Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 26, 2015	2015_343585_0001	T-000023-14	Resident Quality Inspection

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD SUITE 205 TORONTO ON M6A 1J6

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

EATONVILLE CARE CENTRE
420 THE EAST MALL ETOBICOKE ON M9B 3Z9

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

LEAH CURLE (585), CATHIE ROBITAILLE (536), IRENE PASEL (510)

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): January 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 2015.

The RQI inspection was conducted simultaneously with four Critical Incident System (CIS)inspections: T-000837-12, T-000813-12, T-000156-13, and T-000695-14, and three complaint inspections: T-0000470-13, T-000514-14 and T-001283-14.

During the course of the inspection, the inspector(s) spoke with residents, families, registered nursing staff, unregulated nursing staff, the Administrator, the Director of Nursing and Personal Care (DONPC), the Assistant Directors of Care (ADOC), the Social Service Worker (SSW), the Food Service Manager (FSM), the Resident Assessment Instrument (RAI) Coordinator, Maintenance staff, business office staff, dietary aids, and activity aids.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **12 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 #300 and #302 were protected from abuse.

A) In April 2012, resident #300 was noted to have bruising. When interviewed by registered staff and management, the resident stated that a personal support worker (PSW) had pulled their arm, when they said no they did not want to go to the dining room. Resident #300 passed away in December 2013. The inspector reviewed the resident's plan of care and the home's investigation notes. The Director of Nursing and Personal Care confirmed that this event was unwitnessed; however, the resident was cognitively aware and discipline of the staff involved was based on the residents' recollection.

B) In May 2014, resident #302 had a post admission visit from a corporate consultant. The resident informed the consultant that they requested to be given the call bell, and a PSW working at that time refused to give it to them. The inspector interviewed resident #302; however, they were unable to recall the specifics, however, stated if I said it happened it did. The inspector reviewed the residents' plan of care and the home's investigation notes. The Director of Nursing and Personal Care confirmed once again that it was an unwitnessed event; however, the resident was cognitively aware and discipline of the staff involved was once again based on the residents' recollection.

The Director of Nursing and Personal Care confirmed the same PSW was involved in both incidences with resident #300 and #302.

2. The Director of Nursing and Personal Care also confirmed that the same PSW had several incidences of discipline for negative resident interactions. Despite the home's steps taken to monitor the staff person and their interactions with residents, allegations of abuse and neglect continued.

The discipline history of the PSW included:
i) August 2011, staff did not follow the care plan which resulted in a skin tear to a resident,
ii) February 2012, staff left a resident who was a high risk for falls, unattended, resulting in a fall,
iii) April 2012, resident #300 received bruising when handled roughly,
iv) March 2014, staff was doing scheduled 1:1 monitoring and left resident unattended and did not report to the nurse they were leaving. The resident's care plan stated they were a high risk of responsive behaviours involving self and others,
v) May 2014, leaving resident #302 without access to a call bell,
vi) September 2014, not following resident's plan of care ie: two staff where required to be present.

The home investigated, disciplined, educated and re-educated the PSW involved; however, the home had not mitigated the risks as the staff's behaviours had not changed. [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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system required by the Act or regulations and put in place, (b) was complied with. O. Reg. 79/10, s. 8 (1).

A) The home’s Pain Management policy #RCS G-60, revised July 15, 2013, directed that “on admission initial heightened monitoring for pain needs to occur by staff and documentation on the evaluation of analgesic needs to occur in the electronic progress notes in PCC.”

Resident #103 was admitted to the home in March 2012 from hospice sometime before 1400 hours when the first assessment notes were entered in Point Click Care (PCC). Pain management orders forwarded from hospice included a medication to be administered every four hours at 0600, 1000, 1400, 1800 and 2200 hours, as well as additional medication when necessary. An entry in PCC at 1457 hours reported no pain at present at that time. Review of internal investigation notes into a complaint from the resident's family indicated they had complaints of pain, and that the resident was asking for medication at or before 2100 hours. The Medication Administration Record (MAR) indicated the resident received their first dose of medication at 2200 hours. Progress notes at 2211 hours reported the resident did not have pain. An Assistant Director of Care (ADOC) confirmed there no pain assessments were documented in PCC between 1457 hours and 2211 hours. The home's policy of heightened monitoring for pain needs and documentation in PCC was not complied with. (510)

B) The home's policy, "Plating and Garnishing - FNSMS132", effective July 5, 2013, stated that the dietary aide was to use appropriate dishes to attractively stimulate residents' appetite and promote food acceptance and enjoyment.

On January 14, 2015, in the second floor dining room, small styrofoam side plates were used to serve crackers with soup during lunch. Regular side plates were observed on the soup cart, however were not being used. The dietary aide confirmed they were aware regular plates were on the cart, however they still used disposable plates. The dietary aide stated there was no reason why they used the disposable plates. The Food Service Manager confirmed the dishes were inappropriate for use during the meal service. [s. 8. (1) (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 and ensuring that where the Act or Regulations require the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the dining and snack service included a review of meal and snack times by the Residents' Council.

An interview with the Food Services Manager on January 14, 2014 confirmed that the meal and snack times were posted in the home; however, they were not reviewed directly by the Residents' Council. [s. 73. (1) 2.]

2. The licensee failed to ensure that techniques to assist the resident with eating, including safe positioning of residents who require assistance, were used.

Resident #035 was identified as having potential for swallowing difficulty related to their requirement for total assistance with eating. The resident had a plan of care to be fed at 90 degrees, and to alternate intake of liquids and solids.

In January 2015, during a lunch meal service, resident #035 was observed receiving total assistance with eating from a PSW. The resident was observed in a chair reclined beyond 90 degrees, with their body and head also positioned at an angle exceeding 90 degrees. The PSW stated the chair would not reach 90 degrees. Another staff attempted to incline the chair and were able to do so, however the chair still did not reach 90 degrees. When asked how long the chair had been unable to incline, the PSW feeding the resident first remarked they did not know. When asked if it had been a month, the PSW responded yes. Registered nursing staff confirmed the resident was not positioned at 90 degrees, as identified in their plan of care.

The PSW was also observed providing the resident with only solids during the main course, and not alternating the resident's intake with liquids and solids. When asked what techniques were required when feeding the resident as per the plan of care, the PSW did not state that they were to alternate fluids and food during feeding, however later confirmed the written plan of care instructed to do so. Registered nursing staff confirmed the resident was to be fed alternating solids and liquids. [s. 73. (1) 10.]

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 and ensuring that techniques to assist residents with eating, including safe positioning of residents who require assistance, are used, and ensuring that the dining and snack service includes a review of meal and snack times by the Residents' Council, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that (b)there were schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

On January 5, 2015, during the initial tour of the home, areas of disrepair were identified on all resident home areas. Disrepair included wall and paint chipped in many resident rooms and hallways, wall repair commenced but sanding and painting not completed, floor tiles chipped, wall tiles broken and holes in walls.

Specific examples throughout the home included:

i) A hole in a wall – room 257. The resident residing in the room reported the hole had been present for approximately three months.
ii) Tiles off a bathroom wall – room 559. The resident residing in the room reported wall had been in disrepair for six months.
iii) Incomplete wall repair – room 310. A detailed report dated December 5, 2014 indicated that a light fixture fell off and was removed and the wall repaired. Sanding and painting was not completed.

A review of the home's Quality Management Audit Summary dated November 12, 2014, directed that repairs in room 257 and 559 would be completed by December 15, 2014, however the home's detail report for December 2014 reported that only the wall in room 310 was repaired December 5, 2014.

On January 9, 2015, a tour was conducted with the Administrator and maintenance staff. The Administrator and maintenance staff confirmed there were areas, including resident rooms and hallways throughout the home, where routine, preventative and remedial maintenance had not been undertaken and/or completed. [s. 90. (1) (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 and ensuring that as part of the organized program of maintenance services under clause 15 (1)(c) of the Act, every licensee of a long-term care home shall ensure that there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including the following: 1. All areas where drugs are stored shall be kept locked at all times, when not in use.

On January 5, 2014, the medication room door on the second floor was found to be open, with no staff present. Two medication carts were in the medication room, one of which was unlocked. The drawers of the medication cart were opened by the inspector, making medications accessible. The registered staff confirmed it was the expectation of the home that medication room doors be locked at all times. This was also confirmed by the Director of Nursing and Personal Care. The area where drugs were stored were not kept locked at all times when not in use. [s. 130. 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 and ensuring that every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including all areas where drugs are stored shall be locked at all times, when not in use, to be implemented voluntarily.

WN #6: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

Resident #031 had a plan of care to receive one-on-one visits from recreation staff six to eight times per month. The home's multi-month participation report was reviewed for November and December 2014, and indicated that no one-on-one visits occurred. Recreation staff stated that the resident received the one-on-one visits as per the plan of care, however these visits were not documented. [s. 6. (9) 1.]

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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to report in accordance with subsection O, Reg. 79/10, s. 104(2) the results of the investigation and the action undertaken in regards to the CIS filed.

The Director was not notified of the results of the investigation within 10 days of becoming aware of the alleged or suspected incident. On April 12, 2012, a CIS was submitted to the Toronto Service Area office indicating a mandatory report of resident abuse. On April 22, 2012, a report on the results of the investigation should have been submitted to the Director. The Director of Nursing and Personal Care confirmed that an amendment to the CIS was not submitted. [s. 23. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that a written response was provided to the Residents' Council within 10 days of receiving concerns or recommendations.

Review of the Residents' Council minutes for 2014 identified that in January, May and September, recommendations and/or concerns were raised by council, however there was no written response within 10 days from the licensee. This was confirmed by the Administrator. [s. 57. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a written response was provided to Family Council within 10 days of receiving concerns or recommendations.

Review of the Family Council minutes for 2014 identified that in February and May, recommendations and/or concerns were raised by council, however there was no written response within 10 days from the licensee. This was confirmed by the Administrator. [s. 60. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures are developed and implemented for, (d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

During stage one of the Resident Quality Inspection (RQI), January 5-7, 2015, a lingering, offensive odour was identified in the bathroom of room 545.

On January 8, 2015, the odour was noted to be present in the bathroom. Housekeeping staff confirmed the presence of the odour and reported that the bathroom was cleaned at least daily but the odour remained. PSWs confirmed a continued presence of the odour in the bathroom.

On January 9, 2015, the Administrator and a maintenance staff confirmed the presence of the lingering offensive odour in the bathroom of room 545. [s. 87. (2) (d)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that the names of the persons who participated in the annual evaluation of the abuse program were kept in a written record.

Review of the home's 2013 abuse program evaluation completed in January 2014, identified the Leadership Team as the name of the person(s) conducting the evaluation, not the names of the persons participating. This was confirmed by the Director of Nursing and Personal Care. [s. 99. (e)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
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 failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response been 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.

The home's records indicated a complaint was received from the family of resident #103 in April 2, 2012. In January 2015, the complainant reported in a telephone conversation that they had not received follow up on the results of the complaint. The home's Client Service Response Form indicated the complainant was last contacted on April 2, 2012, and advised that "an investigation was in process". This entry was confirmed by an ADOC. There was no final resolution documented on the Client Service Response Form, which was signed off by the Administrator on April 5, 2012. The licensee did not provide a response to the complainant regarding the results of the completed investigation. [s. 101. (1) 3.]

Issued on this 26th day of February, 2015

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

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LEAH CURLE (585), CATHIE ROBITAILLE (536), IRENE PASEL (510)
Inspection No. / No de l'inspection :	2015_343585_0001
Log No. / Registre no:	T-000023-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 26, 2015
Licensee / Titulaire de permis :	RYKKA CARE CENTRES LP 50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6
LTC Home / Foyer de SLD :	EATONVILLE CARE CENTRE 420 THE EAST MALL, ETOBICOKE, ON, M9B-3Z9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	EVELYN MACDONALD

To RYKKA CARE CENTRES LP, 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

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

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 the home protects residents from abuse by staff. The plan is to include but is not limited to: the development and implementation of a protocol mitigating the risk to residents' so they are not exposed to possible or potential abuse and neglect.

The plan is to be submitted on or before March 11, 2015 to Cathie Robitaille at cathie.robitaille@ontario.ca, or by mail: Ministry of Health and Long-Term Care Performance, Improvement and Compliance Branch, 119 King Street West, 11th Floor, Hamilton, ON L8P 4Y7

Grounds / Motifs :

1. 1. The licensee failed to ensure that resident #300 and #302 were protected from abuse.

A) In April 2012, resident #300 was noted to have bruising. When interviewed by registered staff and management, the resident stated that a personal support worker (PSW) had pulled their arm, when they said no they did not want to go to the dining room. Resident #300 passed away in December 2013. The inspector reviewed the resident's plan of care and the home's investigation notes. The Director of Nursing and Personal Care confirmed that this event was unwitnessed; however, the resident was cognitively aware and discipline of the staff involved was based on the residents' recollection.

B) In May 2014, resident #302 had a post admission visit from a corporate consultant. The resident informed the consultant that they requested to be given the call bell, and a PSW working at that time refused to give it to them. The inspector interviewed resident #302; however, they were unable to recall the

specifics, however, stated if I said it happened it did. The inspector reviewed the residents' plan of care and the home's investigation notes. The Director of Nursing and Personal Care confirmed once again that it was an unwitnessed event; however, the resident was cognitively aware and discipline of the staff involved was once again based on the residents' recollection.

The Director of Nursing and Personal Care confirmed the same PSW was involved in both incidences with resident #300 and #302.

2. The Director of Nursing and Personal Care also confirmed that the same PSW had several incidences of discipline for negative resident interactions. Despite the home's steps taken to monitor the staff person and their interactions with residents, allegations of abuse and neglect continued.

The discipline history of the PSW included:
i) August 2011, staff did not follow the care plan which resulted in a skin tear to a resident,
ii) February 2012, staff left a resident who was a high risk for falls, unattended, resulting in a fall,
iii) April 2012, resident #300 received bruising when handled roughly,
iv) March 2014, staff was doing scheduled 1:1 monitoring and left resident unattended and did not report to the nurse they were leaving. The resident's care plan stated they were a high risk of responsive behaviours involving self and others,
v) May 2014, leaving resident #302 without access to a call bell,
vi) September 2014, not following resident's plan of care ie: two staff where required to be present.

The home investigated, disciplined, educated and re-educated the PSW involved; however, the home had not mitigated the risks as the staff's behaviours had not changed. [s. 19. (1)] (536)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 21, 2015

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 26th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Leah Curle

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