a staff member yelling at Resident #50 in the hallway sometime during the night; Resident #52 reports hearing staff yell at Resident #50 to go back to bed and then reports hearing a slapping sound followed by a yelping sound from Resident #50. According to the CI report, Resident #52 reported the incident to family; in turn, Resident #52's family reported the incident of verbal/physical abuse to Resident Care Area Manager (RCAM #123).

The home's Director of Quality-Nursing and the former Director of Care who was involved with the investigation failed to:
- contact the local police authorities of the allegation of physical abuse as per the Home`s policy. [s. 20. (1)]

WN #16: The Licensee has failed to comply with LTCHA, 2007, 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. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse or neglect of a resident by anyone that the licensee knows of, or that was reported was immediately investigated.

1.During stage one of the Resident Quality Inspection Oct 27-30, 2014:
-Interview of Resident #8 (by Inspector # 554) stated they "had a confrontation with a staff member, and at the time, I hurt my arm, had to use manual chair, and they left me in the dining room. I asked staff member "Can you take me back? I had to ask several times". Staff responded "I'm looking after a specified unit not your unit, get someone else."

Review of the progress notes for Resident #8 indicated during the care conference on a specified date, the home was notified of the resident's concern of neglect of care and indicated a "client feedback form was completed" at that time. The client feedback form or an investigation into the allegation could not be found. A "Client Feedback" form was provided to the inspector by the DQN on November 4, 2014 indicating Resident #8 had been re-interviewed and identified the staff member involved in the allegation of staff to resident neglect as PSW#136 but the staff member had not yet been interviewed. Review of the staff schedule for PSW #136 indicated the PSW worked evening shift on 6 occasions following the home becoming aware of the incident.

-Interview of Resident #30 stated "a couple of weeks ago, a staff member was yelling at me in the morning when they were washing my face but I don't know their name". On October 30, 2014 the Administrator was notified of the allegation of staff to resident verbal abuse towards Resident #30. Review of the "Client Feedback" form provided by the DQN indicated on November 4, 2014 the resident was interviewed by the DQN and indicated PSW #137 was the staff member allegedly involved in staff to resident verbal abuse. The form indicated staff member had not yet been interviewed regarding the allegation. Review of the PSW schedule indicated that PSW#137 worked 5 day shifts after the home became aware of the incident.

2. Related to Log #00051:

A critical Incident Report was received on a specified date for a resident to resident sexual abuse incident that occurred the day before. The CIR indicated at a specified time Resident #55 was seen walking with a PSW towards his/her room crying uncontrollably. The Charge Nurse asked the resident why he/she was crying and stated that Resident #54 was sitting on a chair across from him/her at the nursing station Resident #54 inappropriately touched Resident #55 and made a sexual gesture. Resident #55 was reassured and provided emotional support, head to toe completed with no noted injuries.

Review of the progress notes for Resident #54 (from a specified date range) indicated:
-on a specified date the resident was observed "displaying inappropriate sexual behaviour towards another resident". The PSW observed the resident inappropriately touch another resident. There was no indication which resident and no documented evidence of an investigation.
-on a specified date and time staff overheard voices in the residents room and when

entered the room, found another resident laying in the resident's bed. The resident was distracted while staff removed the other resident from the room. There was no incident report completed and no indication who the other resident was.
-on a specified date and time the resident was found in his/her room with door closed and Resident #57 in the room. Staff removed Resident #57 from the room. The resident followed them out of the room and then sat with Resident #57 near nursing station. The Resident was then observed inappropriately touching Resident #57 and when the PSW attempted to separate them the resident hit the PSW on the hand. Resident #57 was taken to his/her room. The POA of resident was not notified of incident.

Review of the homes investigations and interview of staff indicated there was no investigations completed related to witnessed or suspected incidents of sexual abuse that occurred on 3 specified dates in 2014. [s. 23. (1) (a)]

2. Related to Log #O-000584-14 for Resident #50:

The licensee failed to comply with LTCHA, 2007, s. 23 (1) (b), by ensuring that the appropriate action is taken in response to every such alleged, suspected or witnessed incident of abuse of a resident by anyone.

According to a Critical Incident Report submitted, by the home's former Director of Care, on a specified date an incident of alleged Staff to Resident (verbal/physical) Abuse was reported to have occurred one day earlier. The CI was later amended indicating the incident of alleged abuse was to have occurred on or about 3 days prior to the previous date submitted.

Details of the CI are as follows:

- Resident #52 reported hearing a staff member yelling at Resident #50 in the hallway sometime during the night; Resident #52 reports hearing staff yell at Resident #50 to go back to bed and then reports hearing a slapping sound followed by a yelping sound from Resident #50. According to the CI report, Resident #52 reported the incident to family; in turn, Resident #52's family reported the incident of verbal/physical abuse to Resident Care Area Manager (RCAM #123).
- Resident #50 was assessed by RCAM on a specified date; no injury was visible. Resident did not recall the incident due to poor short term memory.

During an interview, on November 04, 2014, the Director of Care and Director of

Quality-Nursing, indicated that RCAM #123 notified the former Director of Care of the allegation of Abuse on the date he/she became aware of it.

Director of Quality indicated that Resident #52 was interviewed on or about a specified date; resident indicated in the interview that the incident did not occur on a specified date but occurred two days prior on the Saturday at a specified time; according to the Director of Quality, Resident #52 indicated over hearing the incident, but did not look into the hallway to see which staff was involved nor was the incident reported to anyone on the night of the incident.

Director of Care indicated that Resident #52 has since deceased but was cognitively well when the incident was reported.

Director of Care (current) indicated that there were three staff (a Registered Practical Nurse and two Personal Support Workers) assigned to work the night shift, on Resident #50 and #52's home area, on the Saturday in question. DOC indicated not being involved with the staff interviews, and deferred further comments to the Director of Quality.

Director of Quality-Nursing stated that he and the former Director of Nursing interviewed the three staff as to the allegation of Abuse; Director of Quality indicated Staff #120, #121 and #122 were not interviewed as to the allegations until 7 and 8 days after the home becoming aware of the incident.

A review of the home's Staffing Assignment Schedule, for a specified date range, indicated that Staff #120, #121 and #122 worked shifts following the allegation and prior to being interviewed by the licensee or its designate on dates indicated above.

Director of Quality could not comment as to why there was a delay in investigating the incident of alleged Staff to Resident Abuse.

Director of Quality commented the investigation as to the allegation of abuse was completed on a specified date and findings were inconclusive.

Director of Quality indicated that the practice of the home is to immediately investigate all allegations of suspected or witness abuse and that during the investigation, staff alleged to be involved are normally placed on a leave of absence pending the outcome of the investigation. [s. 23. (1) (b)]

3. Related to Log #O-001171-14, for Resident #42:

Complainant #76 contacted the home on a specified date, to report that Resident #42 had asked a staff member to turn off the television, as remote control was not within resident's reach; complainant indicated that a staff member stated, to the resident, "I'm not your bloody slave". Complainant indicated being concerned as to the way his/her loved one is being treated in the home when family is not around.

Complainant #76 stated the concern surrounding verbal abuse was brought to the attention of Registered Practical Nurse #148, who was the Charge Nurse working on Birch Resident Home Area that day.

Staff #148, during an interview on a specified date, indicated that only two of the day staff were spoken with as to the allegation and both had denied such. Staff #148 indicated only staff wearing glasses were spoken with as the complainant commented that Resident #42 thought the individual having made the comment was wearing glasses.

Staff #148 indicated not speaking with Resident #42 as to the allegation as family were the one's making the complaint not the resident; staff indicated Resident #42 was cognitively well.

Staff #148 indicated communicating the concern to the Registered Nurse Supervisor, in charge of the home, on the date of the allegation, who directed to place the complaint into the progress notes.

Resident Care Area Manager (RCAM #145) indicated being made aware of the allegation of verbal abuse on 2 days after the allegation while reading weekend progress notes but stated nothing further was needed to be done as two of the day staff were spoken to on a specified date by Staff #148 and the situation was deemed unfounded. RCAM indicated not speaking to Resident #42 nor the family as to the complaint.

RCAM #145 stated that the allegation of verbal abuse was not brought to the attention of the Director of Care as she had forgotten to.

Administrator indicated that the Registered Practical Nurse, Registered Nurse and Resident Care Area Manager should have spoken to the resident, family and all staff specific to the allegation of verbal abuse. [s. 23. (1) (b)]

4. The licensee has failed to ensure that appropriate action was taken in response to every such incident of abuse and/neglect.

-Interview of Resident #15 on a specified date stated "a staff member yells at him/her and is rude". The Administrator was notified of the allegation the following day. Review of the "client feedback form" provided by the DQN on a specified date indicated that PSW #134 was the alleged staff member involved in the incident and was to be interviewed by the DOC. Review of the staff schedule indicated that PSW #134 had worked 3 day shifts between from the date of the allegation until the home provided Inspectors with the client feedback form.

- Resident #29 stated during an interview on a specified date that "I had an earache and reported it to the RPN who told me the doctor would be in tomorrow to assess. The following day I saw the physician but he did not come to see me. A week later, the physician came in to see me and I stated I still have the earache and the physician said very loudly and abruptly to me "do you realize people die here". I just wanted my ear ache dealt with but I didn't like that." On a specified date the Administrator was notified of the allegation of physician to resident emotional abuse towards Resident #29. Review of the homes investigation indicated on a "client feedback log" on the date the home became aware of the incident, the resident was interviewed and confirmed what was reported to the inspector. The form indicated under further action: "speak to Dr." to be completed by Administrator and DOC. There was no indication the physician was interviewed as of 7 days later and the physician had been in the home on 4 times since the home becoming aware of the incident. [s. 23. (1) (b)]

WN #17: 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, 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 Log #O-000658-14 for Resident #16:

The licensee failed to comply with LTCHA, 2007, s. 24(1), by not ensuring the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specific to:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by another other than a resident.

A home's former Director of Care, submitted a Critical Incident Report on a specified date. The CI details an incident of Staff to Resident (verbal) abuse, which was said to have occurred 2 days prior; details of the incident are as follows:

- Staff #119 was asked by Resident #16 to make resident's bed; Resident #16 called

staff 'a lazy bitch'. Staff #119 responded 'I'm not a bitch, you are the bitch'.

The allegation of Staff to Resident (verbal) abuse was reported by the Registered Practical Nurse (#124) to the Resident Care Area Manager (RCAM #123), who was the supervisor in the home during the incident which occurred on a specified date.

According to the CI report, the RCAM contacted the Director of Care of the incident.

The incident of Staff to Resident Verbal Abuse was not reported to the Director within the timeframe required by legislation.

The DOC and the Director of Quality-Nursing both indicated awareness of the requirements under Section 24. [s. 24. (1)]

2. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm was immediately reported to the Director.

Related to log 000551:

Review of the progress notes for Resident #54 indicated:
-on a specified date and time the resident was found in his/her room with door closed and Resident #57 in the room. Staff removed Resident #57 from the room and the resident followed them out of the room as well. The resident then sat with Resident #57 at the nursing station and was observed "inappropriately touching Resident #57 and when the PSW attempted to separate them the resident hit the PSW on the hand" Resident #57 was taken to his/her room.

Interview of the DOC indicated the incident was not reported to the Director. [s. 24. (1)]

3. Related to Log #O-001171-14 for Resident #42:

The licensee failed to comply with LTCHA, 2007, s. 24 (1), by not ensuring that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director;
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by another other than a resident.

Complainant #76 contacted the home on a specified date and time to report that Resident #42 had asked a staff member to turn off the television, as remote control was not within resident's reach; complainant indicated that a staff member stated, to the resident, "I'm not your bloody slave". Complainant indicated being concerned as to the way his/her loved one is being treated in the home when family is not around.

Resident #42, during an interview on a specified date, indicated feeling belittled by the comment of staff; resident further commented 'I can't wait to get out of this place'.

Complainant #76 stated the concern surrounding verbal abuse was brought to the attention of Registered Practical Nurse #148, who was the Charge Nurse, working on Birch Resident Home Area that day.

Staff #148 commented during an interview on a specified date, that the allegation of verbal abuse was brought to the attention of the Registered Nurse Supervisor, who was in charge of the home, on November 01, 2014.

Staff #148 indicated that MOHLTC was not contacted as to the allegation of verbal abuse, as that is not staff's role, but a supervisor's job.

Resident Care Area Manager (#145) indicated awareness of the allegation but commented such was not reported to Director.

The DOC indicated no awareness of Complainant #76's allegation of verbal abuse.

The Administrator indicated that all staff are to report allegations of Abuse. [s. 24. (1)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. Related to log #000551:

The licensee has failed to ensure that direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours require heightened monitoring because those behaviours pose a potential risk to the resident or others.

A critical Incident Report was received on a specified date for a resident to resident sexual abuse incident that occurred on a specified date and time. The CIR indicated at a specified time Resident #55 was seen walking with a PSW towards his/her room crying uncontrollably. The CN asked the resident why he/she was crying and Resident #55 stated that Resident #54 was sitting on a chair across from him/her at the nursing station and reached over and placed his/her hand between his/her legs, touching his/her private area and then touched him/herself.

Review of the current care plan for Resident #54 indicated the resident is diagnosed with cognitive impairment, is independently mobile, and demonstrates specified responsive behaviours and specified strategies to deal with the responsive behaviors.

Interview of PSW #101 by Inspector #541 who works part time on the unit where Resident #54 resides, had no knowledge of the Resident's demonstrated behaviours of physical aggression and sexually inappropriate behaviours. [s. 55. (b)]

WN #19: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. Related to Log #O-000658-14, for Resident #16:

The licensee failed to comply with LTCHA, 2007, s. 76(4), by not ensuring that all staff have received retraining annually relating to the following:
• The Residents' Bill of Rights
• The home's policy to promote zero tolerance of abuse and neglect of residents
• The duty to make mandatory reports under section 24
• The whistle-blowing protections

An incident of Staff to Resident abuse was reported to CIATT (Centralized Intake, Assessment and Triage Team) on a specified date involving Staff #119. The investigation by the home, concluded on or about 2 days later, concluding Resident #16 was verbally abused by Staff #119.

A review of annual education records (SURGE Learning) specific to Staff #119 failed to provide evidence to support that this staff member received retraining specific to Zero Tolerance of Abuse, Section 24, and Resident Bill of Rights in 2013, nor prior to incident (allegation of abuse) which occurred on a specified date.

According to staff annual education records, Staff #119 has since received education, as described above, on September 24 and September 28, 2014.

The DOC indicated it is the practice of the home that all staff receive annual re-training specific to Zero Tolerance of Abuse and Resident's Bill of Rights. The DOC did confirm that Staff #119 did not complete re-training in 2013 nor prior to to the incident on June 07, 2014. [s. 76. (4)]

WN #20: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Residents' Council is sought in developing and carrying out the satisfaction survey, and in acting on its results.

On November 3, 2014 during an interview with Inspector #541, Resident Council President was unable to recall the satisfaction survey being discussed with the Resident's Council.

On November 4, 2014 during an interview with the Program Manager, she confirmed that because the resident satisfaction survey is administered by a third party, the advice of the resident's council was not sought in the development of the survey. This was confirmed by the Administrator on November 6, 2014. [s. 85. (3)]

2. The licensee has failed to ensure that the advice of the Family Council is sought in developing and carrying out the satisfaction survey.

On November 5, 2014 during a phone interview with Inspector #541, the president of the family council stated that no input from the council was sought in the development of the satisfaction survey. On November 6, 2014 during an interview with Inspector #541 the Administrator confirmed that the advice of the Family Council was not sought in the development of the satisfaction survey. [s. 85. (3)]

WN #21: 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 has failed to ensure that the licensee's written policy to promote zero tolerance of abuse and neglect of residents identified 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.

Review of the homes policy "Required Abuse and Neglect Reporting" Revised July 1, 2012 (HRM-POL-003) under procedures (items 5-8)indicated:
5. If an employee(s) is involved, immediately notify of the pending investigation requiring alleviation from duty pending completion of the investigation, including reporting requirements to the Director (MOHLTC) and local police authorities.
6.Any person who witnesses, suspects, becomes aware of or is involved in abuse or neglect of a Resident are required to immediately report the abuse or neglect incident to the Administrator or General Manager and or Director of Care or Wellness Coordinator, and/or designate.

7. The Administrator, General Manager, Director of Care, Wellness Coordinator and/or designate will immediately report the incident to the Director (MOHLTC) and local police authorities. Subsequent immediate mandatory critical incident system reporting will be completed for the Long Term Care homes only.
8. The Registered Staff and the person discovering the abuse shall prepare a written incident report.
Interview of the Director of Care (DOC) by Inspector #554 indicated that all allegations of abuse and/or neglect related to nursing staff are forwarded to the Director of Quality Nursing (DQN) to complete the investigation.
Interview of the Director of Quality Nursing (DQN) by Inspector #111 on November 4, 2014 indicated that when the Administrator is notified of allegations of staff to resident abuse/neglect, are by nursing staff, it is forwarded to DOC, who then forwards it to the DQN to complete the investigation. The DQN indicated "any of the managers could complete the client feedback form". The DQN indicated that the DOC and/or Administrator also completed interviews during investigations. The DQN indicated he was notified of the allegations of staff to resident abuse/neglect approximately two days ago (November 2, 2014). The DQN indicated that the Administrator had completed the client feedback form for Resident #29's allegations but he had not completed the "client feedback form" for any of the remaining 3 allegations (for Resident #8, 15& #30) and would initiate the investigations today. The DQN was not aware a "Resident Incident Report" was to be completed for allegations of abuse/neglect instead of a "Client Feedback Form" and was provided a copy of the "Resident Incident Report" form during the interview. On November 5, 2014, the DQN provided the inspector copies of "Client Feedback Forms" for 3 out of the 4 reported allegations (for Resident #8, 15, & #30) of staff to resident abuse/neglect. The DQN indicated only the resident's had been interviewed regarding the allegations and staff members identified. The DQN indicated that the "Client Feedback Form" for Resident #29 was completed by the Administrator and was on the Administrator's desk. There was no indication that any of the staff had been interviewed or notified of the allegations (despite working or in the home during that time period).

Under this policy, item #5 does not indicate who is responsible to immediately notify the staff of the pending investigation. Item #6 indicates that any person, who witnesses, suspects or becomes aware of or is involved in abuse or neglect of a Resident is required to immediately report to Administrator or General Manager but does not indicate when it is the Administrator (who receives the report of abuse or neglect) what their responsibility is. Item #7 indicates only the Administrator, General Manager, DOC, Wellness Coordinator or designate will report incidents to Director (MOHLTC) and local police authorities but there is no "General Manager"' or

"Wellness Coordinator" position in the home. The policy does not reflect the current practice in the home where the Administrator (who received 4 allegations of abuse and/or neglect) notified the Director of care, who then notified the Director of Quality Nursing" who was then responsible for completing the investigations. The DQN also indicated that the investigations where to be completed in conjunction with the DOC and/or Administrator. [s. 96. (d)]

WN #22: 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).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident, were immediately notified upon becoming aware of alleged, or suspected incident of abuse or neglect of a resident that resulted in a physical injury or pain to the resident or caused distress to the resident that could potentially be

detrimental to the resident's health or well-being.

During stage one of the Resident Quality Inspection which took place October 27-30, 2014:
-interview of Resident #30 stated: "a couple of weeks ago, a staff member was yelling at me in the morning when they were washing my face but I don't know their name". The resident did not report the incident to anyone.
-interview of Resident #8 (by Inspector # 554) stated they "had a confrontation with a staff member, and at the time, I hurt my arm, had to use manual chair, and they left me in the dining room. I asked staff member "Margaret can you take me back? I had to ask several times". Staff responded "I'm looking after Maple not Birch, get someone else."

The Administrator was notified of the above allegations of staff to resident emotional abuse and neglect by Inspector #111 on October 29, 2014. Review of the homes investigation for Resident #30 indicated on November 4, 2014 the resident was re-interviewed by the DQN but there was no indication the SDM was notified. Review of the homes investigation for Resident #8 completed by the DQN indicated on November 4, 2014 the resident was interviewed but no indication the SDM was notified.

Review of the health care records for Resident #30 had no documented evidence that the SDM, or any other person specified by the resident were notified of an alleged incident of verbal abuse. Review of the health care record for Resident #8 indicated a care conference note indicated the home was notified of the resident's concern of neglect of care regarding that incident and a "client feedback form was completed". Inspector #554 reviewed the complaint binder and there was no indication of a "client feedback form" completed or an investigation to indicate the SDM was notified of the alleged staff to resident neglect. A "client feedback form" (home's investigation) was provided to the inspector by the DQN on November 4, 2014 indicating Resident #8 had been re-interviewed but the SDM had still not been notified. [s. 97. (1) (a)]

2. Related to Log #O-001171-14 for Resident #42:

The licensee failed to comply with O. Reg. 79/10, s. 97 (2), by not ensuring that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Complainant #76 reported an allegation of verbal abuse on a specified date to

Registered Practical Nurse #148, who is the unit Charge Nurse. Complainant indicated that to date no one from the home has contacted the family as to the allegation or the outcome of any investigation.

Complainant indicated that this is not the first complaint and that family is concerned as to how their loved one is being treated when family are not present.

Staff #148, during an interview on a specified date, indicated not contacting the complainant following family voicing their concern on a specified date; staff indicated communicating concern to the Registered Nurse Supervisor, who was in charge of the home and working the day of the allegation.

Resident Care Area Manager #145, who oversees the care area where Resident #42 resides, indicated being aware of the allegation but indicated neither the resident nor family had been contacted by her. RCAM indicated that she felt the situation was resolved as staff had denied the allegation; RCAM did not feel the need to contact family.

The DOC indicated no awareness of the allegation which occurred on a specified date and agreed that someone should have contacted the family as a follow up. [s. 97. (2)]

WN #23: 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 #O-000584-14 for Resident #50:

The licensee failed to comply with O. Reg. 79/10, s 98, by not ensuring that the appropriate police force is immediately notified of any alleged, suspected, or

witnessed incident of abuse of a resident.

According to a Critical Incident Report submitted, by the home's former Director of Care, on a specified date an incident of alleged Staff to Resident (verbal/physical) abuse was reported to have occurred on one day earlier. The CI was later amended indicating the incident of alleged abuse was to have occurred on or about two days prior to the original date submitted.

Details of the CI are as follows:

- Resident #52 reported hearing a staff member yelling at Resident #50 in the hallway sometime during the night; Resident #52 reports hearing staff yell at Resident #50 to go back to bed and then reports hearing a slapping sound followed by a yelping sound from Resident #50.
- According to the CI report, Resident #52 reported the incident to family; in turn, Resident #52's family reported the incident of verbal/physical abuse to Resident Care Area Manager (RCAM #123).

The DOC and Director of Quality both indicated the allegation of abuse (verbal/physical) was not reported to the police.
The Director of Quality, who was present during the investigation of the abuse, indicated the incident was not reported to the police as Resident #50 was assessed by registered nursing staff and found to have had no visible injuries nor could resident recall the incident. [s. 98.]

2. Related to Log #000551:

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

A Critical Incident Report (CIR) was submitted by the home on a specified date for a resident to resident sexual abuse incident that occurred on a specified date and time. The CIR indicated Resident #55 was seen walking with a PSW towards own room and "was crying uncontrollably". When CN ask resident why the he/she was crying, the resident stated that Resident #54 was sitting on a chair across from him/her at the nursing station when [Resident #54] reached over and placed his/her hand between his/her legs, touching his/her private area and then touched him/herself. The CIR had no indication that police were called.

Review of the progress notes for Resident #55 and Resident #54 on the date of the incident had no indication the police were notified.

Interview of the DOC indicated that if it was not indicated on the CIR then they were not notified. [s. 98.]

Issued on this 30 day of January 2015 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ottawa Service Area Office
347 Preston St, 4th Floor
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : AMBER MOASE (541) - (A1)

Inspection No. / No de l'inspection : 2014_280541_0035 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-001065-14 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jan 30, 2015;(A1)

Licensee / Titulaire de permis : COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

LTC Home / Foyer de SLD : COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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 : Mona Babb

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To COMMUNITY LIFECARE 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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.

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

3. A response shall be made to the person who made the complaint, indicating,

i. what the licensee has done to resolve the complaint, or

ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to achieve compliance with O. Reg. 79/10, s. 101.

The licensee shall ensure the plan includes:
- a review the home's policy relating to complaints and or concerns for all staff; awareness of roles and responsibility as it relates to the same
- a process in place to ensure complaints and concerns received are documented/recorded, investigated, resolution made were possible and outcome communicated with resident or family
- a process in place to ensure complaints documented are reviewed and analyzed for trends at least quarterly; and that the review is used to make improvements within the home
- a process in place to monitor that all written complaints received are forwarded to the MOHLTC, along with the outcome of the investigation and accompanying resolution
- measures in place when non-adherence to the home's policy and or legislation is identified

The plan shall be submitted in writing and emailed to Inspector, Amber Moase at amber.moase@ontario.ca on or before February 2, 2015. The plan shall identify who will be responsible for each of the corrective action listed.

Grounds / Motifs :

1. Related to log #O-000903-14 for Resident #48:

The licensee failed to comply with O.Reg.79/10, s.101 (1)1 by not ensuring 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:
• has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and
• where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately investigated

The Action Line was contacted on a specified date by Complainant #75 voicing concerns relating to Hot Weather Temperature. The complainant indicated having had contacted the Administrator 6 days prior as to excessive temperatures within the home. The Administrator, during an interview on November 03, 2014, indicated

receiving a written (email) complaint from Complainant #75 on a specified date; details of the complaint were as follows:

- Complainant indicated visiting a family member (a resident of the home) on several occasions; while sitting in the dining room assisting resident observed sweat pouring of the faces of kitchen and nursing staff, as well as off the faces of many of the residents. Complainant indicated during the same observation, resident's faces being flushed. The written complaint indicated the temperatures in the dining room were oppressively hot and quite unbearable.

The Administrator provided further email correspondence written by Complainant #75 on three other dates requesting a meeting with the Administrator and Resident Care Area Manager to discuss excessive hot temperatures and other concerns. The Administrator did comment that a meeting with the complainant occurred on a specified date, but agreed the meeting and or communication was twenty days following the initial complaint.

According to the Meeting Minutes, on a specified date, the response provided by the Administrator to the Complainant, surrounding excessive temperature within the home, was 'everything that could be done was being done'.

The Administrator indicated that an investigation relating to complainants concerns was not completed as the home was doing everything possible to control the home's heating and cooling.

The Environmental Services Manager (ESM), on a specified date, indicated no awareness of this complaint with regards to excessive temperatures within the home. [s. 101. (1) 1.]

2. The licensee failed to comply with O. Reg. 79/10, s. 101 (2), as it relates to a verbal complaint made by complainant #76 and Residents #07, 53 and 08 by not ensuring that a documented record is kept in the home that includes:
(a) the nature of each verbal complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a

description of the response, and
(f) any response made by the complainant

Related to Log #O-001184-14, for Resident #42:

Complainant #76 contacted the ActionLine on a specified date voicing a concern as to the temperature in the home and its effect on complainant's loved one. Family indicated that concerns have been voiced to the Director of Care (DOC) and the home has not done anything about the concern.

The Director of Care indicated that a call was received by Complainant #76 regarding the heat once sometime last month. The DOC indicated a Client Feedback Form had not been completed as the call was not taken as a complaint but a concern. The DOC indicated that the home is sometimes warmer than usual but the heating system is older and difficult to regulate.

The Administrator and Environmental Services Manager indicated no awareness of this family's complaint.

Relating to Residents #07 and #53:

Residents #07 and #53 indicated reporting complaints to the management and or nursing staff, relating to a) their room being cold, especially the washroom and; b) that two residents across the hall cry all night long. Residents indicated these are long standing complaints without resolution. Residents indicated they have stopped voicing concern as their complaints go unheard. It was also noted that the vent in bathroom has been covered with cardboard and masking tape; On a specified date residents indicated staff had covered the vent.

The ESM indicated that Residents #07 and #53 frequently complain of their rooms being cold but when investigated the ESM finds the window open; ESM indicated no awareness of the vent in the room being covered with cardboard and masking tape.

Staff # 102, who works on the resident home area where Resident #07 and #53 resides, indicated being aware of the resident's concerns about the two residents crying or frequently calling out, indicating the (responsive) behaviour is normal for the residents.

The DOC indicated no awareness of the complaints by Resident #07 and #53 re: residents crying all night, but did indicate the concern would be addressed with Resident Care Area Manager.

Relating to Resident #08:

Resident #08 indicated voicing several complaints to the management team during a care conference on a specified date; resident indicated voicing the following complaints, a) the drapes in the resident's room had not been cleaned in over two years, b) when resident rings call bell for assistance, staff enter the room, cancel the call bell and indicate they will get someone to assist; resident indicated staff rarely return; and c) referred to an incident where resident asked for assistance in returning to room and staff shouted I'm busy helping residents on a specified unit, I'm not assigned to your unit, you will need to ask someone else to assist you. A progress note in resident #08's health record indicated that Staff #124 completed a Client Feedback Form following the conference.

The DOC indicated no awareness of Resident #08's concerns which were voiced at the annual care conference held on a specified date, despite Staff #124 indicating in the progress notes that a Client Feedback Form had been completed. Both the Director of Care and Director of Quality had no record to a form being completed. The Director of Quality indicated that Staff #124 can not recall if a form had been completed.

A review of the home's Client Feedback Forms 2014 binder (complaints log) for a 4 month period failed to provide any supporting documentation that the complaints voiced by Resident #07, 08, 53 and Complainant #76 were recorded on the Client Feedback Forms as indicated in the home's policy (Complaint Handling Process, ADM-QUA-100) nor is there any supporting records indicating the management of the home responded to the complainants.

The home's policy, Complaint Handling Process (ADM-QUA-100) directs that a Client Feedback Log is to be completed by any person receiving a concern or complaint. The policy communicates that it is the responsibility of the person receiving a concern or complaint to document the information on the Client Feedback Log Form, if follow up is required; identifying actions taken or recommended actions and names of persons accountable for these actions. The completed form is to be submitted to the Administrator.

The policy indicates that resident, family and visitor concerns are to be addressed promptly in an efficient manner and that client satisfaction is evidenced.

The Administrator indicated not being aware of any of the above concerns, despite resident's and family indicating concerns were voiced to the management team and asked that inspector addresses these concerns to others on the management team. [s. 101. (2)]

3. The licensee failed to comply with O. Reg. 79/10, s. 101 (3), by not ensuring that complaints received are reviewed and analyzed for trends at least quarterly and that the results of the review and analysis are taken into account in determining what improvements are required in the home.

The Administrator indicated, in an interview on November 03, 2014, that the Admission's Coordinator tracks all complaints and completes trending and analysis; the Administrator indicated that trending and analysis of complaints is completed but was unsure how often and commented complaints are to be reviewed at quarterly Leadership meetings but this has not been consistently occurring over the past year.

The Admission's Coordinator indicated being recently assigned the role of grouping complaints into categories (e.g. communication, lost money, clothing or property, resident issues, food issues, etc.) but indicated the management team has not yet utilized the information to determine trends occurring nor has information been used in determining improvements required in the home. The Admission's Coordinator indicated that this is a new process for the home and has not been completed on a quarterly basis.

The home's policy, Complaint Handling Process-Client Feedback Log (ADM-QUA-100) directs that the Administrator will complete the Client Feedback Log Summary Log on a monthly basis and will provide a summary of all Client Feedback Logs for the previous month to the Leadership/Partnership Team.

The policy further directs that the client feedback summary (monthly) is to be utilized for identifying trends, risk problems, and recommendations. [s. 101. (3)] (554)

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

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

Feb 02, 2015

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to achieve compliance with O. Reg. 79/10, s. 229.

The licensee shall ensure the plan includes:
- a review of infection control program and related policies to ensure staff are aware of their roles and responsibilities within the program and in mitigating risk of transmission of infections
- education for all staff relating to infection control including but not limited to, modes of transmission, use of personal protective equipment, and hand hygiene
- a process to monitor the effectiveness of infection prevention and control education
- measures to be taken when non-adherence to infection control policies, practices and procedures are identified

The plan shall be submitted in writing and emailed to Inspector, Amber Moase at amber.moase@ontario.ca on or before January 30, 2015. The plan shall identify who will be responsible for each of the corrective action listed.

Grounds / Motifs :

1. The licensee failed to comply with O. Reg. 79/10, s. 229 (4), by not ensuring that staff participate in the implementation of the infection prevention and control program.

The following observations were made:

- Staff #117 was observed, on a specified date, cleaning a specified room; staff was observed not wearing personal protective equipment (PPE), despite signage on the door indicating Contact Isolation/Precautions. Staff #117 indicated being told by Registered Nursing Staff that PPE's were not required. It is noted that this is a shared resident room.

- Staff #118 was observed, on a specified date, cleaning room a specified room; staff was observed not wearing personal protective equipment (PPE), despite signage on the door indicating Contact Isolation/Precautions. During this same observation, Staff #118 had the housekeeping cart inside of the room. Staff indicated that the residents residing in the room were not contagious and that PPE's were not required when

cleaning the room. It is noted that this is a shared resident room.

- On a specified date, two nursing staff were observed caring for a resident in bed, in a specified room; staff were not seen wearing personal protective equipment (PPE), despite signage on the indicating Contact Isolation/Precautions.

The home's policy, Isolation - Daily Cleaning (HKG D-10-05) directs that the Housekeeping Aide is to gown and glove at entrance of isolation rooms prior to cleaning.

The ESM indicated that Housekeeping Staff are to wear personal protective equipment (gown, gloves, ect.) at all times when cleaning rooms with signage indicating Contact Precautions /Isolation or any other infection precautionary signs. The DOC and ESM confirmed that the Registered Nursing staff had provided improper direction to the staff regarding the PPE.

The ESM confirmed that both Staff #117 and #118 had annual education specific to infection control, which included cleaning and disinfection and additional precautions / use of PPE's; training was completed May and June 2014.

The DOC, who is the lead for infection control, indicated that staff providing direct resident care and/or housekeeping staff cleaning resident rooms are to wear the indicated PPE when any resident is designated as being in isolation or infection precautions. The DOC further indicated that housekeeping carts are not to be in resident rooms, but are to be in the hallway outside the room.

Other Observations on a specified date:

- Staff #105, who was working Linden Home Area, was observed administering medications during the noon medication pass; staff was observed administering medications to three residents, including once administering insulin without performing hand hygiene before or after any of the three residents.

- Staff #124, who was working Maple Resident Home Area, was observed administering medications during the noon medication pass; staff was observed administering medications to three residents without performing hand hygiene before or after any of the three residents.

The DOC indicated that all staff are provided infection control education upon hire and annually; education includes, 4 Moments of Hand Hygiene. The DOC indicated it is the expectation that all staff perform hand hygiene before and after contact with all residents. [s. 229. (4)] (554)

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

May 22, 2015

Order # /
Ordre no : 003

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

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 :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 s. 19 (1) to ensure all residents are protected from abuse and or neglect.

This plan shall include :
-a revised Zero Tolerance of Abuse and Neglect policy to identify 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.
-a system to monitor and evaluate staff adherence to the Zero Tolerance of Abuse and Neglect Policy.
-a system to monitor and ensure that all staff complete the Licensee's retraining requirements at times or at intervals provided for in the regulations.

-The development and implementation of a monitoring process to ensure that:
- the resident's SDM is immediately notified of every incident of alleged, suspected or witnessed incident of abuse and are notified with 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.
- the Director is immediately notified if there are reasonable grounds to suspect the 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.
-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.
-that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated and appropriate action is taken: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff
-the plan should also identify who is responsible for ensuring the completion of each and every item listed above.

The plan shall identify the time line for completing the tasks

The plan is to be submitted to Amber Moase by February 2, 2014 via email to amber.moase@ontario.ca

Grounds / Motifs :

1. 1. The licensee has failed to ensure that Residents #8, #15, #30, #29, #42, #16, #50, #57, #55 are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Emotional Abuse Definition
Under O.Reg.79/10, s.2(1)(a) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Related to Resident #8
During stage one of the RQI:
-Interview of Resident #8 (by Inspector # 554) stated they "had a confrontation with a staff member, and at the time, I hurt my arm, had to use manual chair, and they left me in the dining room. I asked staff member "Can you take me back? I had to ask several times". Staff responded "I'm looking after Maple not Birch, get someone else." Review of the progress notes for Resident #8 indicated during the care conference on a specified date, the home was notified of the resident’s concern of neglect of care and indicated a "client feedback form was completed” at that time. There was no documented evidence a “client feedback form” was completed at that time or an investigation into the allegation completed. A “Client Feedback” form was provided to the inspector by the DQN indicating Resident #8 had been re-interviewed and identified the staff member involved in the allegation of staff to resident neglect as PSW #136 but the staff member had not yet been interviewed. Review of the staff schedule for PSW#136 indicated the PSW worked 6 evening shifts since the home becoming aware of the incident.

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures states:
- If an employee(s) is involved, immediately notify of the pending investigation requiring alleviation from duty pending completion of the investigation, including reporting requirements to the Director (MOHLTC) and local police authorities.
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation
-the Registered staff will report the alleged, actual, or suspected abuse to the Administrator, General Manager, Director of Care, Wellness Coordinator, and or designate, local police authorities, and the Director (MOHLTC).

- registered nursing staff and the person discovering the abuse shall prepare a written incident report. The report shall include: what occurred, when it occurred, who was involved, names of witnesses, where it occurred, what was observed and heard. The report shall be submitted to the Administrator, Director of Care and or designate.

Related to Resident #29
- Resident #29 stated during an interview on a specified date that "I had an earache and reported it to the RPN who told me the doctor would be in tomorrow to assess. The following day I saw the physician but he did not come to see me. A week later, the physician came in to see me and I stated I still have the earache and the physician said very loudly and abruptly to me "do you realize people die here". I just wanted my ear ache dealt with but I didn't like that." On a specified date the Administrator was notified of the allegation of physician to resident emotional abuse towards Resident #29. Review of the homes investigation indicated on a "client feedback log", dated the day the home became aware of the incident, the resident was interviewed and confirmed what was reported to the inspector. The form indicated under further action: "speak to Dr." to be completed by Administrator and DOC. There was no indication the physician was interviewed as of 7 days later and the physician had been in the home on 4 occasions since the home becoming aware of the incident.

There was no documented evidence that when the allegations of staff to resident abuse/neglect for Residents #8 and #29 were reported to the Administrator on the dates specified, that the Administrator completed the resident incident report as indicated in the home's policy as "the person discovering the abuse". The progress notes and plan of care were not updated regarding the allegations, as well as interventions to prevent recurrence and no indication that the substitute decision makers of the residents were notified of the allegations.

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures states:
- registered nursing staff and the person discovering the abuse shall prepare a written incident report. The report shall include: what occurred, when it occurred, who was involved, names of witnesses, where it occurred, what was observed and heard. The report shall be submitted to the Administrator, Director of Care and or designate.
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation
-the Registered staff will immediately notify the Resident's substitute decision maker,

if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident

The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA, 2007 s. 23.(1)a 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 (Refer to WN#16)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

Verbal Abuse Definiton
Under O.Reg.79/10, s.2(1) (a) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Related to Resident #15
-Interview of Resident #15 on a specified date "a staff member yells at him/her and is rude". The Administrator was notified of the allegation on October 30, 2014. The DQN indicated becoming aware of the allegation of staff to resident abuse on approximately 3 days later and initiated the investigation 2 days afterwards using the "client feedback forms". The DQN was not aware a "Resident Incident Report" was to be completed for allegations of abuse instead of a "Client Feedback Form". Review of the "client feedback form" provided by the DQN on a specified date indicated that PSW #134 was the alleged staff member involved in the incident and was to be interviewed by the DOC. The DQN indicated only the resident had been interviewed regarding the allegations. There was no indication that any of the staff had been interviewed or notified of the allegation or any other actions taken 4 days after the

allegation was reported to the home by the Inspector. Review of the staff schedule indicated that PSW#134 had worked day shift on three occasions since the home becoming aware of the incident.

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation.
-The Registered Staff and the person discovering the abuse shall prepare a written incident report. All documentation of an alleged, actual, or suspected abuse incident will use descriptive and precise language free from opinion and conjecture. The report shall contain the following information and shall be submitted to the Administrator, General Manager, Director of Care, Wellness Coordinator and/or designate: what occurred, when it occurred, who was involved (including the names of witnesses or those who were in the vicinity when it occurred), what was observed/heard, written statements from witnesses including information pertaining to the incident.
-the Registered staff will immediately notify the Resident's substitute decision maker, if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident.
The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

Related to Resident #30
-Interview of Resident #30 stated "a couple of weeks ago, a staff member was yelling at me in the morning when they were washing my face but I don't know their name". On a specified date the Administrator was notified of the allegation of staff to resident verbal abuse towards Resident #30. Review of the health care records for Resident #30 had no documented evidence that the SDM, or any other person specified by the resident were notified of an alleged incident of verbal abuse. Review of the "Client

Feedback" form provided by the DQN indicated 5 days after the home becoming aware of the incident, the resident was interviewed by the DQN and indicated PSW #137 was the staff member allegedly involved in staff to resident verbal abuse. The form indicated staff member had not yet been interviewed regarding the allegation. Review of the PSW schedule indicated that PSW #137 worked day shift on 5 occasions since the home becoming aware of the incident.

Review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation.
-The Registered staff will immediately notify the Resident's substitute decision maker, if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident.
The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

There was no documented evidence that when the allegations of staff to resident abuse/neglect for Residents #15 and #30 that were reported to the Administrator on specified dates, that the Administrator completed the resident incident report as indicated in the home's policy as "the person discovering the abuse" . The progress notes and plan of care were not updated regarding the allegations, as well as interventions to prevent recurrence and no indication that the substitute decision makers of the residents were notified of the allegations.

Related to Resident #16:
The home's former Director of Care, submitted a Critical Incident Report on a specified date. The CI details an incident of Staff to Resident (verbal) abuse, which was said to have occurred 2 days earlier; details of the incident are as follows:
- Staff #119 was asked by Resident #16 to make resident's bed; Resident #16 called

staff 'a lazy bitch'. Staff #119 responded 'I'm not a bitch, you are the bitch'.
The allegation of Staff to Resident (verbal) abuse was reported by the Registered Practical Nurse (#124) to the Resident Care Area Manager (RCAM #123), who was the supervisor in the home during the incident which occurred.
According to the CI report, the RCAM contacted the Director of Care of the incident. The incident of Staff to Resident Verbal Abuse was not reported to the Director within the time line required under legislation.

A review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- the Administrator, Director of Care and or designate will immediately report the incident to the Director (MOHLTC) and local police authorities.

The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA 2007 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: 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. (Refer to WN #17)

Related to Log #O-000584-14 for Resident #50
A critical incident, submitted, by the home's former Director of Care, on a specified date describes an incident of alleged Staff to Resident (verbal/physical) abuse reported to have occurred 1 day earlier.
Details of the CI are as follows: According to a Critical Incident Report Resident #52 reported hearing a staff member yelling at Resident #50 in the hallway sometime during the night; Resident #52 reports hearing staff yell at Resident #50 to go back to bed and then reports hearing a slapping sound followed by a yelping sound from Resident #50. According to the CI report, Resident #52 reported the incident to family; in turn, Resident #52's family reported the incident of verbal/physical abuse to Resident Care Area Manager (RCAM #123).

Director of Care indicated that Resident #52 has since deceased but was cognitively well when the incident was reported.

The current DOC indicated that there were three staff (a Registered Practical Nurse and two Personal Support Workers) assigned to work the night shift, on Resident #50 and #52's home area, on the date in question. The DOC indicated not being involved with the staff interviews, and deferred further comments to the Director of Quality. Director of Quality-Nursing stated that he and the former Director of Nursing interviewed the three staff as to the allegation of Abuse; Director of Quality indicated Staff #120, 121 and #122 were not interviewed as to the allegations until 7 and 8 days after becoming aware of the incident.
A review of the home's Staffing Assignment Schedule for a specified period, indicated that Staff #120, 121 and #122 worked shifts following the allegation and prior to being interviewed by the licensee or its designate on dates indicated above.

The Director of Quality could not comment as to why there was a delay in investigating the incident of alleged Staff to Resident Abuse. The Director of Quality commented the investigation as to the allegation of abuse was completed on a specified date and findings were inconclusive.
The Director of Quality indicated that the practice of the home is to immediately investigate all allegations of suspected or witness abuse and that during the investigation, staff alleged to be involved are normally placed on a leave of absence pending the outcome of the investigation.
The DOC and Director of Quality both indicated the allegation of abuse (verbal/physical) was not reported to the police. The Director of Quality, who was present during the investigation of the abuse, indicated the incident was not reported to the police as Resident #50 was assessed by registered nursing staff and found to have had no visible injuries nor could resident recall the incident.

A review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- Immediately remove the persons allegedly or suspected of inflicting abuse from the immediate area and any resident home area, pending further investigation.
The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- O. Reg 79/10 r. 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 (Refer to WN #23)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

Related to Resident #42
Complainant #76 contacted the home on a specified date and time, to report that Resident #42 had asked a staff member to turn off the television, as remote control was not within resident's reach; complainant indicated that a staff member stated, to the resident, "I'm not your bloody slave". Complainant indicated being concerned as to the way his/her loved one is being treated in the home when family is not around. Resident #42, during an interview on a specified date, indicated feeling belittled by the comment of staff; resident further commented 'I can't wait to get out of this place'.

Complainant #76 stated the concern surrounding verbal abuse was brought to the attention of Registered Practical Nurse #148, who was the Charge Nurse, working on Resident Home Area that day.
Staff #148 commented during an interview on a specified date, that the allegation of verbal abuse was brought to the attention of the Registered Nurse Supervisor, who was in charge of the home, on the date of the incident.
Staff #148 indicated that MOHLTC was not contacted as to the allegation of verbal abuse, as that is not staff's role, but a supervisor's job.

Resident Care Area Manager (#145) indicated awareness of the allegation but commented such was not reported to Director. The DOC indicated no awareness of Complainant #76's allegation of verbal abuse. The Administrator indicated that all staff are to report allegations of Abuse. The RCAM #145 stated during an interview on a specified date that the resident was not spoken to following the incident. Staff #148, RN supervisor and RCAM #145 all indicated they did not contact the resident's substitute decision maker following becoming aware of the incident. Staff #148 spoke with only two of the three staff working on the day of the incident.

A review of the homes policy "Required Abuse and Neglect Reporting" revised July 2012 (HRM-POL-003) indicated under procedures:
- If an employee(s) is involved, immediately notify of the pending investigation requiring alleviation from duty pending completion of the investigation, including reporting requirements to the Director (MOHLTC) and local police authorities.

-The Registered Staff and the person discovering the abuse shall prepare a written incident report. All documentation of an alleged, actual, or suspected abuse incident will use descriptive and precise language free from opinion and conjecture. The report shall contain the following information and shall be submitted to the Administrator, General Manager, Director of Care, Wellness Coordinator and/or designate: what occurred, when it occurred, who was involved (including the names of witnesses or those who were in the vicinity when it occurred), what was observed/heard, written statements from witnesses including information pertaining to the incident.
-the Registered staff will immediately notify the Resident's substitute decision maker, if any and any other person specified by the Resident, and they are to be notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a Resident.
The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA 2007 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: 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. (Refer to WN #17)
As of November 6, 2014, the Director of Care was investigating the concern of Complainant #76.

O.Reg. 79/10, s.2(1)(b) defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff member.

Log #00051 related to resident #57:
Review of the progress notes for Resident #54 indicated:
-on a specified date Resident #54 was found in his/her room with door closed and Resident #57 in the room. Staff removed Resident #57 from the room and Resident #54 followed them out of the room as well. Resident #54 then sat with Resident #57 at the nursing station and was observed with "his/her hands on Resident #57's private area and when the PSW attempted to separate them the resident hit the PSW on the hand" Resident #57 was taken to his/her room. Interview of the DOC

indicated the incident was not reported to the Director.
Review of the current care plan for Resident #54 indicated the resident is diagnosed with Dementia, is independently mobile, and demonstrates specified responsive behaviors. Strategies to deal with the responsive behaviors are specified in the care plan.

The licensee failed to comply with:
- LTCHA, 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with (Refer to WN #15)
- LTCHA 2007 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: 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. (Refer to WN #17)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

Related to Resident #55
A Critical Incident Report (CIR) was submitted by the home on a specified date for a resident to resident sexual abuse incident that occurred on a specified date. The CIR indicated Resident #55 was seen walking with a PSW towards own room and "was crying uncontrollably". When CN ask resident why the resident was crying, the resident stated that Resident #54 was sitting on a chair across from him/her at the nursing station when Resident #54 reached over and placed his/her hand between the resident's legs, touching his/her private area and then touched his/her self. The CIR had no indication that police were called.
Review of the progress notes for Resident #54 from a specified date range indicated:
-on a specified date the resident was observed “displaying inappropriate sexual behaviour towards another resident”. The PSW observed the resident inappropriately touch another resident. There was no indication which resident and no documented evidence of an investigation.
-on a specified date staff overheard voices in the residents room and when entered the room, found another resident laying in the resident's bed. The resident was distracted while staff removed the other resident from the room. There was no

incident report completed and no indication who the other resident was.
-on a specified date the resident was found in his/her room with door closed and Resident #57 in the room. Staff removed Resident #57 from the room. The resident followed them out of the room and then sat with Resident #57 near nursing station. The resident was then observed inappropriately touching Resident #57 and when the PSW attempted to separate them the resident hit the PSW on the hand" Resident #57 was taken to his/her room. The POA of resident was not notified of incident.

Review of the homes investigations and interview of staff indicated there was no investigations completed related to witnessed or suspected incidents of sexual abuse that occurred on the identified dates.
Review of the progress notes for Resident #55 and Resident #54 on a specified date had no indication the police were notified. Interview of the DOC indicated that if it was not indicated on the CIR then they were not notified.

The licensee failed to comply with:
- O. Reg 79/10 r. 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 (Refer to WN #23)
- LTCHA, 2007 s. 23.(1)a 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 (Refer to WN #16)
- LTCHA, 2007 s. 23(1)(b) Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident that the licensee knows of, or that is reported to the licensee: (i) abuse of a resident by anyone (Refer to WN #16)

In addition to the individual incidents and the areas of non-compliance identified for the incidents involving Residents #8, #29, #15, #30, #16, #50, #42, #57, #55, the following was also identified:

The licensee failed to comply with O. Reg. 79/10, s. 101(2), as it relates to a verbal complaint made by complainant #8 by not ensuring that a documented record is kept in the home that includes:
(a) the nature of each verbal complaint

(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant (As identified in WN #1)

The licensee failed to comply with LTCHA, 2007, s. 76(4), by not ensuring that all staff have received retraining annually relating to the following:
• The Residents' Bill of Rights
• The home's policy to promote zero tolerance of abuse and neglect of residents
• The duty to make mandatory reports under section 24
• The whistle-blowing protections (As identified in WN #19)

The licensee has failed to comply with 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, (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. (As identified in WN #21) [s. 19. (1)] (111)

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

Apr 20, 2015

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:

1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided.
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided.
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount.
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Order / Ordre :

The licensee shall ensure that residents in preferred accommodation are not charged more than what can be charged for basic accommodation unless the preferred accommodation was provided under an agreement.

The accommodation rate for Resident #44 shall be reviewed for a specified 19 month period. Resident #44 shall be reimbursed for any charges that exceed the preferred semi-accommodation rate as outlined in the admission agreement dated March 16, 2010.

The home shall also conduct an audit to ensure all residents paying a preferred accommodation rate have a signed agreement indicating consent to such charges.

Grounds / Motifs :

1. Related to Log #000146:

The licensee has failed to ensure that residents in preferred accommodation are not charged more than what can be charged for basic accommodation unless the preferred accommodation was provided under an agreement.

A complaint was received from the SDM of Resident #44 indicating on a specified date in 2012 the resident was transferred from a semi-private room to a private room and the SDM was not made aware of the transfer until after the resident was transferred. A review of the progress notes from a specified date range in 2012 for Resident #44 indicated the resident was transferred from one unit on a specified date in 2012 to another unit and there was no indication the SDM was notified.

The complaint submitted by the SDM of Resident #44 also indicated being overcharged for accommodations at a rate that was not agreed to in the admission agreement. Review of Resident #44's admission agreement indicated the resident was admitted into semi-private accommodation room/rate on a specified date in 2010. There were no other accommodation agreements in place.

Review of the resident's charges for accommodation indicated the resident was admitted on a specified date in 2010 at semi-private rate. The resident remained on semi-private rate (along with annual increases in July of each year) until a specified date in 2012 when the monthly accommodation charge was increased to private accommodation rate. The private rate was charged until a specified date in 2014 when the accommodation charge was changed to a basic accommodation rate. The SDM requested the funds be reimbursed.

Interview of the Administrative Assistant (AA) indicated she was given verbal direction by the previous DOC during a specific month of 2012 to change Resident #44's accommodation rate from semi-private to private rate as the resident was moved to a private room from a semi-private room. The AA indicated she did not complete a new accommodation agreement or contact the family regarding the new rate change. The AA indicated on a specified date in 2014 she received an email from the Administrator that the resident's rate was to be reduced to basic rate and the accommodation rate was changed. [s. 91. (1) 2.] (111)

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

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

Apr 20, 2015

Order # /
Ordre no : 005

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

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 ensure that:

- Education will be provided to Personal Support Workers in using safe transferring devices or techniques when assisting residents.
- Mechanical lifts, are kept in good repair, and maintained at a level that meets manufacturer specifications, at a minimum.

Grounds / Motifs :

1. Related to Log #O-001202-14

The licensee has failed to ensure that staff use safe transferring devices or techniques when assisting residents.

Resident #49's progress notes were reviewed. On a specified date, RPN #141

documented that 2 staff were transferring Resident #49 from bed to wheelchair by a full mechanical lift (ergo). During the transfer, the resident was on the sling up in the air over the wheelchair and the mechanical lift tilted entirely with the sling backward. The resident was over the wheelchair and landed on it, no injury was noted. Resident Care Manager (RCAM) and maintenance were notified and the lift was taken to be repaired.

On November 6, 2014 interview with RPN #141 indicated that on the date of the incident, two PSWs were transferring Resident #49 from bed to wheelchair when the whole lift tilted entirely backwards with the resident. The lift had a defect or a problem and could not tell what was wrong with the lift. RPN #141 indicated that the expectation is that PSWs should have checked the lift before use. An out of order sign was placed on the lift after the incident.

During an interview with PSWs #108, #142 and #143 they indicated that lifts are checked if working properly before use. The lifts are checked for charged batteries, proper sling, make sure the lift is clean, check arms if moving up and down and legs moving in and out, check if lift is easy to move, check sling is clean and not damaged. If a problem noted the nurse is informed, requisition is completed on computer and out of order sign will be placed on lift.

On a specified date and time, interview with Environmental Services Manager (ESM) indicated that lifts are inspected on monthly basis for preventative maintenance. The lifts are checked for the up and down and legs for out and close. If the lift is defective it will be removed for repair.

Review of a note by maintenance staff #144 indicated that an Ergo lift was tagged out of service and removed for inspection by maintenance on the date of the incident, after the incident occurred. A note by ESM indicated that the lift was tagged out in the maintenance shop from the date of the incident and a request for inspection was sent to Arjohuntleigh 15 days later.

Review of Arjohuntleigh service call report indicated the Ergo lift Maple #3 serial number ERLI-1887 which was used on the date of the incident, was inspected and found that the legs were loose and not aligned properly. The lift was repaired and technician suggested the some parts of the lift to be replaced including: 1 braked caster, emergency stop switch, hanger bar cover and pin assembly. The recommended parts were replaced.

There is no documented evidence that the Ergo lift Maple #3 serial number ERLI-1887 was inspected to be in good repair and safe for use prior to the incident by maintenance staff or by PSW staff prior to use with Resident #49. There was no maintenance record of this lift prior to the date of the incident and there was no documentation the lift was checked monthly similar to other lifts in the home as it was not included in the assets inventory of the home. [s. 36.] (570)

2. Related to Log #O-001255-13

The licensee has failed to ensure that staff use safe transferring techniques when assisting residents.

A Critical Incident indicated that on a specified date PSW #128 was getting Resident #46 dressed out of bed for lunch. Resident was sitting upright at side of bed. PSW #128 turned around to get wheelchair and Resident #46 fell forward onto the floor sustaining an injury that required sutures at hospital.

Review of Resident #46's plan of care related to transferring and Falls/Balance indicated the resident requires extensive assistance – two + persons physical assist and the resident's risk of falls is high related to history of falls, unsteadiness, and self transferring but too weak to do so.

Resident #46's progress notes were reviewed. On a specified date, RPN #131 documented that Resident #46 fell from bed and sustained an injury. The resident was unconscious for a few minutes.

On a specified date, interview with PSW #128 indicated at the time of the incident, PSW#128 assisted Resident #46 to dress up and sat him/her up at edge of bed. Resident's feet at the time were not entirely flat on the floor. PSW #128 was aware of resident's transfer status of 2 persons assist and was waiting for another staff member to help. The resident fell, while PSW #128 was reaching over to pull the wheelchair and could not prevent the resident from falling.

On a specified date, interview with DOC indicated at the time of the incident, a bang was heard from Resident #46's room and found Resident #46 on the floor. The DOC indicated that PSW #128 should have not left Resident #46 sitting at edge of bed as the resident could not maintain upright sitting position and requires two persons assist for transfer.

An internal investigation completed by the home confirmed that PSW #128 had failed to use safe transferring techniques when the resident was left sitting at the edge of bed, unsupported. [s. 36.] (570)

3. Related to Log #O-000500-14

The licensee has failed to ensure that staff use safe transferring techniques when assisting residents

A Critical Incident indicated that on a specified date while PSW #127 and PSW #110 were transferring Resident #46 from bed to wheelchair using a mechanical lift, the resident fell out of the sling onto the floor approximately 4 feet to the ground, sustaining an injury.

Resident #46's progress notes were reviewed. On the date of the incident, RPN #124 documented that PSWs on Pine unit were transferring Resident #46 from the bed to the wheelchair using a mechanical lift. During the transfer, Resident # 46 fell from the sling and sustained a skin tear. Sling used for transfer was blue with red boarder (Arjohuntleigh Article Num MAA4100m-s). No visible deficit was noted on sling all four clips were present and intact.

On a specified date interview with PSW #127 indicated at the time of incident the left hook snapped and had no idea how that happened. PSW #127 was operating the lift when PSW #110 was coming around. The hook was not broken, it was just snapped. PSW #127 stated "I should pay more attention".
On November 6, 2014 interview with PSW #110 indicated at time of incident he/she was assisting staff #127 to transfer Resident #46. PSW #110 hooked up the left side and checked it and PSW #127 hooked up the other side. While Resident #46 was lifted, the left hook came off causing the resident to slide down and roll to the floor. PSW #110 was not guiding the resident when the resident fell. PSW #110 was coming around to direct the resident to the chair.

A written statement by PSW #110 on the date of the incident indicated that while helping a staff member to transfer Resident #46 from the bed to the wheelchair, the resident slid out of the sling onto the floor.

A written statement by PSW #127 on the date of the incident indicated that while getting Resident #46 up from bed with my partner, we used the full lift that we were supposed to use. When lifting the resident up, the sling at the left side snapped and the resident slid out of the sling and fell.

An interview with DOC on a specified date indicated that, she was called to unit and found Resident # 46 on the floor. The DOC confirmed that PSW #127 and PSW #110 did not follow policy of operating the mechanical lift to ensure the resident is safe during the transfer. One PSW forgot to clip his/her side of the sling and the other PSW started to operate the lift while his/her partner was not ready to guide and reassure the resident during the transfer.

An internal investigation completed on a specified date by the home concluded that PSW #127 and PSW #110 had performed an improper mechanical lift which resulted in injury to resident.

The staff failed to ensure the Resident's safety during transfer. [s. 36.] (570)

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

Apr 20, 2015

Order # /
Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(a) the behavioural triggers for the resident are identified, where possible;

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

Ontario

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

(A1)
The licensee shall ensure that, for Resident #54 demonstrating responsive behaviours, (a) the behavioural triggers for Resident #54 are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee shall ensure the care plan for Resident #54 clearly outlines the current strategies to manage responsive behaviors. The strategies will be reviewed with Resident #54 s health care team. The licensee shall ensure that any identified strategies for Resident #54 will be consistently implemented. When strategies developed for Resident #54 are deemed ineffective, the Resident will be reassessed and that assessment will be documented.

The licensee shall develop a monitoring system to ensure that strategies are developed and implemented to respond to responsive behaviors. This system shall include:
- Who is responsible to implement the strategies to responsive behaviors
- How long each strategy is to be in place
- When the resident will be re-assessed and who is responsible to complete the re-assessment

The licensee shall also ensure all staff on each shift are aware of each resident exhibiting responsive behaviors and the strategies in place to manage these behaviors

Grounds / Motifs :

1. Related to Log #000551:

The licensee has failed to ensure that strategies were developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Review of the current care plan for Resident #54 indicated the resident is diagnosed with cognitive impairment, is independently mobile, and demonstrates specified responsive behaviours and specified strategies to manage the responsive behavior.

Review of the progress notes over a 6 month period for Resident #54 indicated on specified dates and times 4 incidents where Resident #54 inappropriately touched another resident, 2 incidents where another resident was found in Resident #54's room without staff being aware, 3 incidents where Resident #54 attempted to hit or touch another resident but was stopped by staff. On one specified date Resident #54's monitoring was decreased from every 15 minutes to every 1 hour monitoring.

Interview of PSW #140 by Inspector #541 indicated that they are not currently monitoring Resident #54 as "his/her behaviours have calmed down". Observation of the resident's room by Inspector #541 indicated the specified interventions in Resident #54's care plan were not in place.

Review of the progress notes for Resident #54 indicated the resident demonstrated inappropriate sexually touching and sexual comments to several residents and staff. The resident also wandered into other resident's rooms and other residents wandering into the resident's room. The resident also displayed verbal and physical aggression towards staff and residents. The resident was placed on every 15 minute checks following the second incident of resident to resident sexual abuse.

The current care plan for Resident #54 indicated that some of the specified strategies suggested were not effective, but still in use and some of the specified strategies were not consistently implemented. Some of the specified strategies identified were not clear as to when they would be implemented. Some of the specified strategies to prevent sexually inappropriate responsive behaviour were not implemented. [s. 53. (4) (b)] (111)

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

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

Feb 09, 2015(A1)

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

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

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 30 day of January 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : AMBER MOASE - (A1)

Service Area Office /
Bureau régional de services : Ottawa