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 prévue 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 soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 15, 2019	2019_781729_0005	010576-18, 011128-18, 016883-18, 020276-18, 028382-18, 030359-18, 030360-18, 030361-18, 030362-18, 032520-18, 032521-18, 032522-18, 001520-19, 003905-19	Critical Incident System

Licensee/Titulaire de permis

King Nursing Home Limited
49 Sterne Street Bolton ON L7E 1B9

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

King Nursing Home
49 Sterne Street Bolton ON L7E 1B9

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

KIM BYBERG (729), AMANDA COULTER (694), KIYOMI KORNETSKY (743)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 28, 29, April 1, 2, 3,

4, 5, 8, 12, 15, 16, 17, 18, 2019.

The following intakes were completed in this critical incident inspection;
-Log #010576-18 related to improper/incompetent treatment of a resident;
-Log #011128-18, Log #016883-18, Log #020276-18, Log #001520-19, were all related to the same issue of alleged abuse of a resident;
-Log #028382-18 and Log #003905-19 were related to an injury that resulted in the transfer to hospital with significant change in status;
-Log #030359-18, Follow up to compliance order #001, 2018_737640_0020 related to weekly skin assessments;
-Log #030360-18, Follow up to compliance order #002, 2018_737640_0020 related to continence care and assessment;
-Log #030361-18, Follow up to compliance order #004, 2018_737640_0020 related to abuse of a resident;
-Log #030362-18, Follow up to compliance order #005, 2018_737640_0020 related to responsive behaviours;
-Log #032520-18, Follow up to compliance order #001, 2018_760527_0021 related to knowledge and immediate access to the plan of care;
-Log #032521-18, Follow up to compliance order #002, 2018_760527_0021 related to safe transferring and positioning devices;
-Log #032522-18, Follow up to compliance order #003, 2018_760527_0021 related to fall prevention policy.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Supports Ontario (BSO) RPN, Fall Prevention Team Lead RPN, Continence Care Team Lead RPN, Physiotherapy Assistant (PTA), Family members and Residents.

The inspectors also observed resident rooms and common areas, meal and snack service, residents and the care provided to them; reviewed health care records and plans of care for identified residents, and relevent policies and procedures of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **3 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
O.Reg 79/10 s. 24. (7)	CO #001	2018_760527_0021	729
O.Reg 79/10 s. 36.	CO #002	2018_760527_0021	729
O.Reg 79/10 s. 50. (2)	CO #001	2018_737640_0020	729
O.Reg 79/10 s. 53. (4)	CO #005	2018_737640_0020	729
O.Reg 79/10 s. 8. (1)	CO #003	2018_760527_0021	729

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 all residents were protected from abuse by anyone

and free from neglect by the licensee or staff.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, the use of physical force by anyone other than a resident that causes physical injury or pain, administering or withholding a drug for an inappropriate purpose, or the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre physique"). O. Reg. 79/10, s. 2 (1).

A) A critical incident system (CIS) report that was submitted to the Director on a specified date, indicated that PSW #112 witnessed an incident of physical abuse towards resident #003.

Resident #003's clinical record and the investigation notes, indicated that on a specified date, resident #003 was being assisted with personal care. PSW #113 was assisting resident #003, when they heard PSW #112, yell "stop it, stop it". PSW #111 was witnessed to be physically abusive towards resident #003. PSW #112 reported this incident to RN #116 approximately three hours later. PSW #111 continued to care for residents for the remaining three hours of their shift.

In separate interviews with PSW #112 and #113, they said resident #003 was physically abused by PSW #111. Both staff stated they did not immediately report the incident to the charge nurse. DOC #101 confirmed resident #003 was physically abused by PSW #111.

B) A second CIS report that was submitted to the Director indicated that PSW #112 witnessed an incident of physical abuse on a specified date. While reporting to RN #116, PSW #112 also informed them that they witnessed an incident of physical abuse of resident #007 that occurred ten days prior.

Resident #007's clinical record and the investigation notes were reviewed. PSW #112 was assisting resident #007 with personal care and PSW #111 came to help. PSW #111 physically abused the resident while assisting with care. Resident #007 was assessed ten days later, when the incident was reported to RN #116.

Resident #003 and #007 both remain in the home, but could not be interviewed.

Included in the home's investigation notes was an interview between PSW #111 and the management. PSW #111 was advised of the allegation of physical abuse of resident

#007, it was concluded that they were physically abusive towards a resident on two different occasions.

In an interview with PSW #112, they confirmed resident #007 was physically abused by PSW #111 and this was not reported until ten days later when PSW #111 physically abused another resident.

The licensee failed to ensure that resident's #003 and #007 were protected from abuse by PSW #111. [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. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent received an assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence; and that each resident who was incontinent had an individualized plan, to promote and manage bowel and bladder continence based on the assessments; and that the plan was implemented.

Resident #002 was admitted to the home on a specified date. The resident's admission progress notes indicated that the resident was incontinent, as did the former Community Care Access Center (CCAC) transfer notes. However, documentation in the resident's care plan, did not match the admission progress notes and they did not have an individualized toileting plan.

During the inspection, the inspector reviewed the minimum data set (MDS) assessment. The MDS was initiated on a specified date and listed the resident as continent of both bowel and bladder. Documentation in point click care (PCC) in the continence section H of MDS, showed that within fourteen days of the assessment period, resident #002 was incontinent on four separate occasions. A review of the residents assessments located in PCC showed that the bowel and bladder assessment tool had not been completed for resident #002.

RPN #106, ADOC #122 and DOC #101, said that the Bowel and Bladder Assessment Tool was to be completed for every new admission within 14 days of their admission.

The licensee failed to ensure that resident #002 received a continence assessment using the home's clinically appropriate Bowel and Bladder Assessment Tool; and thus failed to ensure that the resident had an individualized plan to promote bowel and bladder continence. [s. 51. (2) (a)]

Additional Required Actions:

CO # - 002 will be 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's policy titled "Prevention of Abuse and Neglect of a Resident", policy number VII-G-10.00, current revision January 2015, directed all employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents, and families to immediately report any suspected or known incident of abuse or neglect to the Director of the Ministry of Health and Long Term Care (MOHLTC) and the Executive Director or designate in charge of the home. The procedure staff were to follow if any employee or volunteer witnessed an incident, or had any knowledge of an incident, that constituted resident abuse or neglect; all staff were responsible to immediately take steps that included; removing the resident from the abuser, or if that was not possible, remove the abuser from the resident if safe for them to do so while ensuring the safety of the resident.

A CIS report that was submitted to the Director on a specified date, stated that PSW #112 witnessed two incidents of physical abuse by PSW #111, one towards resident #007 and one towards resident #003.

PSW #112 witnessed PSW #111 physically abuse resident #007. PSW #112 did not report the incident to the licensee until ten days later, when they witnessed a second incident of physical abuse where PSW #111 physically abused resident #003.

DOC #101 agreed staff had not followed the procedure outlined in the home's policy titled "Prevention of Abuse and Neglect of a Resident".

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents, which directed staff to immediately report witnessed incidents of physical abuse towards resident #003 and #007, was complied with. [s. 20. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 28th day of May, 2019

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

Ministère 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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KIM BYBERG (729), AMANDA COULTER (694), KIYOMI KORNETSKY (743)
Inspection No. / No de l'inspection :	2019_781729_0005
Log No. / No de registre :	010576-18, 011128-18, 016883-18, 020276-18, 028382-18, 030359-18, 030360-18, 030361-18, 030362-18, 032520-18, 032521-18, 032522-18, 001520-19, 003905-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 15, 2019
Licensee / Titulaire de permis :	King Nursing Home Limited 49 Sterne Street, Bolton, ON, L7E-1B9
LTC Home / Foyer de SLD :	King Nursing Home 49 Sterne Street, Bolton, ON, L7E-1B9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janice King

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

Ministère 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

To King Nursing Home 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

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

Ministère 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) (a)

Linked to Existing Order / Lien vers ordre existant: 2018_737640_0020, CO #004;

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 must be compliant with s. 19 (1).

Specifically the licensee must:
Ensure that residents #003 and #007 and any other resident are protected from abuse by anyone.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order (CO) #004 from inspection #2018_737640_0020 issued on October 18, 2018, with a compliance date of November 2, 2018.

The licensee was ordered to:

Ensure that residents #009, #016, #017, #018, #025, #034, #035 and any other resident was protected from abuse by anyone.

The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, the use of physical force by anyone other than a resident that causes physical injury or pain, administering or withholding a drug for an inappropriate purpose, or the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre physique"). O. Reg. 79/10, s. 2 (1).

A) A critical incident system (CIS) report that was submitted to the Director on a specified date, indicated that PSW #112 witnessed an incident of physical abuse towards resident #003.

Resident #003's clinical record and the investigation notes, indicated that on a specified date, resident #003 was being assisted with personal care. PSW #113 was assisting resident #003, when they heard PSW #112, yell "stop it, stop it". PSW #111 was witnessed to be physically abusive towards resident #003. PSW #112 reported this incident to RN #116 approximately three hours later. PSW #111 continued to care for residents for the remaining three hours of their shift.

In separate interviews with PSW #112 and #113, they said resident #003 was physically abused by PSW #111. Both staff stated they did not immediately report the incident to the charge nurse. DOC #101 confirmed resident #003 was physically abused by PSW #111.

B) A second CIS report that was submitted to the Director indicated that PSW #112 witnessed an incident of physical abuse on a specified date. While reporting to RN #116, PSW #112 also informed them that they witnessed an incident of physical abuse of resident #007 that occurred ten days prior.

Resident #007's clinical record and the investigation notes were reviewed. PSW #112 was assisting resident #007 with personal care and PSW #111 came to help. PSW #111 physically abused the resident while assisting with care. Resident #007 was assessed ten days later, when the incident was reported to RN #116.

Resident #003 and #007 both remain in the home, but could not be interviewed.

Included in the home's investigation notes was an interview between PSW #111 and the management. PSW #111 was advised of the allegation of physical abuse of resident #007, it was concluded that they were physically abusive towards a resident on two different occasions.

In an interview with PSW #112, they confirmed resident #007 was physically abused by PSW #111 and this was not reported until ten days later when PSW

#111 physically abused another resident.

The licensee failed to ensure that resident's #003 and #007 were protected from abuse by PSW #111 [s. 19. (1)]

The severity of this issue was determined to be a level 2, minimal harm or potential for actual harm. The scope of the issue was isolated, as it related to two of the eight residents reviewed. The home had a level 5 history as they had on-going non-compliance with this section of the LTCHA that included:

-Compliance Order #001 issued December 29, 2017 with a compliance due date of January 31, 2018. (2017_482640_0025)
-Compliance Order #001 issued February 28, 2018, with a compliance due date of May 7, 2018. (2018_724640_007)
-Compliance Order #004 issued October 18, 2018 with a compliance due date of November 2, 2018. (2018_737640_0020)

(694)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2019

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

Ministère 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 : 002

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

Linked to Existing Order / Lien vers ordre existant: 2018_737640_0020, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must comply with s. 51 (2) of O. Reg. 79/10.

Specifically the licensee must:
a) Ensure that resident #002 and any other resident who is incontinent receives an assessment which includes obtaining information about the resident's bladder routine using a clinically appropriate assessment instrument specifically designed for the assessment of continence.
b) Ensure that resident #002 and any other resident who is incontinent has an individualized plan as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment, that the plan is implemented.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #002 from inspection #2018_737640_0020 issued on October 18, 2018 with a compliance date of November 30, 2018.

The licensee was ordered to:

a) Ensure that resident's #001, #006, #028 and #030 and any other resident have a continence assessment completed to include obtaining information about the resident's bladder routine using a clinically appropriate assessment instrument specifically designed for the assessment of continence, and based on that assessment, develop and implement an individualized toileting plan to promote and manage their bowel and bladder continence.

The licensee failed to ensure that each resident who was incontinent received an assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence; and that each resident who was incontinent had an individualized plan, to promote and manage bowel and bladder continence based on the assessments; and that the plan was implemented.

Resident #002 was admitted to the home on a specified date. The resident's admission progress notes indicated that the resident was incontinent, as did the former Community Care Access Center (CCAC) transfer notes. However, documentation in the resident's care plan, did not match the admission progress notes and they did not have an individualized toileting plan.

During the inspection, the inspector reviewed the minimum data set (MDS) assessment. The MDS was initiated on a specified date and listed the resident as continent of both bowel and bladder. Documentation in point click care (PCC) in the continence section H of MDS, showed that within fourteen days of the assessment period, resident #002 was incontinent on four separate occasions. A review of the residents assessments located in PCC showed that the bowel and bladder assessment tool had not been completed for resident #002.

RPN #106, ADOC #122 and DOC #101, said that the Bowel and Bladder Assessment Tool was to be completed for every new admission within 14 days of their admission.

The licensee failed to ensure that resident #002 received a continence assessment using the home's clinically appropriate Bowel and Bladder Assessment Tool; and thus failed to ensure that the resident had an individualized plan to promote bowel and bladder continence. [s. 51. (2) (a)]

The severity of this issue was determined to be a level 2 as there was minimal harm or potential of actual harm to the residents. The scope of the issue was isolated, as it related to one of four residents reviewed. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

- a Voluntary Plan of Correction (VPC) was issued August 19, 2015 during inspection #2015_275536_0015
- a Compliance Order (CO) was issued October 18, 2018, during inspection #2018_737640_0020

(743)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2019

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

Ministère 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 : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the LTCHA.

Specifically the licensee must:
a) Ensure that all employees are provided with education on the home's policy and procedures that promotes zero tolerance of abuse and neglect of residents.
b) The education shall include but is not limited to:
- the definitions of abuse including what constitutes abuse of residents,
- what the roles and responsibilities of staff are when they become aware of an incident of alleged, suspected or witnessed abuse.

Grounds / Motifs :

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

The home's policy titled "Prevention of Abuse and Neglect of a Resident", policy number VII-G-10.00, current revision January 2015, directed all employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents, and families to immediately report any suspected or known incident of abuse or neglect to the Director of the Ministry of Health and Long Term Care (MOHLTC) and the Executive Director or designate in charge of the home. The procedure staff were to follow if any employee or volunteer witnessed an incident, or had any knowledge of an incident, that constituted resident abuse or neglect; all staff were responsible to immediately take steps that included; removing the resident from the abuser, or if that was not possible, remove the abuser from the resident if safe for them to do so while ensuring the safety of the

resident.

A CIS report that was submitted to the Director on a specified date, stated that PSW #112 witnessed two incidents of physical abuse by PSW #111, one towards resident #007 and one towards resident #003.

PSW #112 witnessed PSW #111 physically abuse resident #007. PSW #112 did not report the incident to the licensee until ten days later, when they witnessed a second incident of physical abuse where PSW #111 physically abused resident #003.

DOC #101 agreed staff had not followed the procedure outlined in the home's policy titled "Prevention of Abuse and Neglect of a Resident".

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents, which directed staff to immediately report witnessed incidents of physical abuse towards resident #003 and #007, was complied with. [s. 20. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm or risk to the residents. The scope of the issue was isolated, as it related to two of eight residents reviewed. The home had a level 3 history as they had on-going non-compliance with this section of the LTCHA that included:

- voluntary plan of correction (VPC) issued April 10, 2018 (2018_724640_0007)

(694)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 15th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kim Byberg

Service Area Office /
Bureau régional de services : Central West Service Area Office