



**Ministry of Health and
Long-Term Care**

**Ministère 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) : LAUREN TENHUNEN (196)

Inspection No. /

No de l'inspection : 2013_104196_0006

Log No. /

Registre no: S-000055-13,S-000921-12

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Jul 31, 2013

Licensee /

Titulaire de permis : REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA,
ON, L5R-4B2

LTC Home /

Foyer de SLD : ROSEVIEW MANOR
99 SHUNIAH STREET, THUNDER BAY, ON, P7A-2Z2

Name of Administrator /

**Nom de l'administratrice
ou de l'administrateur :** JOANNE LENT

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:



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Order # /

Ordre no : 001

Order Type /

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee shall ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm and who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Grounds / Motifs :



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1. A Critical Incident report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in February 2013 outlining an altercation between resident #001 and resident #006. The altercation resulted in transfer to hospital for resident #006 because of injury and resident #001 was admitted to hospital for an evaluation.

The health care record for resident #001 was reviewed by the inspector. The behavioural progress notes from the date of admission in November 2012 through to the date of the altercation noted numerous incidents of physical aggression from resident #001 to staff members and towards other residents. The progress notes for days in November 2012 reported that resident #001 had exhibited numerous incidents of physical aggression towards staff. On days in December 2012, resident #001 exhibited further physical aggression towards staff. In January 2013, this behaviour continued. Progress notes for days in November and December 2012 noted incidents of physical aggression towards other residents.

The care plan that was in place at the time of the February 2013 altercation, identified behavioural problems as evidenced by physical aggression but did not identify interventions that would minimize the risk of harmful altercations and potentially harmful interactions between resident #001 and other residents or staff members.

As a result of the failure to identify and implement interventions that would have minimized the risk to resident #006 and any other residents, resident #006 sustained an injury that resulted in transfer to hospital.

The licensee failed to ensure that, procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents;

(196)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013



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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



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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.



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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, 11^e 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.



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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 31st day of July, 2013

Signature of Inspector /

Signature de l'inspecteur : 

Name of Inspector /

Nom de l'inspecteur : Lauren Tenhunen

Service Area Office /

Bureau régional de services : Sudbury Service Area Office



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Homes Act, 2007**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
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**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**

**Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133**

**Bureau régional de services de
Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133**

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 31, 2013	2013_104196_0006	S-000055- 13,S-000921 -12	Critical Incident System

Licensee/Titulaire de permis

**REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2**

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

**ROSEVIEW MANOR
99 SHUNIAH STREET, THUNDER BAY, ON, P7A-2Z2**

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

LAUREN TENHUNEN (196)

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 20, 21, 22, 2013

**Ministry of Health and Long-Term Care (MOHLTC) Logs
Critical Incident Reports**

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RAI Coordinator, Residents and family members

During the course of the inspection, the inspector(s) conducted a tour of all resident home areas, observed the provision of care and services to residents, observed the interactions between staff members and residents, reviewed the health care records of several residents

**The following Inspection Protocols were used during this inspection:
Falls Prevention**

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités



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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. 55. Behaviours and altercations

Every licensee of a long-term care home shall ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :



1. A Critical Incident report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in February 2013 outlining an altercation between resident #001 and resident #006. The altercation resulted in transfer to hospital for resident #006 because of injury and resident #001 was admitted to hospital for an evaluation. The health care record for resident #001 was reviewed by the inspector. The behavioural progress notes from the date of admission in November 2012 through to the date of the altercation noted numerous incidents of physical aggression from resident #001 to staff members and towards other residents. The progress notes for days in November 2012 reported that resident #001 had exhibited numerous incidents of physical aggression towards staff. On days in December 2012, resident #001 exhibited further physical aggression towards staff. In January 2013, this behaviour continued. Progress notes for days in November and December 2012 noted incidents of physical aggression towards other residents. The care plan that was in place at the time of the February 2013 altercation, identified behavioural problems as evidenced by physical aggression but did not identify interventions that would minimize the risk of harmful altercations and potentially harmful interactions between resident #001 and other residents or staff members.

As a result of the failure to identify and implement interventions that would have minimized the risk to resident #006 and any other residents, resident #006 sustained an injury that resulted in transfer to hospital.

The licensee failed to ensure that, procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents;

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. 53. Responsive behaviours



Specifically failed to comply with the following:

- s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
- (a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
 - (b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
 - (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

Findings/Faits saillants :

1. A Critical Incident report was submitted to the MOHLTC in February 2013 for an incident of physical aggression by resident #001 toward another resident. This other resident was transferred to hospital for an assessment, and returned to the home with some injury. Resident #001 was subsequently admitted to hospital for an evaluation. During the course of the inspection, the health care records for resident #001 were reviewed. The progress notes, specific to behaviours, from the date of admission through to the date of the incident were reviewed and identified numerous instances of resident #001 threatening and exhibiting physical aggression towards others. The care plan that was in effect at the time of the incident of physical abuse included the focus of "Behavioural problems as evidenced by: resists care or medications, verbal or physical aggression, wandering, cognitive impairment" but the plan did not include interventions or strategies aimed at responding to these aggressive behaviours.

The licensee failed to ensure that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible. [s. 53. (4) (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 that ensures that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. During the course of inspection, the progress notes for resident #002 were reviewed. A note from a particular day in August 2012 outlined an incident that occurred that same day, in which this resident eloped from the home. The police were notified and the resident returned to the home, without injury, accompanied by a staff member and the police. An interview was conducted with staff member #100 in March 2013 and resident #002's elopement from a secure unit and the home was never reported to the MOHLTC.

The licensee failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. [s. 107. (3) 1.]



Ontario

Ministry of Health and
Long-Term Care

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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

Issued on this 2nd day of August, 2013

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

Lauren Lenhunen #196.