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

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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
Jan 7, 2016	2015_401616_0020	025740-15	Follow up

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

LAKEHEAD MANOR
135 SOUTH VICKERS STREET THUNDER BAY ON P7E 1J2

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

JENNIFER KOSS (616), DEBBIE WARPULA (577), SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 25, 26, 27, December 1, 2, 3, 4, 2015

This inspection was conducted concurrently with Critical Incident inspection 2015_401616_0022 and Complaint inspection 2015_401616_0021.

Additional intakes completed during this inspection: 025671-15; 011508-15; 023709-15; 024698-15; 027914-15; 028736-15; 028600-15; 026509-15; 026497-15; 022576-15; 021402-15; 003890-14; 004696-15.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), interim Executive Director, Acting Director of Care (DOC), Associate Director of Care, Manager of Clinical Services, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Registered Dietitian (RD), Physiotherapist (PT), Food Service Manager (FSM), Environmental Service Manager (ESM), Resident Assessment Instrument (RAI) Coordinators, Life Enrichment, residents and family members.

Observations were made of the home areas, meal services, and the provision of care and services to residents during the inspection. The home's policies and procedures and resident clinical records were reviewed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Snack Observation
Training and Orientation

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
LTCHA, 2007 S.O. 2007, c.8 s. 11.	WN	2014_380593_0001	616
LTCHA, 2007 S.O. 2007, c.8 s. 11.	WN	2015_380593_0020	616
LTCHA, 2007 S.O. 2007, c.8 s. 11. (1)	CO #006	2015_380593_0020	617
O.Reg 79/10 s. 129.	WN	2015_380593_0020	616
O.Reg 79/10 s. 129.	WN	2015_269597_0003	616
O.Reg 79/10 s. 129. (1)	CO #009	2015_380593_0020	616
O.Reg 79/10 s. 50. (2)	CO #001	2015_380593_0019	577
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2015_380593_0020	616
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #004	2015_380593_0020	577
LTCHA, 2007 S.O. 2007, c.8 s. 6. (2)	CO #002	2015_380593_0020	577
LTCHA, 2007 S.O. 2007, c.8 s. 8.	WN	2015_380593_0020	616
LTCHA, 2007 S.O. 2007, c.8 s. 8.	WN	2015_269597_0003	616
LTCHA, 2007 S.O. 2007, c.8 s. 8. (1)	CO #005	2015_380593_0020	617

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. 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).

Findings/Faits saillants :

1. The licensee had failed to ensure that the nutrition and hydration care set out in the plan of care was provided to resident #002 as specified in the plan.

A review of resident #002's care plan revealed that this resident was at a nutritional risk. Care planned interventions included dietary orders and supplements.

The Medication Administration Record (MAR) revealed that the resident was to have a supplement as needed (prn) if required. A review of the resident's MARS over a 46 day period, revealed that the supplement was administered once.

A review of the clinical record for resident #002 revealed that the supplement was required on 43 of the 45 days reviewed.

An interview with PSW #105 revealed that they were unaware of any additional supplements to be offered if needed. They further reported that the registered staff provided the supplement to the PSWs as it is considered a prescribed medication.

An interview with RPN #106 revealed that the resident was known to require a supplement and that they have not offered the supplement.

Interviews with the Registered Dietitian and a Manager, each confirmed that staff should have offered the supplement to the resident. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the responsive behaviour plan of care was provided to resident #003 as specified in the plan.

The most current care plan for resident #003 indicated a responsive behaviour intervention which included a Dementia Observation System (DOS) to be completed and tracked until further notice. The home's Dementia Care policy #LTC-E-100 dated August 2012, stated monitoring of responsive behaviours will be completed using an objective, systematic tracking tool such as the Dementia Observation System.

Inspector #616 reviewed two weeks of DOS monitoring in resident #003's clinical record. Documentation for 12 of the 14 days, or 86 per cent, was incomplete.

The Executive Director (ED) stated the home's expectation for completion of DOS monitoring for resident #003 was to be done by the assigned staff. Interviews with Personal Support Workers (PSW) #104, #103, and #101 all reported the same DOS monitoring documentation expectation.

PSWs #104 and #103 both stated to the Inspector that blanks in resident #003's DOS

record during the reviewed period indicated that the monitoring documentation had not been completed as per the resident's care plan.

The specific monitoring tracking record for two months in 2015 provided and confirmed by the ED, indicated in the first month, the specific monitoring did not occur for resident #003 on one day shift, and one evening shift. Review of the DOS record for these dates indicated the monitoring documentation was incomplete on the evening shift. In the second month, on two evening shifts and one day shift, the specific monitoring for resident #003 did not occur. DOS monitoring documentation was incomplete during three evening shifts, and one day shift. For each of the three dates in the second month, progress notes were also reviewed by the Inspector related to responsive behaviours and none were found.

As per the resident's current care plan, the required intervention for monitoring resident #003 did not occur as specified in the plan. [s. 6. (7)]

3. The licensee had failed to ensure that the care set out in the plan of care related to skin and wound was provided to resident #002 as specified in the plan.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to personal care provided to resident #002. Specifically, the complaint addressed the improper positioning of this resident by staff.

The interventions identified for resident #002 instructed staff on the proper positioning for the resident. A review of the resident's current care plan confirmed the same directions for positioning.

Inspector #577 observed six occurrences over four days, on two shifts, where resident #002 was improperly positioned on all four days, 100 per cent of the times observations were made.

An interview with one of the multidisciplinary team members revealed that it was the expectation of staff to follow the positioning directions, as per the resident's plan of care.

As per the resident's care plan, the required interventions for skin and wound related to repositioning did not occur as specified in the plan. [s. 6. (7)]

4. The licensee had failed to ensure that the care set out in the plan of care related to

pain was provided to resident #002 as specified in the plan.

A complaint was submitted to the MOHLTC related to personal care provided to this resident. Specifically, the complaint addressed the lack of monitoring and management of resident #002's pain.

A review of resident #002's current care plan and MARS instructed staff to monitor pain with specific frequency and document on a pain monitoring sheet.

A review of the pain monitoring sheets indicated pain monitoring documentation on 20 out of 49 days, or 41 per cent, was incomplete. Pain monitoring documentation from 2300 hrs to 0700 or 0800 hrs was incomplete 17 of the 20 days, and missing pain monitoring documentation ranged from eight to 17 hours.

An interview with a manager and the Acting DOC confirmed that the pain monitoring sheet should have been documented as specified in the resident's plan of care. [s. 6. (7)]

5. The licensee had failed to ensure that the care set out in the plan of care related to dignity, choice and privacy was provided to resident #002 as specified in the plan.

A complaint was submitted to the MOHLTC related to personal care provided to resident #002. Specifically, that the provision of care was not provided as per their preference.

A review of resident #002's current care plan indicated their preference related to personal direct care.

Observations by Inspector #577 of resident #002 on two occasions revealed direct personal care was not provided to this resident as preferred.

A review of the clinical record for resident #002 over one month, indicated that direct personal care was not provided to resident #002 as they preferred on nine of 30 days, or 30 per cent of the time.

An interview with the interim ED confirmed that personal care was not provided to resident #002 as per their preference. [s. 6. (7)]

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 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 has failed to ensure that a long-term care shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

A Critical Incident System (CIS) report was submitted to the Director by the home. This report identified abuse/neglect which involved resident #010 and resident #003. Both residents were reportedly in the hallway when the incident occurred.

Inspector #616 reviewed the CIS report, the home's investigation record provided by the ED, and clinical records for each of the residents involved in the incident. The Inspector determined through a review of two progress notes for resident #003, that prior to the incident, staff were aware of this resident's known behaviour toward co-residents. Further, a Resident Assessment Instrument Minimum Data Set (RAI MDS) full assessment also identified the known behaviour, which had been demonstrated daily by resident #003 during the assessment period.

A copy of resident #003's current care plan was provided to the Inspector by the interim ED that referenced the resident's known behaviours. In addition, they provided a copy of a record where the resident's known behaviour toward co-residents and staff was also noted. Care planned interventions were documented to address these behaviours.

Inspector #616 reviewed records where known behaviour demonstrated by resident #003 was documented by staff on four dates prior to the incident.

In the incident investigation record provided by the ED, staff had reported to management on the day of the incident, a care planned intervention would not be in effect for resident #003 on this day.

On November 26, 2015, in the company of the interim ED and Acting DOC, the ED was interviewed by the Inspector. The ED confirmed that the planned intervention for resident #003, as identified in the CIS report as a long-term action to correct the situation and prevent recurrence of abuse, was not in place at the time of the incident with resident #010. [s. 19. (1)]

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that suspicions of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident was immediately reported to the Director.

Critical incident System report was submitted to the Director regarding reported neglect of resident #006 in which PSW #107 did not respond to the call bell rung several times for assistance.

The incident occurred one day earlier than when the CIS was reported to the Director.

Inspector #617 reviewed the home's investigation notes which did not indicate who reported, or when it was reported to the ED. An internal incident report was completed by the ED four days after the alleged incident occurred.

Inspector #617 reviewed Revera policy #LP-C-20-ON titled "Resident Non-Abuse-Ontario" last updated on September 2014, which indicated that any staff member or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information on which it is based to the Executive Director (ED) of the home or, if unavailable, to the most senior supervisor on shift at that time.

On December 3, 2015, Inspector #617 interviewed the ED, who confirmed that the home was made aware of the suspected neglect of resident #006 and was late in reporting to the Director. [s. 24. (1)]

Additional Required Actions:

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

Issued on this 14th day of January, 2016

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

Original report signed by the inspector.

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) :	JENNIFER KOSS (616), DEBBIE WARPULA (577), SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2015_401616_0020
Log No. / Registre no:	025740-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 7, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT,8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	LAKEHEAD MANOR 135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jonathon Riabov

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_380593_0020, CO #003;

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:

a) Perform an audit of all residents assessed as at high nutrition and hydration risk to ensure their plan of care is current and up to date. Specifically, ensure resident #002 receives their nutritional interventions as required.

b) Specifically ensure that resident #003's responsive behaviour care plan is current and up to date.

c) Perform an audit of all residents who require repositioning support from staff related to increased skin and wound risk, and ensure their assessed needs and plans of care are current and up to date. Based on the results of the audit, the licensee will implement interventions to meet the repositioning needs of identified residents and ensure staff are aware of the interventions. Specifically, ensure resident #002 is repositioned as per their current plan of care related to risk of altered skin and wounds.

d) Perform an audit of all residents with pain interventions to ensure their plan of care is current and up to date determined by their assessed needs. Based on the results of this audit, the licensee will develop a process for staff awareness of those residents at high risk for pain. Specifically ensure resident #002's pain monitoring and management interventions are current, up to date and provided as per their assessed needs.

e) Ensure residents preferences as per their plan of care related to dignity, choice and privacy are current and up to date. The licensee shall ensure nursing staff are aware of resident preferences, specifically resident's #002's preferences related to the provision of direct personal care.

Grounds / Motifs :

1. The licensee had failed to ensure that the care set out in the plan of care related to dignity, choice and privacy was provided to resident #002 as specified in the plan.

A complaint was submitted to the MOHLTC related to personal care provided to resident #002. Specifically, that the provision of care was not provided as per their preference.

A review of resident #002's current care plan indicated their preference related

to personal direct care.

Observations by Inspector #577 of resident #002 on two occasions revealed direct personal care was not provided to this resident as preferred.

A review of the clinical record for resident #002 over one month, indicated that direct personal care was not provided to resident #002 as they preferred on nine of 30 days, or 30 per cent of the time.

An interview with the interim ED confirmed that personal care was not provided to resident #002 as per their preference. [s. 6. (7)] (577)

2. The licensee had failed to ensure that the care set out in the plan of care related to pain was provided to resident #002 as specified in the plan.

A complaint was submitted to the MOHLTC related to personal care provided to this resident. Specifically, the complaint addressed the lack of monitoring and management of resident #002's pain.

A review of resident #002's current care plan and MARS instructed staff to monitor pain with specific frequency and document on a pain monitoring sheet.

A review of the pain monitoring sheets indicated pain monitoring documentation on 20 out of 49 days, or 41 per cent, was incomplete. Pain monitoring documentation from 2300 hrs to 0700 or 0800 hrs was incomplete 17 of the 20 days, and missing pain monitoring documentation ranged from eight to 17 hours.

An interview with a manager and the Acting DOC confirmed that the pain monitoring sheet should have been documented as specified in the resident's plan of care. [s. 6. (7)] (577)

3. The licensee had failed to ensure that the care set out in the plan of care related to skin and wound was provided to resident #002 as specified in the plan.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to personal care provided to resident #002. Specifically, the complaint addressed the improper positioning of this resident by staff.

The interventions identified for resident #002 instructed staff on the proper positioning for the resident. A review of the resident's current care plan confirmed the same directions for positioning.

Inspector #577 observed six occurrences over four days, on two shifts, where resident #002 was improperly positioned on all four days, 100 per cent of the times observations were made.

An interview with one of the multidisciplinary team members revealed that it was the expectation of staff to follow the positioning directions, as per the resident's plan of care.

As per the resident's care plan, the required interventions for skin and wound related to repositioning did not occur as specified in the plan. [s. 6. (7)] (577)

4. The licensee has failed to ensure that the care set out in the responsive behaviour plan of care was provided to resident #003 as specified in the plan.

The most current care plan for resident #003 indicated a responsive behaviour intervention which included a Dementia Observation System (DOS) to be completed and tracked until further notice. The home's Dementia Care policy #LTC-E-100 dated August 2012, stated monitoring of responsive behaviours will be completed using an objective, systematic tracking tool such as the Dementia Observation System.

Inspector #616 reviewed two weeks of DOS monitoring in resident #003's clinical record. Documentation for 12 of the 14 days, or 86 per cent, was incomplete.

The Executive Director (ED) stated the home's expectation for completion of DOS monitoring for resident #003 was to be done by the assigned staff. Interviews with Personal Support Workers (PSW) #104, #103, and #101 all reported the same DOS monitoring documentation expectation.

PSWs #104 and #103 both stated to the Inspector that blanks in resident #003's DOS record during the reviewed period indicated that the monitoring documentation had not been completed as per the resident's care plan.

The specific monitoring tracking record for two months in 2015 provided and

confirmed by the ED, indicated in the first month, the specific monitoring did not occur for resident #003 on one day shift, and one evening shift. Review of the DOS record for these dates indicated the monitoring documentation was incomplete on the evening shift. In the second month, on two evening shifts and one day shift, the specific monitoring for resident #003 did not occur. DOS monitoring documentation was incomplete during three evening shifts, and one day shift. For each of the three dates in the second month, progress notes were also reviewed by the Inspector related to responsive behaviours and none were found.

As per the resident's current care plan, the required intervention for monitoring resident #003 did not occur as specified in the plan. [s. 6. (7)] (616)

5. The licensee had failed to ensure that the nutrition and hydration care set out in the plan of care was provided to resident #002 as specified in the plan.

A review of resident #002's care plan revealed that this resident was at a nutritional risk. Care planned interventions included dietary orders and supplements.

The Medication Administration Record (MAR) revealed that the resident was to have a supplement as needed (prn) if required. A review of the resident's MARS over a 46 day period, revealed that the supplement was administered once.

A review of the clinical record for resident #002 revealed that the supplement was required on 43 of the 45 days reviewed.

An interview with PSW #105 revealed that they were unaware of any additional supplements to be offered if needed. They further reported that the registered staff provided the supplement to the PSWs as it is considered a prescribed medication.

An interview with RPN #106 revealed that the resident was known to require a supplement and that they have not offered the supplement.

Interviews with the Registered Dietitian and a Manager, each confirmed that staff should have offered the supplement to the resident. [s. 6. (7)]

This is the fifth issuance of non-compliance pursuant to LTCHA, 2007 S.O.

2007, s. 6 (7). The most recent inspection 2015_380593_0020, which was referred to the Director, included a compliance order served September 17, 2015; inspection 2015_269597_0003, included a compliance order served May 22, 2015; inspection 2014_269597_0008, included a compliance order served March 13, 2015; and inspection 2014_246196_0006, included a compliance order served May 29, 2014.

The decision to re-issue this compliance order was based on the scope which affected two residents, one of which was affected in four areas (nutrition and hydration, skin and wound, pain, and dignity, choice and privacy); the severity which indicated a potential for actual harm and the compliance history which despite previous non-compliance has continued with this area of the legislation. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 22, 2016

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

Linked to Existing Order / Lien vers ordre existant: 2015_380593_0020, CO #007;

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:

a) Ensure strategies are updated and implemented in resident #003's plan of care as per their assessed needs related to potentially abusive and responsive behaviours. In addition, ensure that all staff are aware of the required safety interventions.

Grounds / Motifs :

1. The licensee has failed to ensure that a long-term care shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

A Critical Incident System (CIS) report was submitted to the Director by the home. This report identified abuse/neglect which involved resident #010 and resident #003. Both residents were reportedly in the hallway when the incident occurred.

Inspector #616 reviewed the CIS report, the home's investigation record provided by the ED, and clinical records for each of the residents involved in the incident. The Inspector determined through a review of two progress notes for resident #003, that prior to the incident, staff were aware of this resident's known behaviour toward co-residents. Further, a Resident Assessment Instrument Minimum Data Set (RAI MDS) full assessment also identified the known behaviour, which had been demonstrated daily by resident #003 during the assessment period.

A copy of resident #003's current care plan was provided to the Inspector by the interim ED that referenced the resident's known behaviours. In addition, they provided a copy of a record where the resident's known behaviour toward co-residents and staff was also noted. Care planned interventions were documented to address these behaviours.

Inspector #616 reviewed records where known behaviour demonstrated by resident #003 was documented by staff on four dates prior to the incident.

In the incident investigation record provided by the ED, staff had reported to management on the day of the incident, a care planned intervention would not be in effect for resident #003 on this day.

On November 26, 2015, in the company of the interim ED and Acting DOC, the ED was interviewed by the Inspector. The ED confirmed that the planned intervention for resident #003, as identified in the CIS report as a long-term action to correct the situation and prevent recurrence of abuse, was not in place at the time of the incident with resident #010. [s. 19. (1)]

This is the third issuance of non-compliance pursuant to LTCHA, 2007 S.O. 2007, s. 19 (1). The most recent inspection 2015_380593_0020, which was referred to the Director, included a compliance order served September 17, 2015; and inspection 2015_380593_0020, included a compliance order served May 22, 2015.

The decision to re-issue this compliance order was based on the scope which affected two residents; the severity which indicated a potential for actual harm and the compliance history which despite previous non-compliance has continued with this area of the legislation. (616)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 22, 2016

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2015_380593_0020, CO #008;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall:

a) Ensure that all staff members and the leadership team comply with the home's policy #LP-C-20-ON Resident Non-Abuse-Ontario and report all abuse or alleged abuse of a resident immediately to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that suspicions of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident was immediately reported to the Director.

Critical incident System report was submitted to the Director regarding reported neglect of resident #006 in which PSW #107 did not respond to the call bell rung several times for assistance.

The incident occurred one day earlier than when the CIS was reported to the Director.

Inspector #617 reviewed the home's investigation notes which did not indicate who reported, or when it was reported to the ED. An internal incident report was completed by the ED four days after the alleged incident occurred.

Inspector #617 reviewed Revera policy #LP-C-20-ON titled "Resident Non-Abuse-Ontario" last updated on September 2014, which indicated that any staff member or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information on which it is based to the Executive Director (ED) of the home or, if unavailable, to the most senior supervisor on shift at that time.

On December 3, 2015, Inspector #617 interviewed the ED, who confirmed that the home was made aware of the suspected neglect of resident #006 and was late in reporting to the Director. [s. 24. (1)]

This is the third issuance of non-compliance pursuant to LTCHA, 2007 S.O. 2007, s. 24 (1). The most recent inspection 2015_380593_0020, which was referred to the Director, included a compliance order served September 17, 2015; and inspection 2015_269597_0003, included a compliance order served May 22, 2015.

The decision to re-issue this compliance order was based on the scope which affected one resident, the severity which indicated a potential for actual harm and the compliance history which despite previous non-compliance has continued with this area of the legislation. (617)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 22, 2016

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 7th day of January, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Jennifer Koss

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