Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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

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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 5, 2020	2020_669642_0002	021851-19, 022593-19, 023383-19	Critical Incident System

Licensee/Titulaire de permis

Valley East Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Elizabeth Centre
2100 Main Street Val Caron ON P3N 1S7

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

AMY GEAUVREAU (642), MICHELLE BERARDI (679)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 13-17, 2020.

The following intakes were inspected during this Critical Incident System (CIS) inspection:

- One log: related to alleged staff to resident abuse;
- One log: related to a resident fall, which caused an injury to the resident for which the resident was taken to hospital, and resulted in a significant change in the resident's health condition;
- One log: related to alleged resident to resident abuse.

A Sudbury Service Area Office Initiated Inspection #2020_669642_0001, was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Directors of Care (Co-DOCs), Environmental Services Manager (ESM), Education Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed resident health care records, relevant training, policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **1 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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. The licensee has failed to ensure that any person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A Critical Incident (CI) report was submitted to the Director regarding an allegation of staff to resident physical abuse towards resident #001. The CI report identified that resident #001 had notified PSW #103 about another PSW's alleged physical abuse towards them.

During a review of the electronic records for resident #001, Inspector #679 had identified a progress note regarding an allegation of neglect reported by resident #001's, enacted Substitute Decision Maker (SDM).

Inspector #679 reviewed the Ministry of Long-Term Care's online reporting portal and was unable to identify that a CI report was submitted to the Director for this allegation of neglect.

Inspector #679 reviewed the policy titled, "Resident Rights Care and Services- Abuse-Zero Tolerance Policy for Resident Abuse and Neglect," with a revision date of April 25,

2019. The policy indicated that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Ministry of Health and Long-Term Care: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

Inspector #679 reviewed a memorandum titled, "Clarification of Mandatory and Critical Incident Reporting Requirements," dated August 31, 2018, sent by the Director to the Long-Term Care Homes Licensees and Administrators, and posted on the Long-Term Care Homes online reporting portal. The memorandum indicated: 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 was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

In an interview with RPN #106, they identified that they had a conversation with one of resident #001’s enacted SDM's [#1] in which they had alleged that the home had neglected resident #001. RPN #106 identified that they had reported the conversation to Co-DOC #101.

In an interview with Inspector #679, Co-DOC #101 identified that RPN #106 had contacted resident #001’s SDM [#1] to provide personal information about resident #001 and SDM [#1] responded with concerns of neglect. When asked if the home had submitted a CI report to the Director regarding this allegation of neglect, Co-DOC #101 indicated they had not submitted a CI report because they had contacted SDM [#2].

In an interview with the Administrator, they identified that the home did not submit a CI report to the Director because resident #001’s other enacted SDM [#2] was not concerned. [s. 24. (1)]

2. A CI report was submitted to the Director regarding an allegation of staff to resident physical abuse towards resident #001. The CI report identified that resident #001 had notified PSW #103 about another PSW's alleged physical abuse towards them.

Inspector #679 reviewed the home’s internal investigation into the allegation of neglect and identified a typed transcript of an interview with resident #007 regarding PSW #107. The interview transcript identified that PSW #107 had provided resident #007 with personal care, and resident #007 had identified some specific situations and actions, that

they felt was abuse from PSW #107.

Inspector #679 reviewed the Ministry of Long-Term Care's online reporting portal and was unable to identify that a CI report was submitted to the Director for this allegation of abuse.

Inspector #679 reviewed the policy titled, "Resident Rights Care and Services- Abuse-Zero Tolerance Policy for Resident Abuse and Neglect," with a revision date of April 25, 2019. The policy indicated that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Ministry of Health and Long-Term Care: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

Inspector #679 reviewed a memorandum titled, "Clarification of Mandatory and Critical Incident Reporting Requirements," dated August 31, 2018, sent by the Director to the Long-Term Care Homes Licensees and Administrators, and posted on the Long-Term Care Homes online reporting portal. The memorandum indicated: 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 was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

In an interview with Inspector #679, Co-DOC #101 identified that resident #007 had stated, specific information about PSW #107 to them. The Co-DOC indicated that the home did not submit a CI report to the Director regarding this allegation of abuse.

In an interview with the Administrator they identified that they did not view the conversation with resident #007 as an allegation of abuse, and had not put an CI report to the Director for the allegation, as they felt it was inclusive in the CI report submitted for resident #001. [s. 24. (1)]

3. A CI report was submitted to the Director, on a specific day for an incident of alleged resident to resident physical abuse between resident #003 and #004. The CI report identified that resident #003 had a visitor after the incident on a specific day, and the visitor had made a specific statement to a co-resident about resident #004 which PSW #110 had heard and reported. The CI report stated the specific statement was discovered by management on a specific day.

Inspector #642 reviewed the electronic progress notes regarding the incident and identified a statement written by RN #109 on the day of the incident that resident #003's visitor had stated. A progress note written by RPN #115 on that specific date, indicated that PSW #110, had also heard the specific statement that resident's #003's visitor had stated.

The Inspector interviewed RN #109, who stated on the day of the incident, they had been informed about resident #003's visitor's specific statement from PSW #110. RN #109 stated they had not realized the seriousness of the statement, since they had spoken to the visitor, about their comments. RN #109 stated they are able to call the Ministry action line to report incidents; however, they had reviewed the home's physical abuse algorithm of the Long-term care (LTC) home, and felt it did not apply, so they did not report this immediately to the Ministry. RN #109 admitted that they were informed by management on a specific date, that the specific statement from resident's #003's visitor should have been reported right away and the police should have been called immediately.

Inspector reviewed the policy titled, "Resident Rights Care and Services- Abuse- Zero Tolerance Policy for Resident Abuse and Neglect," with a revision date of April 25, 2019. The policy indicated that upon being notified of abuse or neglect of a resident, the most Senior Administrative Personnel or Charge Nurse has the delegated responsibility to report to the Ministry of Health and Long-Term Care immediately.

Inspector #642 interviewed the Co-DOC #102, who the RN had called on a specific date, and they stated that they knew about resident #003's visitor but were not aware of the specific statement. After reviewing the home's verbal abuse algorithm with Co-DOC #102 and the CI report they did identify that this situation involved late reporting to the Director.

In an interview with the Administrator, and review of the documentation from a specific day, in relation to the incident and the specific statement made by resident #003's visitor, the Administrator stated this should have been reported to the Director the day of the incident. They stated that RN's were able to call the Ministry after hours number with incidents, but that incident was not called in immediately. The Administrator stated that they became aware of the specific statements on a specific day, and had informed the police. The Administrator was not sure why the CI reported was not filed until another specific day. [s. 24. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A Critical Incident (CI) report was submitted to the Director regarding an allegation of staff to resident physical abuse towards resident #001. The CI report identified that resident #001 had notified PSW #103 about another PSWs alleged physical abuse towards them.

A) Inspector #679 reviewed the CI report and identified the allegation of physical abuse towards resident #001 was reported to PSW #103 on a specific day. The CI report was submitted to the Director, five days later.

Inspector #679 reviewed the home's internal investigation document's into the incident and reviewed a written statement by PSW #103, which identified on a specific day, resident #001 had stated to them, very specific comments alleging physical abuse about PSW #107.

Inspector #679 reviewed the policy titled, "Resident Rights Care and Services- Abuse-Zero Tolerance Policy for Resident Abuse and Neglect," with a revision date of April 25, 2019. The policy indicated that a person who had reasonable grounds to suspect that any physical abuse had occurred or may occur shall immediately report their suspicion and the information upon which it was based to the most Senior Administrative Personnel

or Charge Nurse on site in the home who would then report it to the Ministry.

In an interview with Inspector #679, PSW #103 indicated that they had notified RPN #105 the day of the incident about the allegation of abuse even though RPN #105 had been occupied. PSW #103 did indicate they had received more education regarding prevention of abuse and neglect the week after the incident, because they had notified Co-DOC #101's five days after the incident.

Inspector #679 interviewed RPN #105, they identified that they did not recall being notified of the allegation of abuse toward resident #001 from PSW #103. RPN #105 further stated, that they didn't recall PSW #103 informing them, or they would have reported it right away and if someone had come to them regarding abuse, they would have discussed it with them and then they would have informed their manager (Co-DOC).

In an interview with Co-Doc #101, they stated that they had not been notified about resident #001's statement about alleged physical abuse from PSW #107, until they had been notified five days after the incident.

B) According to Ontario Regulation 79/10, physical abuse was defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

Inspector #679 further reviewed the investigation documents that the home had provided and a specific document had been addressed to PSW #107. PSW #107 had received disciplinary action following the investigation into the allegation of abuse towards resident #001. The specific document indicated that the home’s policy, zero tolerance for resident abuse and neglect, clearly stated that any form of abuse to the resident's is not acceptable. PSW #107 was not available for interview.

In an interview with Inspector #679, Co-DOC #101 identified that they were notified of an allegation of abuse after the incident, and that the CI report was submitted late. Co-DOC #101 indicated that staff were to report allegations to their supervisor immediately. Co-DOC further identified that they believed the allegation of abuse was substantiated, and that PSW #107 received a specific disciplinary action.

In an interview with the Administrator they identified that if staff had received a report of suspected, alleged or actual abuse they were to report the allegation to the supervisor immediately, that the RN would call the after-hours line to report the allegation and that

management would complete the CI report. The Administrator identified that no one had informed the managers of the incident until five days later. [s. 20. (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 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force were 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.

A CI report was submitted to the Director for an incident of alleged resident to resident physical abuse between resident #003 and #004. The CI report identified that resident #003 had a visitor after the incident, and stated to a co-resident, a specific statement. This incident was reported to RN #109. See WN #1 for further details.

Inspector #642 reviewed the policy titled, “Resident Rights Care and Services- Abuse-Zero Tolerance Policy for Resident Abuse and Neglect," with a revision date of April 25, 2019, indicated that the most senior administrative personnel (or charge nurse if no manager is in the home) who received a report of resident abuse or neglect was to immediately notify the appropriate police force of any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offense, (refer to Ministry of Health and Long-Term Care Abuse and Neglect Algorithm).

A review of the Ministry of Long-Term Care’s, “Licensee Reporting of Verbal Abuse,” decision tree identified the following as a criminal code offence that may apply: Uttering a specific statement.

In an interview with RN #109, they stated that management had informed them on a specific date, that due to resident #003's visitor's specific statement towards resident #004, it should have been reported to the police immediately the day of the incident.

Inspector #642 interviewed the Administrator, and reviewed Regulation 98. which stated that the appropriate police force should be 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. The Administrator stated this incident should have been reported to the police, immediately when the incident had happened. The Administrator further stated they became aware of the specific statement from resident #003's visitor on a specific day, and that's when they should have reported the incident to the police. [s. 98.]

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 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, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knew of, or that was reported was immediately investigated: neglect of a resident by the licensee or staff.

A CI report was submitted to the Director regarding an allegation of staff to resident physical abuse towards resident #001. The CI report identified that resident #001 notified PSW #103 of alleged abuse. See WN #1 for further details.

During a review of the electronic records for resident #001, Inspector #679 identified a

progress note regarding an allegation of neglect by resident #001's enacted Substitute Decision Maker (SDM). The progress note stated that enacted SDM #1, had made a specific statement with concerns about neglect towards resident #001.

Inspector #679 interviewed RPN #106, they identified that they had a conversation with resident #001's enacted SDM [#1] in which the SDM [#1] had identified the concerns of neglect of resident #001. RPN #106 identified that they had reported the conversation to Co-DOC #101.

In an interview with Inspector #679, Co-DOC #101 identified that RPN #106 had contacted resident #001's enacted SDM [#1] to inform them about some personal care. SDM [#1] then was upset and stated their concern of neglect. Co-DOC #101 identified that when the home received allegations of neglect from a family member, they would investigate it. Co-DOC #101 indicated that they did not discuss the concern with the enacted SDM [#1], and that they had no information to substantiate the allegation. Co-DOC #101 indicated that no investigation was conducted into this allegation of neglect because the other enacted SDM [#2] had no concerns.

Inspector reviewed the policy titled, "Resident Rights Care and Services- Abuse- Zero Tolerance Policy for Resident Abuse and Neglect," with a revision date of April 25, 2019. The policy indicated that upon being notified of abuse or neglect of a resident, the Administrator, or Director of Care or the manager on call will ensure that a thorough investigation was completed immediately.

In an interview with the Administrator, they identified that the managers would conduct investigations into incidents of abuse or neglect. When asked if the home conducted a investigation into this allegation of neglect, the Administrator identified that they were unsure, and that from what they recalled the other enacted SDM [#2] had arrived at the home. [s. 23. (1) (a)]

Issued on this 7th day of February, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMY GEAUVREAU (642), MICHELLE BERARDI (679)
Inspection No. / No de l'inspection :	2020_669642_0002
Log No. / No de registre :	021851-19, 022593-19, 023383-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 5, 2020
Licensee / Titulaire de permis :	Valley East Long Term Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	Elizabeth Centre 2100 Main Street, Val Caron, ON, P3N-1S7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Stephanie Zakrocki

To Valley East Long Term Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with section 24 (1), of the Long-Term Care Homes Act, 2007.

Specifically, but not limited to, the licensee shall:
1) Develop and implement a system whereby a staff member with reasonable grounds to suspect that abuse or neglect has occurred or may occur, will immediately report the suspicion and the information upon which it is based to the Director.
2) Design a tool to assist staff members, itemizing all the steps to follow, when a person becomes aware of alleged abuse or neglect. The tool shall identify in chronological order what steps are to be taken, indicating the time frame for each step to occur, and provide for a signature area indicating the step was completed.
3) Educate staff members, who may be involved in reporting to the Director, on the new system and the use of the tool.

Grounds / Motifs :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based

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

A Critical Incident (CI) report was submitted to the Director regarding an allegation of staff to resident physical abuse towards resident #001. The CI report identified that resident #001 had notified PSW #103 about another PSW's alleged physical abuse towards them.

During a review of the electronic records for resident #001, Inspector #679 had identified a progress note regarding an allegation of neglect reported by resident #001's, enacted Substitute Decision Maker (SDM).

Inspector #679 reviewed the Ministry of Long-Term Care's online reporting portal and was unable to identify that a CI report was submitted to the Director for this allegation of neglect.

Inspector #679 reviewed the policy titled, "Resident Rights Care and Services-Abuse- Zero Tolerance Policy for Resident Abuse and Neglect," with a revision date of April 25, 2019. The policy indicated that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Ministry of Health and Long-Term Care: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

Inspector #679 reviewed a memorandum titled, "Clarification of Mandatory and Critical Incident Reporting Requirements," dated August 31, 2018, sent by the Director to the Long-Term Care Homes Licensees and Administrators, and posted on the Long-Term Care Homes online reporting portal. The memorandum indicated: 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 was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

In an interview with RPN #106, they identified that they had a conversation with one of resident #001's enacted SDM's [#1] in which they had alleged that the

home had neglected resident #001. RPN #106 identified that they had reported the conversation to Co-DOC #101.

In an interview with Inspector #679, Co-DOC #101 identified that RPN #106 had contacted resident #001's SDM [#1] to provide personal information about resident #001 and SDM [#1] responded with concerns of neglect. When asked if the home had submitted a CI report to the Director regarding this allegation of neglect, Co-DOC #101 indicated they had not submitted a CI report because they had contacted SDM [#2].

In an interview with the Administrator, they identified that the home did not submit a CI report to the Director because resident #001's other enacted SDM [#2] was not concerned.

(679)

2. A CI report was submitted to the Director regarding an allegation of staff to resident physical abuse towards resident #001. The CI report identified that resident #001 had notified PSW #103 about another PSW's alleged physical abuse towards them.

Inspector #679 reviewed the home's internal investigation into the allegation of neglect and identified a typed transcript of an interview with resident #007 regarding PSW #107. The interview transcript identified that PSW #107 had provided resident #007 with personal care, and resident #007 had identified some specific situations and actions, that they felt was abuse from PSW #107.

Inspector #679 reviewed the Ministry of Long-Term Care's online reporting portal and was unable to identify that a CI report was submitted to the Director for this allegation of abuse.

Inspector #679 reviewed the policy titled, "Resident Rights Care and Services-Abuse- Zero Tolerance Policy for Resident Abuse and Neglect," with a revision date of April 25, 2019. The policy indicated that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Ministry of Health and Long-Term Care: abuse of a resident by anyone or

neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

Inspector #679 reviewed a memorandum titled, "Clarification of Mandatory and Critical Incident Reporting Requirements," dated August 31, 2018, sent by the Director to the Long-Term Care Homes Licensees and Administrators, and posted on the Long-Term Care Homes online reporting portal. The memorandum indicated: 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 was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

In an interview with Inspector #679, Co-DOC #101 identified that resident #007 had stated, specific information about PSW #107 to them. The Co-DOC indicated that the home did not submit a CI report to the Director regarding this allegation of abuse.

In an interview with the Administrator they identified that they did not view the conversation with resident #007 as an allegation of abuse, and had not put an CI report to the Director for the allegation, as they felt it was inclusive in the CI report submitted for resident #001.

(679)

3. A CI report was submitted to the Director, on a specific day for an incident of alleged resident to resident physical abuse between resident #003 and #004. The CI report identified that resident #003 had a visitor after the incident on a specific day, and the visitor had made a specific statement to a co-resident about resident #004 which PSW #110 had heard and reported. The CI report stated the specific statement was discovered by management on a specific day.

Inspector #642 reviewed the electronic progress notes regarding the incident and identified a statement written by RN #109 on the day of the incident that resident #003's visitor had stated. A progress note written by RPN #115 on that specific date, indicated that PSW #110, had also heard the specific statement that resident's #003's visitor had stated.

The Inspector interviewed RN #109, who stated on the day of the incident, they had been informed about resident #003's visitor's specific statement from PSW #110. RN #109 stated they had not realized the seriousness of the statement, since they had spoken to the visitor, about their comments. RN #109 stated they are able to call the Ministry action line to report incidents; however, they had reviewed the home's physical abuse algorithm of the Long-term care (LTC) home, and felt it did not apply, so they did not report this immediately to the Ministry. RN #109 admitted that they were informed by management on a specific date, that the specific statement from resident's #003's visitor should have been reported right away and the police should have been called immediately.

Inspector reviewed the policy titled, "Resident Rights Care and Services- Abuse-Zero Tolerance Policy for Resident Abuse and Neglect," with a revision date of April 25, 2019. The policy indicated that upon being notified of abuse or neglect of a resident, the most Senior Administrative Personnel or Charge Nurse has the delegated responsibility to report to the Ministry of Health and Long-Term Care immediately.

Inspector #642 interviewed the Co-DOC #102, who the RN had called on a specific date, and they stated that they knew about resident #003's visitor but were not aware of the specific statement. After reviewing the home's verbal abuse algorithm with Co-DOC #102 and the CI report they did identify that this situation involved late reporting to the Director.

In an interview with the Administrator, and review of the documentation from a specific day, in relation to the incident and the specific statement made by resident #003's visitor, the Administrator stated this should have been reported to the Director the day of the incident. They stated that RN's were able to call the Ministry after hours number with incidents, but that incident was not called in immediately. The Administrator stated that they became aware of the specific statements on a specific day, and had informed the police. The Administrator was not sure why the CI reported was not filed until another specific day.

The severity of this issue was determined to be a level one no harm. The scope

of the issues was a level three, as it was identified as wide spread among the residents who were reviewed. The home has a level three compliance history, as they had related non-compliance with this section of the LTCHA that included:
-a Voluntary Plan of Correction (VPC) issued September 8, 2017, (#2017_655679_0008);
-a VPC issued May 17, 2017, (#2017_638609_0005).

(642)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 01, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 5th day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amy Geauvreau

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