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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 26, 2016	2016_353589_0005	004616-16	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE ROUGE VALLEY
551 Conlins Road TORONTO ON M1B 5S1

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

JOANNE ZAHUR (589), JULIENNE NGONLOGA (502), SARAH KENNEDY (605), STELLA NG (507), SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, March 1, 2, 3, 4, 7, 8, and 9, 2016.

The following complaint intakes were inspected concurrently with the resident quality inspection: #015595-15 related to staff to resident abuse (theft), #001743-16 related to staff to resident verbal abuse, #031987-15 related to improper care and neglect, #030422-15 related to improper care and neglect, #017124-15 related to

improper care and medication not provided, #006819-15 related to lack of incontinent products and sharing of personal care products, #005158-14 related to catheter care, #024358-15 related to improper care and abuse, #030383-15 related to safety concerns and #030319-15 related to admission refusal to the long term care home.

The following critical incident reports intakes were concurrently inspected with the resident quality inspection: #002563-16, #029268-15, #030309-15, #005068-15 were related to staff to resident abuse, #031501-15 related to resident to resident abuse, and #004313-16 related to fracture and bruising of unknown cause.

The following follow-up intakes were inspected concurrently with the resident quality inspection: #001188-16 (CO #001) related to unsafe transfer, #020683-15 (CO #002) related to unsafe transfer and #020688-15 (CO #003) related to maintenance/leaking roof.

During the course of the inspection, the inspector(s) spoke with Administrator(s), Director of Care (DOC), Assistant Director(s) of Care (ADOCs), Dietary Manager, Registered Dietitian (RD), Central East Community Care Access Centre (CCAC) team assistant, Physiotherapist (PT), Activation Aide (AA), Quality Indicator and Education (QI&E) lead, Registered Practical Nurse (RPN), Registered Nurse (RN), Personal Support Worker(s) (PSWs), minimum data set-resident assessment instrument (MDS-RAI) coder, Dietary Aides (DA), Cook, Residents, Substitute Decision Makers (SDM's), Toronto Public Health Nurse (TPH), Extendicare Corporate Infection Control Lead, Physician, Medical Pharmacies Manager, and Presidents of Residents Council and Family Council.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **14 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #003	2015_353589_0010	589
O.Reg 79/10 s. 36.	CO #001	2015_252513_0018	507
O.Reg 79/10 s. 36.	CO #002	2015_353589_0010	507

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. The licensee failed to ensure that resident #051 was protected from physical abuse by

anyone.

In accordance with the definition in subsection 2 (2) of the Act, the definition of “physical abuse” in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.

Record review of a critical incident report (CIR) submitted on an identified date revealed noises were heard from resident #051's room by staff #168. The resident could be seen from the hallway lying in bed with an identified care giver trying to provide care. Resident #051 was demonstrating responsive behaviours towards the care giver who was seen holding down identified body areas of resident #051. The care giver was immediately sent home. Resident #051 was assessed and did not have any physical injuries as a result of this interaction.

Interviews with staff #168 and staff #105 confirmed that the care giver was physically abusive to resident #051 and therefore not protected from abuse. [s. 19. (1)]

2. The licensee failed to ensure that resident #005 was protected from emotional abuse by anyone.

In accordance with the definition in subsection 2 (1) of the Act "emotional abuse” means, 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.

Record review of an identified CIR submitted on an identified date revealed resident #005 did not get any food the morning of an identified date because he/she did not want to go to the dining room. Staff #134 stated that staff #135 reported resident #005 refused to come out to the dining room and requested that food be brought to his/her room. Staff #134 told staff #135 not to give the resident food unless he/she comes to the dining room. Staff #134 admitted that this was his/her way of punishing residents who do not want to come to the dining room if they are not sick.

Interviews with resident #005 and a family member revealed resident #005 was not feeling well the morning of an identified date and had asked to be left in bed and have food brought to him/her. This had been done in the past and he/she was mad and upset when told by staff #135 that staff #134 refused to allow the PSW to provide a breakfast

tray. According to resident #005 another resident overheard staff #134 stating that if you are not sick, you have to come out of your room for your meal.

An interview with staff #135 revealed he/she told staff #134 that resident #005 did not want to come to the dining room for breakfast on an identified date. According to staff #135, staff #134 told him/her there was nothing wrong with the resident and he/she had to come to dining room. staff #135 prepared a tray but staff #134 did not allow the tray to be taken to the room.

An interview with staff #105 revealed that during the home's investigation staff #134 admitted that refusing to provide meal trays to residents who did not want to come to the dining room was his/her way of punishing those residents. Staff #105 confirmed that this was a clear case of abuse. [s. 19. (1)]

3. The licensee failed to protect resident #052 from physical abuse by anyone.

Record review of an identified CIR revealed resident #052 told staff #128 on an identified date that he/she did not like when an "identified staff" bathed the resident because the staff member pulled at an identified body area and it hurt. According to the resident, he/she had to hide to avoid getting bathed and when he/she complained to the staff the resident was told "why are you complaining? No one likes you here". According to staff #128 resident #052 was shaking in fear as he/she talked to him/her about the times when he/she had been scared of the identified staff member.

An interview with staff #128 revealed resident #052 had told him/her that an identified staff member had been rough with him/her and was upset. Staff #128 further revealed that resident #052 used to have specified symptoms but as soon as the identified staff member stopped providing care, the resident no longer had these symptoms..

An interview with staff #105 revealed that during the home's investigation the identified staff member had resigned. [s. 19. (1)]

4. The licensee failed to ensure residents #063 and #014 were protected from verbal abuse by anyone.

In accordance with the definition in subsection 2 (1) of the Act, "verbal abuse" means, any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident

making the communication understands and appreciates its consequences. (“mauvais traitement d’ordre verbal”)

Review of a complaint submitted to the Ministry of Health on an identified date revealed an alleged resident to resident abuse.

An interview with resident #064 revealed he/she was struck by resident #061 and experienced discomfort. Record review of resident #064’s progress notes revealed on an identified date resident #061 demonstrated verbal aggression toward resident #063, and resident #061 struck resident #064, in the dining room, with his/her assistive device Resident #064 was transferred to hospital for assessment which revealed he/she had not sustained any injuries. Resident #064 further revealed he/she was nervous about resident #061 continuing to reside in the home.

An interview with registered staff #165 confirmed that he/she witnessed resident #061 had demonstrated responsive behaviours towards resident #064.

An interview with staff #105 confirmed resident #061 had struck resident #064 with his/her assistive device and had been verbally aggressive.

Record review of a critical incident report (CIR) submitted to the Ministry of Health on an identified date revealed an alleged staff to resident abuse.

Record review of the CIR revealed resident #014 complained that staff #169 made him/her feel bad and was very rough during morning care. Resident #014 further revealed that staff #169 hurt his/her feelings by saying, "you do not pay me, the government pays me to work here. You are not the only resident I take care of".

Record review of the home's investigation notes revealed that staff #169 admitted to saying the following to the resident: "you do not pay me, the government pays me to work here. You are not the only resident I take care of and that resident #014 needed to cooperate."

Interview with resident #014 revealed that he/she was having a bad day on an identified date and now had no complaints about staff #014. Substitute decision maker (SDM) was present in room and revealed that he/she was appreciative of the home's actions to initiate an investigation.

Interview with staff #169 revealed that resident #014 had been asking repeatedly to get up. At this time staff #169 left and re-approached resident later and transferred into a chair without incident. During breakfast staff #169 revealed he/she told resident that his/her behaviour earlier was not appropriate and that it is not the resident who pays him/her but the government and that he/she also provided care to other residents.

Interview with staff #104 confirmed that staff #169 had not protected resident #014 from verbal abuse.

PLEASE NOTE: Areas of non-compliance related to resident #014 are included in this inspection and correspond with inspection report #2016_353589_0007. [s.19.(1)].

The scope of this non compliance is a pattern as it relates to four residents. The severity is minimal harm or potential for actual harm. The Compliance History Report indicates a prior compliance order was issued June 24, 2015. As a result of scope, severity and the licensee's previous compliance history, a compliance order is warranted. [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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident is assessed and the plan of care reviewed and revised when the resident's care needs change.

Record review of the most recent Minimum Data Set-Resident Assessment Instrument (MDS-RAI) assessment and care plan dated with an identified date for resident #006 revealed the resident required some physical assistance from staff for mobility, with the resident to perform part of the task.

Record review of the progress notes for resident #006 and interview with staff #130 revealed resident #006 had been assessed by staff #130 for his/her mobility status on an identified date. A mobility apparatus with two person assistance had been recommended. Interview with staff #130 revealed that he/she usually verbally updates the charge nurse of any new recommendation(s) after completing an assessment and documentation on Point Click Care (PCC) documentation system. Staff #130 further revealed he/she has never updated the plans of care in regards to resident mobility requirements.

Record review of resident #006's current plan of care and interview with staff #102 revealed that the resident's plan of care was not revised accordingly when the resident was assessed by staff #130 and the use of a mobility apparatus with two person assistance had been recommended.

Interview with staff #105 revealed that this has been the home's practice for the registered nursing staff to update plans of care accordingly after being briefed by staff #130 of any mobility status changes.

Staff #105 confirmed resident #006's plan of care in regards to his/her mobility status should have been revised and updated based on the assessment and recommendation of staff #130.

2. Record review of an MDS-RAI assessment dated on an identified date revealed resident #008 had impaired skin integrity to an identified body area.

Record review of the written care plan on an identified date revealed a focus related to impaired skin integrity with a specified goal, and interventions.

Interviews with staff #138 and staff #105 confirmed the plan of care had not been reviewed and revised to reflect specific wound care requirements when resident #008's care needs changed.

PLEASE NOTE: Areas of non-compliance related to resident #008 are included in this inspection and correspond with inspection report #2016_353589_0008.[s.6.(10)(b)]

3. Interview with resident #004's SDM and review of the resident medical record revealed resident #004 was admitted in the home on an identified date with a history of decreased food and fluid intake and an underlying medical condition.

Review of resident #004's total dietary intake reports for an identified period of time revealed resident #004's total dietary intake had significantly decreased per meal. Review of the progress notes revealed on an identified date resident #004 had experienced an identified medical condition.

Interview with staff #131 confirmed resident #004 had experienced an identified medical condition for two days and decreased dietary intake. Resident #004 was not assessed or referred to the dietitian until seven days after a change in his/her nutritional status.

Interview with staff #155 confirmed he/she had not received a referral for resident #004 indicating the resident had decreased dietary intake.

Interview with staff #105 confirmed the above mentioned change in resident #004's nutritional status and also confirmed resident #004 should have been assessed and referred to the RD and physician after three consecutive days of decreased dietary intake.

PLEASE NOTE: Areas of non-compliance related to resident #004 are included in this inspection and correspond with inspection report #2016_353589_0006. [s.6.(10)(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 that the resident is assessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdowns, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Record review of progress notes for resident #009 revealed that the resident had sustained two areas of impaired skin integrity after an incident on an identified date.

Interviews with staff #106 and staff #117 revealed skin assessments are required for any alteration to skin integrity such as skin tear, bruise, rash, wound or ulcer using the "Skin Tear – Weekly Impaired Skin Integrity Assessment – V3" on the Point Click Care (PCC) documentation system.

Record review of assessments completed for resident #009 and interview with staff #117 revealed skin assessments for resident #009 were not completed for his/her above mentioned altered skin integrity.

Interview with staff #117 confirmed that a skin assessment for resident #009's areas of altered skin integrity should have been completed using the "Skin Tear – Weekly Impaired Skin Integrity Assessment – V3" tool. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdowns, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.

Record review of progress notes for resident #009 revealed that the resident sustained two areas of impaired skin integrity on an identified date.

Interviews with staff #106 and staff #117 revealed resident #009 should have been referred to a registered dietitian (RD) when the resident had exhibited impaired skin integrity.

Record review of the home's policy, "Skin Care & Wound Management (document number: DIET-04-01-12, reviewed January 2007)", section "Individualized Dietary Services" indicated all residents who exhibit skin breakdown and/or wounds will be referred to the Dietitian for a detailed nutritional assessment.

Record review of progress notes for resident #009 and interview with staff #117 confirmed a referral to the RD for nutritional assessment had not been completed. [s. 50. (2) (b) (iii)]

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 a resident exhibiting altered skin integrity, including skin breakdowns, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #4: 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. The licensee failed to ensure procedures and interventions are developed and implemented to minimize the risk of altercations and potentially harmful interactions between residents.

Record review of a CIR submitted on an identified date revealed resident #062 struck resident #061 on an identified body area and threatened to harm him/her. A review of progress notes revealed resident #062 approached resident #061 from behind resulting in impaired skin integrity to an identified body area on resident #061.

Interviews with identified staff members revealed resident #061 and #062 shared a room, and resident #061 could provoke resident #062. A review of the most recent written plan of care revealed interventions staff are to initiate to prevent resident #061 from demonstrating responsive behaviours towards other residents. A review of resident #062's most recent written plan of care also revealed staff need to monitor the resident every 15 minutes.

A review of the Behavioural Support Ontario (BSO) recommendations for resident #062 revealed that on two occasions the BSO recommended a private room for #062 as he/she had continued to demonstrate behaviours.

An interview with staff #163 revealed he/she feels incidents between these residents can only be prevented if they were in separate rooms.

An interview with staff #105 revealed residents #061 and #062 continued to share a room and confirmed the home had not implemented interventions to ensure the risk of potentially harmful interactions between residents #061 and #062 are minimized. [s. 55. (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 procedures and interventions are developed and implemented to minimize the risk of altercations and potentially harmful interactions between residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff receive retraining annually relating to the Residents' Bill of Rights.

Record review of the home's training records on the Resident's Bill of Rights revealed and interview with staff #105 confirmed that 27.8 per cent of staff did not receive annual retraining on the Resident's Bill of Rights for 2015. [s. 76. (4)]

2. The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in abuse recognition and prevention, at times or at intervals provided for in the regulations.

Record review of the home's education records revealed that five per cent of direct care staff who continue to have contact with residents had not received training in abuse recognition and prevention.

Interview with staff #104 confirmed that five per cent of direct care staff who continued to have contact with residents had not received training in abuse recognition and prevention. [s. 76. (7) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff receive retraining annually relating to the Residents' Bill of Rights, to be implemented voluntarily.

WN #6: 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).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the right of the resident to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted.

Interview with resident #012 revealed staff #127 had thrown an identified piece of linen at her/him. The resident also stated staff #127 left him/her lying in bed unattended while he/she was only wearing an incontinent product. Resident #012 stated he/she felt dirty and unwanted. The resident confirmed that he/she had reported the incident to other staff and staff #139.

Interview with staff #127 confirmed he/she provided care to resident #012, but denied leaving the resident uncovered. Interview with staff#153 confirmed on an identified date he/she went to dress resident #012 and found the resident lying across the bed, his/her feet on the ground, and only wearing an incontinent product and an undergarment.

Interviews with staff #149, staff #131 and staff #139 confirmed being aware of the above allegation and confirmed the resident had not been treated with respect and dignity. [s. 3. (1) 1.]

2. The licensee failed to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs is fully respected and promoted.

Record review of a submitted on an identified date revealed resident #051 could be heard verbally from his/her room by staff #168. The resident's room door was partly closed but the resident could be seen without further opening the door. The resident was lying on the bed without clothing and with a care giver trying to provide care.

Record review of resident #051's progress notes on an identified date revealed the resident's door was not properly closed to ensure privacy and he/she was lying on the bed without clothing. Interview with staff #168 who witnessed the incident and who had submitted the report remembered the incident and recalled that the care giver did not provide privacy when caring for the resident's needs.

Interview with staff #105 confirmed that in the above mentioned incident the home did not fully respect and promote the resident's right to be afforded privacy in caring for his or her personal needs. [s. 3. (1) 8.]

WN #7: 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 failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated.

An interview with resident #012 revealed staff #127 had thrown an identified piece of linen at her/him and told him/her "to wipe your face". The resident also stated staff #127 left him/her lying in bed unattended while only wearing an incontinent product and an undergarment. Resident #012 stated he/she felt dirty and unwanted. The resident revealed that he/he reported the incident to staff#149 and staff #139.

Interviews with staff #131 and staff #139 confirmed they became aware of the alleged abuse on an identified date and had not initiated an investigation immediately as required under the Act. [s. 23. (1) (a)]

2. Record review of a complaint submitted to Ministry of Health and Long Term Care on an identified date revealed an incident of alleged staff to resident verbal abuse. The witness revealed resident #030 rang the call bell for assistance, when a member of the staff answered the call bell he/she began screaming at the resident " Don't you know I'm busy, don't you ring this bell again." The witness confirmed he/she notified the DOC.

Interview with staff #105 revealed the above mentioned alleged abuse had been reported to him/her and confirmed the home had not investigated immediately. [s. 23. (1) (a)]

3. Record review of a CIR revealed on an identified date resident #007's family member reported to the staff an area of altered skin integrity. The family member further reported the resident stated a staff member had tried to take an identified piece of jewellery off from this body area.

Review of the home's Complaint Investigation Form and interview with staff #105 revealed the investigation of the above mentioned alleged abuse was not investigated until the next day. Staff #105 confirmed the investigation should have been initiated immediately as required. [s. 23. (1) (a)]

WN #8: 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 failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately reported to the Director.

An interview with resident #012 revealed staff #127 threw an identified piece of linen at her/him and told her/him "to wipe your face". The resident also stated staff #127 left him/her lying in bed unattended while only wearing an incontinent product and an undergarment. Resident #012 stated he/she felt dirty and unwanted. The resident revealed that he/he had reported the incident to staff #149 and staff #139.

Interviews with staff#131 and staff #139 confirmed they became aware of the above mention allegation of abuse and had not reported it to the Director as required under the Act. [s. 24. (1)]

2. Record review of a complaint submitted to the Ministry of Health and Long Term Care on an identified date revealed an incident of alleged staff to resident verbal abuse. The witness revealed resident #030 rang the call bell for assistance, when a member of the staff answered the call bell he/she began screaming at the resident " Don't you know I'm busy, don't you ring this bell again." The witness confirmed he/she had notified staff #105.

Interview with staff #105 confirmed the alleged abuse had not been reported to the Director immediately as required under the Act. [s. 24. (1)]

3. Record review of a CIR revealed on an identified date resident #007's family member reported to the staff an area of altered skin integrity to an identified body area. The family member further reported resident #007 stated a staff member had tried to take a piece of jewellery off from the identified body area two days prior.

Review of the CIR and interview with staff #105 revealed that the above mentioned alleged abuse had been reported to the Director on an identified date which was two days later. Staff #105 confirmed the above mentioned alleged abuse incident should have been reported to the Director immediately. [s. 24. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee failed to comply with subsection 44 (7) of the LTCHA, whereby the licensee refused an applicant's admission without providing sufficient supporting facts to support the grounds provided as a reason to withhold the approval.

Record review of a complaint fax to the Ministry of Health and Long Term Care from the Community Care Access Centre (CCAC) revealed resident #053 was refused admission to the home due to the client having an identified underlying medical condition. The fax stated that the hospital's resource personnel had indicated the client required a private room and that the client had applied for a private room.

Interview with CCAC complainant revealed there was no indication that this was an emergency placement and the client was willing to wait for a private room.

Record review of the written notice addressed to the client from the home indicated the home was not able to accept the client due to not being able to provide adequate and safe level of care for him/her without putting other residents at risk. The decision was based on the information received regarding client having an identified underlying medical condition.

Record review of an identified home policy last updated September 2015, revealed specific procedures for all staff to follow. Interview with the Extendicare’s corporate infection control lead revealed a private room at this home would have been an acceptable placement for resident #053. [s. 44. (7)]

2. The licensee failed to comply with subsection 44 (9) (b) and 44 (9) (c) of the LTCHA, whereby the licensee withholds approval for admission, but did not provide in any of the written notices a detailed explanation of the supporting facts, as they relate both to the home and to the applicant’s condition and requirements of care, and an explanation of how the supporting facts justify the decision to withhold approval.

Record review of a complaint fax to the Ministry of Health and Long Term Care from the CCAC revealed resident #053 was refused admission to the home due to the client having an underlying medical condition. The fax states that the hospital's resource personnel revealed the client required a private room and the client had applied for a private room.

Interview with CCAC complainant revealed there was no indication that this was an emergency placement and the client was willing to wait for a private room.

Record review of the written notice addressed to the client indicated that the home was not able to accept the client due to not being able to provide adequate and safe level of care for him/her without putting other residents at risk. The decision was based on the information received regarding client having an underlying medical condition. This explanation that was sent to the client had not provided a detailed explanation of the supporting facts as how the home could not care for resident #053's underlying medical condition.

An interview with a representative from the East Region Infection Control Network (RICN) revealed a long term care home would have to manage the admission of a person with an underlying medical condition unless there were extenuating circumstances such as the home being in outbreak.

An interview with staff #104 confirmed the letter sent from the home had not included a detailed explanation of the supporting facts as they related to the home and to the applicant's condition and requirements of care. [s. 44. (9)]

WN #10: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

An interview with resident #012 revealed staff #127 had thrown an identified piece of linen at her/him. The resident also stated staff 127 left him/her lying in bed unattended while he/she was wearing an incontinent product and undergarment. Resident #012 stated he/she felt dirty and unwanted. The resident confirmed that he/he reported the incident to other staff and staff #139.

Interview with staff #153 confirmed he/she went to dress resident #012 and found resident #012 lying across the bed, with his/her feet on the ground, wearing an incontinent product and an undergarment and had not been covered.

Interviews with staff#131 and staff #139 confirmed they became aware of the above mention allegation of abuse on an identified date and had not notified resident #012's SDM. [s. 97. (1) (b)]

2. Record review of a complaint to the Ministry of Health and Long Term Care revealed an alleged abuse witnessed by a visitor had been reported to the Director. The witness revealed resident #030 had rung the call bell for assistance, when the nurse answered the call bell he/she began screaming at the resident saying "don't you know I'm busy, don't you ring this bell again". The witness also indicated a recreational activity staff had witnessed the alleged abuse. The witness confirmed he/she had reported the incident to staff #105.

Interview with staff #152 confirmed he/she had a meeting with staff #105, staff #104 and the union representative related to the above mention allegation of abuse, but denied witnessing the alleged abuse.

Interview with staff #105 confirmed he/she had not notified resident #030's SDM when he/she had become aware of the above mentioned allegation of abuse. [s. 97. (1) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is informed of an incident under subsection (3) within 10 days of becoming aware of the incident.

1. Record review of the progress notes for resident #043 revealed the resident had an incident on an identified date and was sent to the hospital the next day due to complaints of pain. The resident was diagnosed with an injury to an identified body area and returned to the home on an identified date.

Record review of the Critical Incident System (CIS) and interview with staff #104 confirmed that the home had not reported the above mentioned incident to the Director as required.

2. Record review of a CIR submitted on an identified date revealed the home received a phone call from the hospital informing the home that the hospital had diagnosed resident #063 with an injury to an identified body area.

Record review of resident #063's progress notes revealed staff#131 had called the hospital and was informed resident #063 had been diagnosed with an injury to an identified body area.

An interview with staff #104 confirmed the Director had not been informed no later than one day after a significant change to resident #063's health condition.

PLEASE NOTE: Areas of non-compliance related to resident #063 are included in this inspection and correspond with inspection report #2016_398605_0009. [r. 107(3)(4)] (605) [s. 107. (3) 4.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or in a medication cart that is secure and locked.

On an identified date the inspector observed on an identified resident home area the medication room door had been left open and unlocked with no staff in attendance. Medication was found in an unlocked refrigerator and on the counter top. As well, in an unlocked cupboard which was labeled drug destruction there was an unsealed pail that contained four prescription medications.

Interview with staff #102 revealed that he/she had forgotten to lock the door and the door should be locked at all times.

At the same time, observation by the inspector revealed an unlocked treatment cart outside the medication room that contained prescription creams.

Interview with staff #102 admitted that the treatment cart should have been locked.

Interview with staff #105 confirmed that the medication room and the treatment cart should have been locked. [s. 129. (1) (a) (ii)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes:
(a) hand hygiene;
(b) modes of infection transmission;
(c) cleaning and disinfection practices and;
(d) use of personal protective equipment.

Record review of the home's 2015 education attendance records revealed that five per cent of staff had not received annual retraining in infection prevention and control.

Interview with staff #105 confirmed that five per cent of staff had not received annual retraining in infection prevention and control. [s. 219. (4)]

WN #14: 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 ensure that all staff participates in the implementation of the infection prevention an control program.

Interview with staff #118 revealed that care carts used by personal support workers (PSW) are to have clean linens, gloves, towels, and incontinent products stored on them and on occasion there will be other items such as barrier cream and vaseline if a resident requires this product replaced. Staff #118 further revealed that staff are provided with markers to label the previously mentioned personal care items.

On two identified dates observations by the inspector on two identified resident home areas revealed the following unlabeled resident personal care items on three care carts:
-two vaseline jars
-one tube of barrier cream
-two bottles of green coloured bath soap and shampoo
-one deodorant stick
-one bottle of Natura body lotion
-one blue disposable razor

Interviews with staff #122, #113 and #124 revealed that the above mentioned items should not have been stored on the care carts as there was a risk for cross-contamination between residents as they were not labeled.

Interview with staff #121 revealed that only clean items are to be stored on the care carts and any resident personal care items are to be labeled.

Interview with staff #105 confirmed that the above mentioned resident personal care items should have been labeled and stored in resident rooms to ensure staff participation in the infection prevention and control program. [s. 229. (4)]

Issued on this 17th day of May, 2016

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE ZAHUR (589), JULIENNE NGONLOGA (502), SARAH KENNEDY (605), STELLA NG (507), SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2016_353589_0005
Log No. / Registre no:	004616-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 26, 2016
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE ROUGE VALLEY 551 Conlins Road, TORONTO, ON, M1B-5S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Terry Pilgrim-Deane

To EXTENDICARE (CANADA) 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) (b)

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 prepare, submit and implement a plan to ensure that residents are protected from abuse. The plan shall include, but not be limited to the following:

1) Ensuring education is provided to all staff including the definitions and different types of abuse to ensure that all staff are able to identify signs of possible abuse, and
2) The development and implementation of a process that clearly describes how and when staff who are responsible for investigating and reporting incidents of alleged abuse, take the appropriate actions as required under the Act and Regulations.
3)) The development and implementation of a system of ongoing monitoring to ensure staff are complying with the home's policy and procedures related to zero tolerance of abuse and neglect.

This plan is to be submitted via email to inspector - joanne.zahur@ontario.ca by May 6, 2016.

Grounds / Motifs :

1. The licensee failed to ensure resident #014 was protected from verbal abuse by anyone.

In accordance with the definition in subsection 2 (1) of the Act, "verbal abuse" means, any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its

consequences. ("mauvais traitement d'ordre verbal")

The Ministry of Health received a CIR on an identified date alleging staff to resident verbal abuse.

Record review of the CIR revealed resident #014 complained that staff #169 made him/her feel bad and was very rough during morning care. Resident #014 further revealed that staff #169 hurt his/her feelings by saying, "you do not pay me, the government pays me to work here. You are not the only resident I take care of".

Record review of the home's investigation notes revealed that staff #169 admitted to saying the following to the resident: ""you do not pay me, the government pays me to work here. You are not the only resident I take care of and that resident #014 needed to cooperate.

Interview with resident #014 revealed that he/she was having a bad day on an identified date and now had no complaints about staff #014. Substitute decision maker (SDM) was present in room and revealed that he/she was appreciative of the home's actions to initiate an investigation.

Interview with staff #169 revealed that resident #014 had been asking repeatedly to get up. At this time staff #169 left and re-approached resident later and transferred into a chair without incident. During breakfast staff #169 revealed he/she told resident that his/her behaviour earlier was not appropriate and that it is not the resident who pays him/her but the government and that he/she also provided care to other residents.

Interview with staff #104 confirmed that staff #169 had not protected resident #014 from verbal abuse.

PLEASE NOTE: Areas of non-compliance related to resident #014 are included in this inspection and correspond with inspection report #2016_353589_0007. [s.19.(1)](589).

(605)

2. The licensee failed to protect resident #052 from physical abuse by anyone.

Record review of an identified CIR revealed resident #052 told staff #128 on an identified date that he/she did not like when an "identified staff" bathed the resident because the staff member pulled at an identified body area and it hurt. According to the resident, he/she had to hide to avoid being bathed and when he/she complained to the staff the resident was told "why are you complaining? No one likes you here". According to staff #128 resident #052 was shaking in fear as he/she talked to him/her about the times when he/she had been scared of the identified staff member.

An interview with staff #128 revealed resident #052 had told him/her that an identified staff member had been rough with him/her and was upset. Staff #128 further revealed that resident #052 used to have specified symptoms but as soon as the identified staff member stopped providing care, the resident no longer had these symptoms.

An interview with staff #105 revealed that during the home's investigation the identified staff member had resigned. [s. 19. (1)]

(501)

3. The licensee failed to ensure that resident #005 was protected from emotional abuse by anyone.

In accordance with the definition in subsection 2 (1) of the Act "emotional abuse" means, 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.

Record review of an identified CIR submitted on an identified date revealed resident #005 did not get any food the morning of an identified date because he/she did not want to go to the dining room. Staff #134 stated that staff #135 reported resident #005 refused to come out to the dining room and requested that food be brought to his/her room. Staff #134 told staff #135 not to give the resident food unless he/she comes to the dining room. Staff #134 admitted that this was his/her way of punishing residents who do not want to come to the dining room if they are not sick.

Interviews with resident #005 and a family member revealed resident #005 was

not feeling well the morning of an identified date and had asked to be left in bed and have food brought to him/her. This had been done in the past and he/she was mad and upset when told by staff #135 that staff #134 refused to allow the PSW to provide a breakfast tray. According to resident #005 another resident overheard staff #134 stating that if you are not sick, you have to come out of your room for your meal.

An interview with staff #135 revealed he/she told staff #134 that resident #005 did not want to come to the dining room for breakfast on an identified date. According to staff #135, staff #134 told him/her there was nothing wrong with the resident and he/she had to come to dining room. staff #135 prepared a tray but staff #134 did not allow the tray to be taken to the room.

An interview with staff #105 revealed that during the home's investigation staff #134 admitted that refusing to provide meal trays to residents who did not want to come to the dining room was his/her way of punishing those residents. Staff #105 confirmed that this was a clear case of abuse. [s. 19. (1)]

(501)

4. The licensee failed to ensure that resident #051 was protected from physical abuse by anyone.

In accordance with the definition in subsection 2 (2) of the Act, the definition of "physical abuse" in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.

Record review of a critical incident report (CIR) submitted on an identified date revealed noises were heard from resident #051's room by staff #168. The resident could be seen from the hallway lying in bed with an identified care giver trying to provide care. Resident #051 was demonstrating responsive behaviours towards the care giver who was seen holding down identified body areas of resident #051. The care giver was immediately sent home. Resident #051 was assessed and did not have any physical injuries as a result of this interaction.

Interviews with staff #168 and staff #105 confirmed that the care giver was physically abusive to resident #051 and therefore not protected from abuse. [s.

19. (1)]

(501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de sions de longue durée
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
Inspection de sions de longue durée
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 26th day of April, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joanne Zahur

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