Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 04, 2018;	2018_671684_0021 (A1)	024644-17, 025447-17, 003560-18	Critical Incident System

Licensee/Titulaire de permis

Wikwemikong Nursing Home Limited
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

Wikwemikong Nursing Home
2281 Wikwemikong Way P.O. Box 114 Wikwemikong ON P0P 2J0

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

Amended by SHELLEY MURPHY (684) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Amendment required to specify date for submission of compliance plan.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 4 day of October 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by SHELLEY MURPHY (684) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): September 18-21, 2018.

The following intakes were inspected during this Critical Incident (CI) Inspection:

-One CI related to misuse/misappropriation of residents money,

-One CI related to resident to resident abuse, and;

-One CI related to staff to resident abuse.

A Complaint inspection #2018-671684-0020, was conducted concurrently with this Critical Incident Inspection.

The inspector also conducted a tour of the resident care areas, reviewed residents' health care records, home policies and procedures, mandatory training records, observed resident rooms, observed resident common areas, observed the delivery of resident care and services, including resident-staff interactions.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Dietary/Maintenance Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping (Hskg), Maintenance staff and residents.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

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

3 WN(s)
0 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knew of, or that was reported to the licensee, was immediately investigated: (i) Abuse of a resident by anyone.

A Critical Incident (CI) report, was submitted to the Director on a specified day in 2017, for an incident of staff to resident abuse.

Inspector #684 asked the Administrator for the investigation notes for this CI; no investigation notes were found or available for review.

Inspector #684 reviewed page nine of the home's policy titled, "3.2 Abuse and Neglect Prevention Program". In section seven, under the heading of, "Investigation process for resident abuse by formal caregiver, volunteer or visitor" the procedure indicated that, “an investigation shall be commenced immediately”.

During an interview with the Administrator they informed Inspector #684 that there was no investigation conducted. [s. 23. (1) (a)]

2. A CI report, was submitted to the Director on a specified day in 2017, for resident to resident abuse.

Inspector #684 asked the Administrator for investigation notes; the Administrator stated they had looked for investigation notes and were unable to find any notes.

Inspector #684 asked the Administrator if they could confirm that there was an investigation conducted, the Administrator stated there were no notes to indicate that an investigation was conducted. [s. 23. (1) (a)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or 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 Local Health System Integration Act.

A CI report was submitted to the Director on a specified day in 2017, identifying that resident #002 and #003 had a altercation with one another.

Inspector #684 reviewed the electronic progress notes of residents #002 and #003 over a nine day time span in 2017. The progress notes identified that the altercation involving residents #002 and #003 occurred on a specified day in 2017, however, the report submitted to the Director identified that the incident had happened a number of days prior to the CI being submitted to the Director.

Inspector #684 reviewed home policy, "3.2 Abuse and Neglect Prevention Program" last revised May 2018. On page six of the policy, under Mandatory Reporting of Abuse or Neglect, it stated,
"Any 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 their Supervisor, the Director of Care or the Administrator:
1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.
2. Abuse of a resident or anyone or neglect of a resident by the home or staff that resulted in harm or risk of harm to the resident.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of resident's money.
5. Misuse or misappropriation of funding provided to the Home".

Inspector #684 interviewed the DOC, and reviewed the CI, which was submitted to the Director on a specified day in 2017, and identified that resident #002 and #003's electronic progress notes indicated that the incident occurred five days earlier; the DOC stated that this was late reporting.

During an interview with Inspector #684, the Administrator stated that, "my expectation was that when a critical incident occurred, staff were to submit a CI on the day of the incident". [s. 24. (1)]

2. A CI report was submitted to the Director on a specified day in 2017, identifying staff to resident abuse.

Inspector #684 reviewed the Critical incident which was submitted to the Director by the licensee, the date and time that the alleged staff to resident abuse occurred was on a specified day in 2017, at specific time, and the date of the CI submission

was the following day, twenty-four hours later.

Inspector #684 reviewed the CI with the Director of Care, looking specifically at the date and time of the CI, versus the date and time the CI was submitted to the Director. The DOC confirmed that the CI was reported late.

During an interview with Inspector #684 the Administrator stated that, "my expectation was that when a critical incident occurred, staff were to submit a CI on the day of the incident". [s. 24. (1)]

3. A CI report was submitted to the Director on a specified day in 2018, for misuse/misappropriation of residents money.

Inspector #684 reviewed the CI which showed that the date and time of the CI occurrence was two days prior to the date and time the CI was first submitted to the Director.

Inspector #684 met with the DOC and reviewed the CI looking specifically at the CI date and time, versus the Date and time the CI first was submitted to the Director. The DOC stated that this CI was reported late.

During an interview with Inspector #684 the Administrator stated that, "my expectation was that when a critical incident occurred, staff were to submit a CI on the day of the incident". [s. 24. (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. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
-The long-terms care home's policy to promote zero tolerance of abuse and neglect of residents.

In an interview with Inspector #684, RPN #104 stated that they had not received training on abuse, zero tolerance, and the different types of abuse.

Inspector #684 reviewed the staff education verification for Abuse and Neglect education which was completed and revised May 2018. There were a number of regular staff who did not receive the education; as well, a specified number of newly hired staff had also not received the Abuse and Neglect Education. Some new hires had been employed and working in the home since a specified date in 2018.

Inspector #684 reviewed the home's policy titled, "C-2.1 for Training and Development" last revised May 12, 2010. In the procedure it stated the following: Mandatory training is training that is required for the employee to fulfill their duties. These number from six to ten per year. Six training sessions per year are mandatory. Inservice sessions, including, but not limited to, those dealing with safety, infection control and the special needs of residents are mandatory.

Inspector #684 conducted an interview with the Administrator regarding the home's policy for Abuse Prevention Program, the Administrator verified that the Abuse and Neglect Prevention Program was part of the mandatory training for all staff. The Administrator confirmed that a number of staff members had not received the Abuse and Neglect education as they were missed or were newly hired. [s. 76. (2) 3.]

Issued on this 4 day of October 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by SHELLEY MURPHY (684) - (A1)

Inspection No. / No de l'inspection : 2018_671684_0021 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 024644-17, 025447-17, 003560-18 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Oct 04, 2018;(A1)

Licensee / Titulaire de permis : Wikwemikong Nursing Home Limited
2281 Wikwemikong Way, P.O. Box 114,
Wikwemikong, ON, P0P-2J0

LTC Home / Foyer de SLD : Wikwemikong Nursing Home
2281 Wikwemikong Way, P.O. Box 114,
Wikwemikong, ON, P0P-2J0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Cheryl Osawabine-Peltier

Ontario

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

To Wikwemikong Nursing Home Limited, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 23. (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;

(b) appropriate action is taken in response to every such incident; and

(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

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

(A1)
The licensee must be in compliance with s.23 (1) of the LTCHA.

Specifically the licensee must prepare, submit and implement a plan to ensure that all alleged, suspected or witnessed incidents of abuse are immediately investigated.

The plan must include, but is not limited, to the following:

-Implement a tracking process to monitor each incident, which includes; the date of the incident, the date management became aware of the incident, when the incident was reported to the Director and when the internal investigation was initiated
and completed (including the dates investigations were undertaken and who participated in the investigation).
-Identify who will be responsible for ensuring that all investigation notes/records are accessible for review if required.

The plan must be emailed to the attention of LTCH Inspector Shelley Murphy, at
SudburySAO.moh@ontario.ca. The plan is due on October 26, 2018, and the order is to be complied by November 30, 2018.

Grounds / Motifs :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knew of, or that was reported to the licensee, was immediately investigated: (i) Abuse of a resident by anyone.

A Critical Incident (CI) report, was submitted to the Director on a specified day in 2017, for an incident of staff to resident abuse.

Inspector #684 asked the Administrator for the investigation notes for this CI; no investigation notes were found or available for review.

Inspector #684 reviewed page nine of the home's policy titled, "3.2 Abuse and Neglect Prevention Program". In section seven, under the heading of, "Investigation process for resident abuse by formal caregiver, volunteer or visitor" the procedure indicated that, “an investigation shall be commenced immediately”.

During an interview with the Administrator they informed Inspector #684 that there was no investigation conducted. [s. 23. (1) (a)] (684)

2. A CI report, was submitted to the Director on a specified day in 2017, for resident to resident abuse.

Inspector #684 asked the Administrator for investigation notes; the Administrator stated they had looked for investigation notes and were unable to find any notes.

Inspector #684 asked the Administrator if they could confirm that there was an investigation conducted, the Administrator stated there were no notes to indicate an investigation was conducted. [s. 23. (1) (a)]

The severity of this issue was a level 2 as there was potential for actual harm to the residents. The scope was level 2 as two of the three critical incidents had not been investigated. Compliance history was a level 4; non-compliance continues with the original area of non-compliance, despite MOH action that included:
-Voluntary plan of correction made under section 23 (1) of the LTCHA, issued on October 12, 2017, (#2017_615638_0016),
-Voluntary plan of correction made under section 23(1) of the LTCHA, issued on June 28, 2017 (#2017_562620_0007). (684)

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

Nov 30, 2018

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 must be compliant with s. 24(1) of the LTCHA.

Specifically, the licensee shall ensure:

a)That all critical incidents under s. 24 (1) which may involve:
-Improper or incompetent treatment or care of a resident that results in harm or risk of harm to the resident,
-Abuse of a resident by anyone or neglect of a resident by the licensee or staff that results in harm or a risk of harm to the resident,
-Unlawful conduct that results in harm or a risk of harm to a resident,
-Misuse or misappropriation of a resident's money, and
-Misuse or misappropriation of funding provided to a licensee under this Act or Local Health System Integration Act, are immediately reported to the Director.

b) ensure that all staff who are responsible for submitting critical incidents to the Director are trained on the requirements for reporting, and that a record of when the training occurred and who the training is provided to, is to be maintained.

Grounds / Motifs :

1. 1. The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or 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 Local Health System Integration Act.

A CI report was submitted to the Director on a specified day in 2017, identifying that resident #002 and #003 had a altercation with one another.

Inspector #684 reviewed the electronic progress notes of residents #002 and #003 over a nine day time span in 2017. The progress notes identified that the altercation involving residents #002 and #003 occurred on a specified day in 2017, however, the report submitted to the Director identified that the incident had happened a number of days prior to the CI being submitted to the Director.

Inspector #684 reviewed home policy, "3.2 Abuse and Neglect Prevention Program" last revised May 2018. On page six of the policy, under Mandatory Reporting of Abuse or Neglect, it stated,
"Any 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 their Supervisor, the Director of Care or the Administrator:
1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.
2. Abuse of a resident or anyone or neglect of a resident by the home or staff that resulted in harm or risk of harm to the resident.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of resident's money.
5. Misuse or misappropriation of funding provided to the Home".

Inspector #684 interviewed the DOC, and reviewed the CI, which was submitted to the Director on a specified day in 2017, and identified that resident #002 and #003's electronic progress notes indicated that the incident occurred five days earlier; the DOC stated that this was late reporting.

During an interview with Inspector #684, the Administrator stated that, "my

expectation was that when a critical incident occurs, staff were to submit a CI on the day of the incident". [s. 24. (1)]
(684)

2. A CI report was submitted to the Director on a specified day in 2017, identifying that resident #002 and #003 had a altercation with one another.

Inspector #684 reviewed the electronic progress notes of resident #002 and #003 from a nine day time span in 2017, which indicated that the altercation involving resident #002 and #003, occurred on a specified day in 2017. There were no notes to indicate that the incident occurred five days after the initial electronic progress note was documented, as it was reported in the CI.

Inspector #684 reviewed home policy, "3.2 Abuse and Neglect Prevention Program" last revised May 2018. On page six of the policy, under Mandatory Reporting of Abuse or Neglect, it stated,
"Any 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 their Supervisor, the Director of Care or the Administrator:
1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.
2. Abuse of a resident or anyone or neglect of a resident by the home or staff that resulted in harm or risk of harm to the resident.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of resident's money.
5. Misuse or misappropriation of funding provided to the Home".

Inspector #684 interviewed the DOC, and reviewed the CI, which was submitted to the Director on a specified day in 2017, and identified that resident #002 and #003's electronic progress notes indicated that the incident occurred five days earlier; the DOC stated that this was late reporting.

During an interview with Inspector #684, the Administrator stated that, "my expectation was that when a critical incident occurs, staff were to submit a CI on the day of the incident". [s. 24. (1)] (684)

3. A CI report was submitted to the Director on a specified day in 2017, identifying staff to resident abuse.

Inspector #684 reviewed the Critical incident which was submitted to the Director by the licensee, the date and time that the alleged staff to resident abuse occurred was on a specified day in 2017, and the date of the CI submission was 24 hours later.

Inspector #684 reviewed the CI with the Director of Care, looking specifically at the date and time of the CI, versus the date and time the CI was submitted to the Director. The DOC confirmed that the CI was reported late.

During an interview with Inspector #684 the Administrator stated that, "my expectation was that when a critical incident occurs, staff were to submit a CI on the day of the incident".

The severity of this issue was determined to be a level two, as there was a risk of actual harm to residents of the home. The scope of the issue was a level three, as it was related to all of the critical incidents reviewed. The home had a level three compliance history, as they had non-compliance with this section of the Ontario Regulation 79/10 which included:

-written notification was issued May 22, 2018 (#2018_671684_0012).
(684)

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

Nov 30, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 4 day of October 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by SHELLEY MURPHY - (A1)

Ontario

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

Service Area Office / Bureau régional de services : Sudbury