



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

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Name of Inspector (ID #) /

Nom de l'inspecteur (No) : DIANA STENLUND (163)

Inspection No. /

No de l'inspection : 2013\_139163\_0012

Log No. /

Registre no: 1368-12,104-13,648-12

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : May 23, 2013

Licensee /

Titulaire de permis : ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE  
70 Spine Road, ELLIOT LAKE, ON, P5A-1X2

LTC Home /

Foyer de SLD : ST. JOSEPH'S MANOR  
70 SPINE ROAD, ELLIOT LAKE, ON, P5A-1X2

Name of Administrator /

Nom de l'administratrice  
ou de l'administrateur : SUSAN CLAYTON

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To ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE, you are hereby required to  
comply with the following order(s) by the date(s) set out below:



**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

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**Order # /**  
**Ordre no :** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

**Order / Ordre :**

The licensee shall ensure that the responsive behaviour program for resident #1368, as set out in their plan of care, is provided to the resident as specified in their plan.

**Grounds / Motifs :**

1. Inspector reviewed a Critical Incident (CI) involving cognitively impaired resident #1368 who has a history of aggressive behaviour, and was reportedly physically aggressive toward another resident. Inspector reviewed the resident's #1368 plan of care that outlines the interventions in place to minimize such behaviours. According to the Critical Incident report, the responsive behaviour program for resident #1368 had not occurred as outlined in their plan of care. The licensee has not ensured that the care set out in the plan of care is provided to the resident as specified in the plan. (163)

**This order must be complied with by /**  
**Vous devez vous conformer à cet ordre d'ici le :** May 31, 2013



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<b>Order # /</b>	<b>Order Type /</b>
<b>Ordre no : 002</b>	<b>Genre d'ordre : Compliance Orders, s. 153. (1) (a)</b>

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
  - i. participate fully in the development, implementation, review and revision of his or her plan of care,
  - ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
  - iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

- i. the Residents' Council,
- ii. the Family Council,
- iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according



**Ministry of Health and  
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**Order(s) of the Inspector**  
Pursuant to section 153 and/or  
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Homes Act, 2007*, S.O. 2007, c.8

**Ministère de la Santé et  
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**Ordre(s) de l'inspecteur**  
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de soins de longue durée*, L.O. 2007, chap. 8

to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

**Order / Ordre :**

The licensee shall ensure that resident #648 is protected from abuse, when being provided personal care.

**Grounds / Motifs :**

1. Residents' Bill of Rights, s.3(1) is issued as a VPC in Complaint Inspection #2013-139163-0011 conducted concurrently with this inspection.

Inspector reviewed the Critical Incident report that alleges resident #648 was treated in an abusive manner by staff members when personal care was being provided. An interview with a supervisory staff member confirmed that these events had occurred involving resident #648. The licensee has not ensured that resident # 648 was protected from abuse, specifically when being provided personal care. (163)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le : May 31, 2013**



**Ministry of Health and  
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Pursuant to section 153 and/or  
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### **REVIEW/APEAL 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



**Ministry of Health and  
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**Order(s) of the Inspector**  
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**Ministère de la Santé et  
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**Ordre(s) de l'inspecteur**  
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de soins de longue durée*, L.O. 2007, chap. 8

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](http://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, 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.



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de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée, L.O. 2007, chap. 8*

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](http://www.hsarb.on.ca).

**Issued on this 23rd day of May, 2013**

**Signature of Inspector /  
Signature de l'inspecteur :**

*Diana Stenlund, #1163*

**Name of Inspector /**

**Nom de l'inspecteur :** DIANA STENLUND

**Service Area Office /**

**Bureau régional de services :** Sudbury Service Area Office



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

**Ministère de la Santé et des  
Soins de longue durée**

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

**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**

**Sudbury Service Area Office  
159 Cedar Street, Suite 603  
SUDBURY, ON, P3E-6A5  
Telephone: (705) 564-3130  
Facsimile: (705) 564-3133**

**Bureau régional de services de  
Sudbury  
159, rue Cedar, Bureau 603  
SUDBURY, ON, P3E-6A5  
Téléphone: (705) 564-3130  
Télécopieur: (705) 564-3133**

**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
May 23, 2013	2013_139163_0012	1368-12,104 -13,648-12	Critical Incident System

**Licensee/Titulaire de permis**

**ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE  
70 Spine Road, ELLIOT LAKE, ON, P5A-1X2**

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

**ST. JOSEPH'S MANOR  
70 SPINE ROAD, ELLIOT LAKE, ON, P5A-1X2**

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

**DIANA STENLUND (163)**

**Inspection Summary/Résumé de l'inspection**



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

**This inspection was conducted on the following date(s): April 24 - 26, 2013**

**The following additional SSAO Log# was addressed as part of this inspection:  
S-001200-12**

**During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, registered nursing staff, personal support workers (PSWs), administrative support staff and residents.**

**During the course of the inspection, the inspector(s) walked through resident home areas, reviewed Critical Incident reporting documents, observed resident care and staff-resident interactions and reviewed resident health care records.**

**The following Inspection Protocols were used during this inspection:  
Critical Incident Response  
Prevention of Abuse, Neglect and Retaliation  
Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

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**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

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



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.

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**WN #1: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

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**Findings/Faits saillants :**

Inspector reviewed a Critical Incident (CI) involving cognitively impaired resident #1368 who has a history of aggressive behaviour, and was reportedly physically aggressive toward another resident. Inspector reviewed the resident's #1368 plan of care that outlines the interventions in place to minimize such behaviours. According to the Critical Incident report, the responsive behaviour program for resident #1368 had not occurred as outlined in their plan of care. The licensee has not ensured that the care set out in the plan of care is provided to the resident as specified in the plan.

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

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**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**

**1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**

**2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).**

**3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).**

**4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).**

**5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).**

**6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).**

**7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).**

**8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).**

**9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).**

**10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).**

**11. Every resident has the right to,**

**i. participate fully in the development, implementation, review and revision of his or her plan of care,**

**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**

**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**

**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in**

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accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

- i. the Residents' Council,
- ii. the Family Council,
- iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
- iv. staff members,
- v. government officials,
- vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).



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21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).
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**Findings/Faits saillants :**

1. Inspector reviewed a CI report that alleges resident #648 was treated in an abusive manner by staff members when personal care was being provided. An interview with a supervisory staff member confirmed that the documented events had occurred involving resident #648. The licensee has not ensured that resident # 648 was protected from abuse when personal care was being provided. [s. 3. (1)]

***Additional Required Actions:***

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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





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**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).**
- 2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).**
- 3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**
- 4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**
- 5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

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**Findings/Faits saillants :**

- 1. Inspector reviewed a CI report that outlines resident #1200 went missing outside the home for less than three hours and returned to the home without injury. An interview with a supervisory staff member confirmed that the resident went missing and returned in less than three hours, however the incident was not reported to the Director until 9 days later. The licensee has not ensured that the Director was 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): 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)]**



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

**Ministère de la Santé et des  
Soins de longue durée**

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

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

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**Issued on this 28th day of May, 2013**

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

*Diana Jenlund, #163*