Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 13, 14, 28, Oct 9, 10, 11, 15, 17, 18, 19, 24, 2012	2012_065169_0013	Complaint

Licensee/Titulaire de permis

GRACE VILLA LIMITED
284 CENTRAL AVENUE, LONDON, ON, N6B-2C8

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

GRACE VILLA NURSING HOME
45 LOCKTON CRESCENT, HAMILTON, ON, L8V-4V5

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

YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Nutrition Manager, Food Service Manager, Maintenance Manager, Handyman, Housekeepers, Dietary and Nursing Aides, Registered nursing staff, residents and families.

During the course of the inspection, the inspector(s) reviewed clinical records, reviewed policies and procedures and observed care areas.
This complaint inspection relates to log#H-001909-12, H-001793-12, H-001662-12, H-001768-12, H-002028-12, H-002029-12, H-001508-12

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Family Council

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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 O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has not ensured that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. the complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

In August, 2012 the Substitute Decision Maker (SDM) for resident #2 approached the nursing office staff to express concerns of abuse of Resident #2. In August, 2012 the SDM had not been contacted by the staff at the home to discuss the concerns. The SDM then made a second attempt to speak with someone in management regarding the concerns, which was 6 days later. In September, 2012 the administrator addressed the concerns and the complaint log was completed with action items. The issues were not addressed for 13 days after the original contact. The was no documented record kept in the home in relation to the original complaint. This was confirmed by the administrator.

In July, 2012 the family of Resident #6 contacted the Director of Care and the Assistant Director of Care to discuss concerns about the care of Resident #6. The family did not receive a call back or any follow up from the management team. In August, 2012 the family approached the administrator and a meeting was held in August, 2012 to address the concerns, which was over 30 days after the initial complaint was expressed. The Administrator confirmed the delay in response.

In September, 2012 the family of Resident #5 called the Director of Care regarding concerns for the safety of Resident #5. In September, 2012 the family contacted the Ministry of Health duty inspector to express the same concerns for the safety of Resident #5, as well as concern related to the Director of Care not returning their call. In September, 2012 the duty inspector conducted an inquiry at the home and spoke with the Director of Care to determine the interventions the home had implemented to maintain Resident #5's safety. The Director of Care stated they would contact the family to update them regarding the interventions the same day. The family confirmed they did receive a call from the Director of Care in September, 2012, 3 days after their initial call. The Director of Care did not respond to the safety concerns for Resident #5 and initiate an investigation immediately, instead the Director of Care waited 3 days. This was confirmed by the administrator and the complaint log kept at the home.

Additional Required Actions:

CO # - 901 was 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 subsections:

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).

Findings/Faits saillants :

1. The licensee has not ensured that every resident has the right to 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.

LTCHA, 2007, S.O. 2007, c.8, s. 3(1)11 Resident #2 had a medical device applied within their care area without the consent of the Substitute Decision Maker. The resident was assessed to be high risk for injury and the plan of care was changed to include the application of the medical device. The resident's substitute decision maker was not provided an opportunity to provide consent for the device to be implemented. The nursing staff and the clinical documentation confirmed there was no consent obtained.

LTCHA, 2007, S.O. 2007, c.8, s. 3(1)11 Resident #2 received a medical procedure without consent from the Substitute Decision Maker (SDM). The resident received the procedure in August, 2012 with the consent of the SDM, then another one was completed one week later without the consent or knowledge of the SDM. The clinical chart and the nursing staff confirmed this was completed without consent.

2. The licensee has not ensured every resident has been treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

LTCHA, 2007, S.O. 2007, c.8, s. 3(1)1 Resident #2 was identified at high risk for injury. In August, 2012 the plan of care was changed to include the use of a medical device . The clinical documentation revealed Resident #2 did not want the device. The nursing staff continued to re-apply the device even though the resident did not want it to be used. The resident was not treated with dignity by the staff. The staff and documentation confirmed above.

LTCHA, 2007, S.O. 2007, c.8, s. 3(1)1 The licensee has not ensured that Resident #1's rights were fully respected and promoted to ensure the resident was treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity. Resident #1 was provided a modified textured food item but was assessed to receive a regular textured food item. The resident told the staff member they didn't want the modified texture as they were assessed to receive a regular texture. The staff member ignored the resident's request and told them they had to have the modified texture even when there was a regular textured food item available. The resident expressed frustration and anger as they stated the staff didn't listen to them as they explained they had just finished eating a regular textured main course. The resident stated they was not treated with respect for their decision to make their own choices. The staff member confirmed they did not respect the resident's right to be treated with dignity.

LTCHA, 2007, S.O. 2007, c.8, s. 3(1)1
The licensee did not ensure that Resident #3's right to participate in decision-making was respected. Resident #3 had a fall and was told they would have a treatment in September, 2012 however the treatment were not completed on the scheduled date. The resident stated they asked the nursing staff why they weren't completed and was not provided with an explanation, nor a re-scheduled date. The resident stated this caused them great concern as they have a medical condition the warrants the treatment. The resident stated they felt they were not treated with courtesy and respect by the nursing staff. The resident is their own advocate and capable of making their own decisions, however stated they felt they had to call someone else to talk to the nursing staff as they were not providing the resident with any information. The nursing staff told the person about the treatment but did not tell the resident. The treatments were then completed after the resident's friend asked about them. This was confirmed in the clinical documentation.

Additional Required Actions:

CO # - 902 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

s. 6. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. LTCHA, 2007, S.O. 2007, c.8,s.6(1)c The licensee has not ensured that the plan of care for Resident #1 is developed to provided clear directions to staff and others who provide direct care to the resident. Resident #1 requires a specific treatment. The treatment is quite specific, according to the physiotherapist. The plan of care did not include the specific directions for the Personal Support Workers who were responsible for the treatment. In August, 2012 the treatment was completed with a negative outcome. Staff confirmed direction was not provided to them. The documentation also confirmed absence of the directions to all staff who provide direct care to the resident.

2. LTCHA, 2007, S.O. 2007, c.8,s.6(10)b The licensee did not 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, the resident's care needs change or care set out in the plan is not longer necessary.

In April 2012, Resident #2's began complaining about pain and the physician's assistant ordered a treatment to be completed. Over a period of months, Resident #2 continued to complain of pain. The SDM went to the administrator to express their concerns and then the doctor ordered an alternative treatment to be completed. The alternative treatment showed an injury in the same area where the complaint of pain had been. The report was signed off by the physician's assistant and there wasn't any communication of the results to the SDM, physiotherapist or nursing staff. The resident's care needs changed and the plan of care was not revised to reflect the change in the resident's care needs. This was confirmed by the clinical records, the physiotherapist and the registered nurse.

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 that ensures that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 24th day of October, 2012

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

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2012_065169_0013
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Sep 13, 14, 28, Oct 9, 10, 11, 15, 17, 18, 19, 24, 2012
Licensee / Titulaire de permis :	GRACE VILLA LIMITED 284 CENTRAL AVENUE, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	GRACE VILLA NURSING HOME 45 LOCKTON CRESCENT, HAMILTON, ON, L8V-4V5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LYNETTE TYLER Wendy Hall

To GRACE VILLA LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Order / Ordre :

The licensee must ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. . O. Reg. 79/10, s. 101 (1).

Grounds / Motifs :

1. The licensee has not ensured that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. the complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

In July, 2012 the family of Resident #6 contacted the Director of Care and the Assistant Director of Care to discuss concerns about the care of Resident #6. The family did not receive a call back or any follow up from the management team. In August, 2012 the family approached the administrator and a meeting was held in August, 2012 to address the concerns, which was over 30 days after the initial complaint was expressed. The Administrator confirmed the delay in response.

In September, 2012 the family of Resident #5 called the Director of Care regarding concerns for the safety of Resident #5. In September, 2012 the family contacted the Ministry of Health duty inspector to express the same concerns for the safety of Resident #5, as well as concern related to the Director of Care not returning their call. In September, 2012 the duty inspector conducted an inquiry at the home and spoke with the Director of Care to determine the interventions the home had implemented to maintain Resident #5's safety. The Director of Care stated they would contact the family to update them regarding the interventions the same day. The family confirmed they did receive a call from the Director of Care in September, 2012, 3 days after their initial call. The Director of Care did not respond to the safety concerns for Resident #5 and initiate an investigation immediately, instead the Director of Care waited 3 days. This was confirmed by the administrator and the complaint log kept at the home.

In August 2012 the Substitute Decision Maker (SDM) for resident #2 approached the nursing clerk to express concerns of abuse of Resident #2. In August, 2012 the SDM had not been contacted by the staff at the home to discuss the concerns. The SDM then made a second attempt to speak with someone in management regarding the concerns, which was 6 days later. In September 2012 the administrator addressed the concerns and the complaint log was completed with action items. The issues were not addressed for 13 days after the original contact. The was no documented record kept in the home in relation to the original complaint. This was confirmed by the administrator. (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2012

Order # /
Ordre no : 902

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

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 must prepare, implement and submit a plan that includes: 1. Education for all staff related to Resident's Rights, specifically, that every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, that every resident being given the right to give or refuse consent to any treatment, care or service for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent. 2. A system to monitor, and evaluate ongoing adherence to ensure Resident Rights are respected and promoted.

The plan is to be submitted by November 1, 2012 to Long Term Care Homes Inspector: Yvonne Walton, Ministry of Health and Long-Term Care, Performance and Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7, e-mail Yvonne Walton@ontario.ca or Fax 905 546 8255.

Grounds / Motifs :

1. The licensee did not fully respect and promote the resident's right to give or refuse consent to treatment, care or service. Resident #3 received a treatment without consent from the Power of Attorney. The resident had the treatment in August 2012, and then again one week later. This was unknown to the Power of Attorney, nor had consent been provided. The clinical chart and the nursing staff confirmed this was completed. (169)
2. The licensee has not ensured that Resident #1's rights were fully respected and promoted to ensure the resident was treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity. Resident #1 was provided a modified textured food and was assessed to receive a regular textured food. The resident told the staff member they didn't want a modified texture as they were assessed to receive a regular texture. The staff member ignored the resident's request and told them they had to have the modified texture even when there was a regular textured food available. The resident expressed frustration and anger as they stated the staff didn't listen to them as they explained they had just finished eating a regular textured main course. The resident stated they were not treated with respect for their decision to make their own choices. The staff member confirmed they did not respect the residents decision and treated the resident with a lack of dignity. (169)
3. The licensee did not ensure that Resident #3's right to participate in decision-making was fully respected. Resident #3 had a fall and the doctor ordered a treatment to be completed. The resident was told they would receive the treatment in September, 2012 however this did not occur and the resident was not informed about when they would be receiving the treatment. The resident expressed being anxious about when the treatment would be done and nursing staff did not inform the resident, even when they asked. The resident was not told any information resulting in anxiety, according to the resident. The resident had to contact a friend to talk with the nursing staff as they were not being told when the treatment would occur or even if it was going to occur. The resident expressed not being treated with courtesy and respect. (169)
4. Resident #2 was identified as high risk for injury and the plan of care was changed to include a medical device. The clinical documentation revealed Resident #2 did not want the device. The nursing staff continued to re-apply the device even though the resident did not want it. The Substitute Decision Maker (SDM) was not aware of the bed alarm, nor was the resident's feeling of lack of dignity respected and discussed with the SDM.The nursing staff and documentation confirmed above. (169)
5. Resident #2 also was noted to be high risk for injury in August 2012 and the plan of care was changed to include the application of a medical device. The resident's substitute decision maker did not provide consent for the service to be implemented. The nursing staff and documentation confirmed this. (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2012

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

and the

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

Issued on this 24th day of October, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : YVONNE WALTON

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