Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 24, 2014	2014_332575_0010	S-000173-14, S-000174-14	Follow up

Licensee/Titulaire de permis

VALLEY EAST LONG TERM CARE CENTRE INC.
689 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

LINDSAY DYRDA (575)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 30, July 2, 3, 2014

The following critical incidents/logs were included in this inspection: CI# 2868-000015-14, Log# S-000195-14; CI# 2868-000021-14, Log #S-000227-14; CI# 2868-000022-14, Log# S-000228-14; CI# 2868-000027-14, Log# 000004-14; CI# 2868-000026-14, Log# 000005-14; CI# 2868-000028-14, Log# 000010-14; CI# 2868-000030-14 and #2868-000034-14, Log# 000705-14.

Inspector #595 Marina Moffatt also participated in this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nursing Staff, Personal Support Workers (PSW), Dietary Aides, Nutrition Manager, Staff Educator, and Residents.

During the course of the inspection, the inspector(s) conducted a daily walk-through of the home, made direct observations of the delivery of care and services to residents, reviewed resident health care records, and reviewed various policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Nutrition and Hydration
Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

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. LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) was issued previously as an order during inspection #2014_140158_0004 in March, 2014.

Inspector #595 reviewed two critical incidents pertaining to verbal abuse by staff member #113 to resident #52 and #53 respectively.

On July 2, 2014 Inspector #595 reviewed staff member #113's personnel file.

In 2012 it was confirmed by the home that staff member #113 verbally abused a resident. Inspector #595 noted that as a result, staff member #113 received a suspension and a change in assignment. Additionally, the disciplinary letter identified that 'any further incidents of this nature will result in immediate termination of employment'. This disciplinary action was reduced to a written warning.

In March 2014 during the Resident Quality Inspection, inspector #544 identified through 3 resident interviews (#7978, #7967, #8023) that staff member #113 was verbally abusive. Inspector #595 noted that as a result, the staff member was issued a written warning by the home. Corrective recommendations required the staff member to review various policies and procedures. Additionally, the disciplinary letter identified that 'if these matters are not effectively corrected, then further disciplinary or corrective action will be taken, up to and including termination'.

Three months later it was confirmed by the home that staff member #113 exhibited two separate incidents of verbal abuse to residents #52 and #53. Inspector #595 noted that as a result, the staff member was issued a suspension without pay. Corrective recommendations mirrored the previous corrective recommendations 3 months prior. The staff member's assignment was changed as previously instituted in 2012.

On July 2, 2014 inspector #595 reviewed the home's 'Positive Discipline Overview' policy (revised date 09/01/2012) which indicated that there were three steps in the positive discipline process, including oral reminder, written warning, and decision making leave (suspension). It was also indicated that discharge or termination was not part of the disciplinary process and that 'discharge is taken after the employee has been through all the disciplinary steps and no improvement has resulted...'. Additionally, inspector #595 reviewed the 'Decision Making Leave (Suspension)' policy (revised date 07/01/2006) and it stated that during the meeting with the employee it should be 'indicated that you hope the decision is to continue working but another occurrence of trouble will lead to termination'.

On July 3, 2014 inspector #575 reviewed the home's 'Resident Rights, Care and Services – Abuse' policy (effective 09/16/2013) which indicated that in cases where abuse is confirmed, the abuser shall be subject to disciplinary action, including

termination of employment.

On July 3, 2014 inspector #595 interviewed the DOC regarding how the home is ensuring that residents are safe while in the care of staff member #113. The DOC indicated that the home relies on staff to monitor staff member #113 during their shifts and report any abuse. Additionally, the DOC told inspector #595 that termination was debated however stated that merits of the case were not strong enough and felt that a suspension was safe.

Inspector #575 and #595 interviewed the DOC regarding the home's discipline policies related to abuse and neglect. The DOC stated that the home uses discretion and do not necessarily follow the process as outlined in the policy. They have a zero tolerance for abuse and that staff should technically be fired however, it would create a labour relations issue. The home tries to start with a written warning, followed by a suspension of 3 or 5 days, then termination follows. Discretion is used depending on the area of discipline ie: safety or conduct.

Despite the home's attempt at disciplinary action, staff member #113 continues to subject residents to verbal abuse as indicated in 2012 and 3 separate instances in 2014. The licensee failed to protect residents from abuse by the staff member #113 through a pattern of inaction and/or inappropriate and/or insufficient action. [s. 19. (1)]

2. Inspector #575 reviewed a critical incident pertaining to allegations of verbal abuse by staff member #114 to multiple residents.

On July 3, 2014 inspector #595 reviewed staff member #114's personnel file.

In 2014 it was confirmed by the home that staff member #114 exhibited verbally abusive behaviour. Corrective recommendations included reviewing and signing various policies. Inspector #595 noted that as a result, staff member #114 was issued an oral warning. Additionally, a written warning was issued to staff member #114 for a second instance of verbal abuse. Corrective recommendations mirrored the previous disciplinary action which included reviewing and signing various policies.

For a period of approximately one month in 2014, the home conducted an investigation in response another allegation of abuse by staff member #114. Inspector #575 reviewed the investigation package regarding the allegation. Through the investigation, it was determined that staff member #114 was verbally abusive to

resident #54. As a result, the staff member was issued a suspension without pay. Corrective recommendations included reviewing various policies and procedures. At the end of the disciplinary letter, it was stated that should the unacceptable behaviour continue it would be grounds for further disciplinary action and may result in termination.

On July 2, 2014 inspector #595 reviewed the home's 'Positive Discipline Overview' policy (revised date 09/01/2012) which indicated that there were three steps in the positive discipline process, including oral reminder, written warning, and decision making leave (suspension). It was also indicated that discharge or termination was not part of the disciplinary process and that 'discharge is taken after the employee has been through all the disciplinary steps and no improvement has resulted...'. Additionally, inspector #595 reviewed the 'Decision Making Leave (Suspension)' policy (revised date 07/01/2006) and it stated that during the meeting with the employee it should be 'indicated that you hope the decision to is continue working but another occurrence of trouble will lead to termination'.

On July 3, 2014 inspector #575 reviewed the home's 'Resident Rights, Care and Services – Abuse' policy (effective 09/16/2013) which indicated that in cases where abuse is confirmed, the abuser shall be subject to disciplinary action, including termination of employment.

On July 3, 2014 inspector #575 interviewed the DOC regarding how the home is ensuring that residents are safe while in the care of staff member #114. The DOC indicated that staff member #114 changed assignments. The DOC stated that although changing assignments does not fix the problem, at least the residents who had problems with staff member #114 before do not have to see them.

Inspector #575 and #595 interviewed the DOC regarding the home's discipline policies related to abuse and neglect. The DOC stated that the home uses discretion and do not necessarily follow the process as outlined in the policy. They have a zero tolerance for abuse and that staff should technically be fired however, it would create a labour relations issue. The home tries to start with a written warning, followed by a suspension of 3 or 5 days, then termination follows. Discretion is used depending on the area of discipline ie: safety or conduct.

Inspector #575 reviewed an email attached from the staff member #505 to the Administrator and staff member #502 that stated that staff #114 'is just not getting it

and doesn't realize that her interactions are inappropriate'.

Despite the home's attempt at disciplinary action, staff member #114 has continually subjected residents to verbal abuse as indicated by 3 instances in 2014, and through resident testimonies throughout the home's investigation. The licensee failed to protect residents from abuse by the staff member #114 through a pattern of inaction and/or inappropriate and/or insufficient action. [s. 19. (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. 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).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
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).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions,

pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).

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).

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

16. Every resident has the 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. 2007, c. 8, s. 3 (1).

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers

of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) was issued previously as an order during inspection #2014_140158_0004 in March, 2014 in relation to resident #200.

On June 30, 2014 inspector #575 reviewed the most recent care plan and master diet list for resident #200. The inspector noted that the care plan and diet list both indicated the resident's behavioural responses during meal times and interventions to manage these responses.
On June 30, July 2, 3, 2014 inspector #575 observed resident #200 during lunch dining service. On all occasions the interventions specified on the care plan were not being followed.
Inspector #575 reviewed the progress notes for a period of 2 weeks in 2014. The notes indicated the interventions to be used for resident #200 during meal times. One day later, the notes indicated opposite interventions for resident #200.
On June 30, 2014 inspector #575 interviewed staff member #300 who confirmed that staff refer to the diet list for information pertaining to the resident's type of diet and specifications. The staff member also confirmed to inspector #575 that the diet list does not identify current interventions used for resident #200. The staff member was unsure why the care plan or diet list was not updated.
On July 3, 2014 inspector #575 interviewed the DOC regarding the resident's plan of care. The DOC confirmed that the care plan was unclear and needed to be updated.
The licensee did not ensure that resident #200 was protected from neglect. [s. 3. (1)]

2. On July 2, 2014 inspector #575 reviewed the staff training records for choking interventions. Records indicated that out of 35 registered staff, only 25 completed the training. Inspector interviewed staff member #301 regarding the training. The staff member indicated that 5 of the staff are currently on leaves of absence or perform other duties. Therefore 25 of the 30 available registered staff completed the training on choking interventions.
The licensee did not ensure that all registered staff received training on choking interventions by June 1, 2014, in order to protect residents from neglect. [s. 3. (1)]

Additional Required Actions:

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

Issued on this 24th day of July, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LINDSAY DYRDA (575)
Inspection No. / No de l'inspection :	2014_332575_0010
Log No. / Registre no:	S-000173-14, S-000174-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 24, 2014
Licensee / Titulaire de permis :	VALLEY EAST LONG TERM CARE CENTRE INC. 689 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 :	SHELLY MURPHY

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:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_140158_0004, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) was issued previously as an order during inspection #2014_140158_0004 in March, 2014.

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Despite the home's attempt at disciplinary action, staff member #113 continues to subject residents to verbal abuse as indicated in 2012 and 3 separate instances in 2014. The licensee failed to protect residents from abuse by the staff member #113 through a pattern of inaction and/or inappropriate and/or insufficient action. [s. 19. (1)] (575)

2. Inspector #575 reviewed a critical incident pertaining to allegations of verbal abuse by staff member #114 to multiple residents.

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In 2014 it was confirmed by the home that staff member #114 exhibited verbally abusive behaviour. Corrective recommendations included reviewing and signing various policies. Inspector #595 noted that as a result, staff member #114 was issued an oral warning. Additionally, a written warning was issued to staff member #114 for a second instance of verbal abuse. Corrective recommendations mirrored the previous disciplinary action which included reviewing and signing various policies.

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Despite the home's attempt at disciplinary action, staff member #114 has continually subjected residents to verbal abuse as indicated by 3 instances in 2014, and through resident testimonies throughout the home's investigation. The licensee failed to protect residents from abuse by the staff member #114 through a pattern of inaction and/or inappropriate and/or insufficient action. [s. 19. (1)] (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 15, 2014

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_140158_0004, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the 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.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according

to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that educational sessions are provided to staff related to choking interventions, and that residents' written plans of care, including resident #200, give clear directions to staff providing care.

Grounds / Motifs :

1. LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) was issued previously as an order during inspection #2014_140158_0004 in March, 2014 in relation to resident #200.

On June 30, 2014 inspector #575 reviewed the most recent care plan and master diet list for resident #200. The inspector noted that the care plan and diet list both indicated the resident's behavioural responses during meal times and interventions to manage these responses.
On June 30, July 2, 3, 2014 inspector #575 observed resident #200 during lunch dining service. On all occasions the interventions specified on the care plan were not being followed.
Inspector #575 reviewed the progress notes for a period of 2 weeks in 2014. The notes indicated the interventions to be used for resident #200 during meal times. One day later, the notes indicated opposite interventions for resident #200.
On June 30, 2014 inspector #575 interviewed staff member #300 who confirmed that staff refer to the diet list for information pertaining to the resident's type of diet and specifications. The staff member also confirmed to inspector #575 that the diet list does not identify current interventions used for resident #200. The staff member was unsure why the care plan or diet list was not updated.
On July 3, 2014 inspector #575 interviewed the DOC regarding the resident's plan of care. The DOC confirmed that the care plan was unclear and needed to be updated.
The licensee did not ensure that resident #200 was protected from neglect. [s. 3. (1)] (575)

2. On July 2, 2014 inspector #575 reviewed the staff training records for choking interventions. Records indicated that out of 35 registered staff, only 25 completed the training. Inspector interviewed staff member #301 regarding the training. The staff member indicated that 5 of the staff are currently on leaves of absence or perform other duties. Therefore 25 of the 30 available registered staff completed the training on choking interventions.
The licensee did not ensure that all registered staff received training on choking interventions by June 1, 2014, in order to protect residents from neglect. [s. 3. (1)] (575)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 15, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 24th day of July, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lindsay Dyrda

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