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 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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 3, 2014	2014_163109_0023	T-698-14	Complaint

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF YORK
17250 Yonge Street, NEWMARKET, ON, L3Y-6Z1

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

YORK REGION NEWMARKET HEALTH CENTRE
194 EAGLE STREET, NEWMARKET, ON, L3Y-1J6

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

SUSAN SQUIRES (109), ALEX MCWILLIAM (212)

Inspection Summary/Résumé de l'inspection

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

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 28, 29, June 2, 3, 4, 5, 6, 9, 10, 11, 16, 17, 18, 19, 23, 24, 25, 30, July 3, 2014.

During the course of the inspection, the inspector(s) spoke with administrator, Director of Care, nurse managers, registered nursing staff, volunteer coordinator, medical director, programs manager, president of Residents' Council and council executive, residents, volunteers, accreditation and compliance advisor, program analyst, food services supervisor, executive director of Ontario Association Residents' Councils (OARC), Educator for OARC, recreation staff, housekeeping staff, family members, Family Council member, York Region LTC director and general manager.

During the course of the inspection, the inspector(s) reviewed health records for identified residents, reviewed Residents' Council minutes, reviewed identified policies, procedures and programs, reviewed consultants report, observed the care unit, reviewed electronic communications, and reviewed home's surveys.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Pain
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Reporting and Complaints
Residents' Council

Findings of Non-Compliance were found during this inspection.

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. 3. Residents' Bill of Rights

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).

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

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

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

Findings/Faits saillants :

1. The licensee failed to fully respect resident #1's right to be treated with courtesy and respect and in a way that fully recognizes his/her individuality and respects his/her

dignity.

Resident and staff interviews revealed that on an unspecified date approximately one year ago resident #1 was spoken to by a manager in a rude and loud voice causing the resident to feel infantilized. The witness to the conversation stated that he/she was shocked at the manner in which the manager spoke to the resident and told inspectors that the residents' rights were violated.

Interview with an OARC representative indicated that during a meeting with the President of the Resident's Council and the home's management in March 2014 she observed a manager using a condescending tone of voice on resident #1 and changing the wording of resident #1's sentence around causing the resident to get flustered.

Staff and resident interview reveal resident #1 was observed by several other persons including other supervisors and volunteers to be upset and crying after having conversations with management.

Inspectors observed resident #1 to become visibly upset and crying every time he/she discussed the relationship with management. On one occasion the resident was crying because he/she had been told by management to change the minutes of a meeting and he/she disagreed with the management's request and stated that he/she did not know what to do. [s. 3. (1) 1.]

2. The licensee failed to promote and respect the resident's right to raise concerns or recommend changes in policies and services on behalf of themselves or others to a government official without interference and without fear of coercion, discrimination or reprisal, whether directed at the residents or anyone else.

On June 5, 2014, inspectors entered the home and conducted private interviews with several residents. According to an identified resident, the management of the home questioned the residents on the following day to determine what the purpose of the inspectors visit was and what the residents had told the inspectors.

An identified resident who was questioned by the management of the home confirmed that he/she had been questioned about the inspectors' visit. The resident further stated that he/she felt very uncomfortable and was concerned about retaliation against his/her family by the management. As a result of this, the resident told the

inspector that he/she did not want to speak further with the inspectors.

Two other identified residents confirmed the management was questioning the residents about their interviews with the Ministry of Health and Long-term Care home inspectors. [s. 3. (1) 17. v.]

3. The licensee failed to fully respect and promote resident #1's right to form friendships and relationships and to participate in the life of the long-term care home. Resident, staff and volunteer interviews revealed that staff and volunteers were instructed by the manager not to speak with resident # 1. Staff and volunteers told inspectors that they were afraid to speak to resident #1 due to a perceived fear of reprisal from management. [s. 3. (1) 18.]

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. 65. No interference by licensee
A licensee of a long-term care home,
(a) shall not interfere with the meetings or operation of the Residents' Council or the Family Council;
(b) shall not prevent a member of the Residents' Council or Family Council from entering the long-term care home to attend a meeting of the Council or to perform any functions as a member of the Council and shall not otherwise hinder, obstruct or interfere with such a member carrying out those functions;
(c) shall not prevent a Residents' Council assistant or a Family Council assistant from entering the long-term care home to carry out his or her duties or otherwise hinder, obstruct or interfere with such an assistant carrying out those duties; and
(d) shall ensure that no staff member, including the Administrator or other person involved in the management or operation of the home, does anything that the licensee is forbidden to do under clauses (a) to (c). 2007, c. 8, s. 65.

Findings/Faits saillants :

1. The licensee failed to ensure that the meetings or operation of the Residents' Council are not interfered with.

Over the past 3 years the Newmarket Health Center has undergone senior management changes with subsequent staffing and policy changes within the home. Prior to this, the Residents' Council played a strong and active role in organizing, funding and executing resident social programs and other activities within the home.

According to staff, volunteers and other managers that were interviewed during the inspection process, there is a prevailing culture in the home which enforces the chain of command to such an extent that there is constant conflict between the management and the Residents' Council as the Residents' Council attempts to exercise the powers of the Residents' Council.

On a specified date an email from a manager was sent to the President of the Residents' Council asking him/her to revise the minutes from April 30, 2014.

On a specified date an email from a manager was sent to the President of the Residents' Council questioning why the Residents' Council meeting minutes had been posted before he/she and others at the meeting had approved them.

On a specified date a meeting was held between the management and the Residents' Council. During this meeting a manager told the President of the Residents' Council that technically he/she is in charge of the building and everything in the building has to be approved by the manager before being posted to the public.

On a specified date after the final minutes had been sent from the Residents' Council meeting of May 28, 2013, an email from a manager was sent to the President of the Residents' Council questioning why the revisions that he/she had made were not reflected on the final minutes.

Staff opined that the Council is like a thorn in the management's side. The management gives very limited information to the Residents' Council and there is a lack of transparency. A staff member further stated that it is not a good working relationship in that management does not work with the Council and communications are described as tense. [s. 65. (a),s. 65. (b),s. 65. (c),s. 65. (d)]

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's pain management policy is complied with.

The licensee's policy #RC-0702-00 entitled Pain Management indicates the Pain Monitoring for the Cognitively Impaired resident will be completed on residents when the resident complains of or exhibits signs of pain. The policy states that the team determines together the pain indicators to monitor and to list them accordingly.

Record review and staff interview reveal resident #7 identified to have "horrible daily pain" was cognitively unable to answer questions for the home's Pain Assessment tool. Staff interview revealed that while they completed the online Pain Assessment tool for 7 days straight, they confirmed that the resident was cognitively unable to answer the questions on the assessment tool related to pain.

When the home implemented the Pain Monitoring for the Cognitively Impaired tool 7 days later, there were no pain indicators identified as per the homes policy.

The home's policy was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policy for pain management is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 16. Volunteer program

Specifically failed to comply with the following:

s. 16. (1) Every licensee of a long-term care home shall ensure that there is an organized volunteer program for the home that encourages and supports the participation of volunteers in the lives and activities of residents. 2007, c. 8, s. 16 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the organized volunteer program encourages and supports the participation of volunteers in the lives and activities of the residents.

Some of the volunteers for the home have been volunteering for decades at the home.

On a specified date inspectors received a letter of concern related to perceived inappropriate treatment of a volunteer during a meeting on a specified date.

Resident and volunteer interviews reveal the home does not promote an environment which encourages and supports the participation of the volunteers in the lives and activities of the residents.

An identified volunteer told the inspector that he/she was told by staff that the staff were not allowed to talk to him/her. The volunteer further stated that there is a lot of tension among the staff.

Three volunteers reported that during a meeting on a specified date a manager raised his/her voice at another volunteer in a loud and condescending tone. The volunteer reported feeling humiliated. One of the volunteers told the inspectors that this has happened before that the manager had yelled at another volunteer and added often the discussions with the manager were heated.

The volunteers told the inspectors that their responsibilities have been diminished and they are now only allowed to porter the residents to and from the activity programs. The volunteers stated that the feeling in the building is unfriendly and they do not feel welcomed. They stated that they have lost their identity as an auxiliary.

The manager justified his/her actions by stating that he/she had to be direct when speaking to the volunteers. He/she stated that he/she had to hold them accountable to ensure the home is compliant with the Act and the expectations related to the lines of communication with the residents and families. While it is important to ensure safety of residents and volunteers, it is apparent that the outcome of the manager exerting his/her authority has resulted in the volunteers now feeling a lack of appreciation for their efforts. [s. 16. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the organized volunteer program encourages and supports the participation of volunteers in the lives and activities of the residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 incident of abuse of a resident by anyone that the licensee knows of, or that is reported is immediately investigated.

On a specified date resident #11 submitted a Client Complaint Form alleging that an identified staff member always yells at him/her and the resident believes the staff member has a personal vendetta against the resident.

Interview with the management indicate all complaints are reviewed by the administrator.

Record review of the homes complaint form indicates that there was no immediate investigation into this allegation of the staff member yelling at resident #11.

Staff interview confirmed there was no investigation into the allegation of verbal abuse by the staff member who allegedly yelled at the resident. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged incident of abuse of a resident by anyone that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 62. A licensee shall co-operate with the Residents' Council, the Family Council, the Residents' Council assistant and the Family Council assistant and shall provide them with such financial and other information and such assistance as is provided for in the regulations. 2007, c. 8, s. 62..

Findings/Faits saillants :

1. The licensee failed to respond in a timely manner to the request from the Residents' Council to review the financial statements of the home filed with the Director under the regulations or provided to a local health integration network.

On September 18, 2013 the Residents' Council requested to review the home's financial statements that the home filed with the Director and a detailed allocation of funding including residents' contribution. There was no response to this request and the request was repeated every month thereafter.

On January 29, 2014 the Residents' Council requested to the home's management to have a date chosen to present the annual financial statement and a date chosen to present the detailed allocation of funding including residents' contribution. There was no response to this request.

On February 26, 2014 the minutes state that on February 24, 2014 the Council received an email stating the home's financial statement would be reviewed at the Residents' Council meeting on April 30, 2014. On March 7, 2014 an email was received by the Residents' Council from a manager indicating that the financial statements for 2013 would not be available until September. [s. 62.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the licensee co-operates with the Residents' Council, and shall provide them with such financial and other information and such assistance as is provided for in the regulations, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 64. A licensee of a long-term care home shall attend a meeting of the Residents' Council or the Family Council only if invited, and shall ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of either Council only if invited. 2007, c. 8, s. 64.

Findings/Faits saillants :

1. The licensee failed to ensure the administrator and staff attend Residents' Council meetings only when invited.

Record review, staff and resident interview reveal staff are required by management to attend all Resident Council meetings even though the Residents' Council has objected to this practice.

The President of the Residents' Council stated that the meeting room provides a call bell for residents in case of an emergency. Furthermore, the President of the Residents' Council has a mobile telephone which can be used to call for assistance if an emergency should arise.

A manager confirmed that staff are in attendance at all meetings to ensure that residents are safe. [s. 64.]

2. According to the Residents' Council minutes dated November 27, 2013 an unapproved guest identified as a staff member was in attendance at the meeting. [s. 64.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure administrator and staff attend Residents' Council meetings only when invited, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 9. Restorative care

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that there is an organized interdisciplinary program with a restorative care philosophy that,
(a) promotes and maximizes independence; and 2007, c. 8, s. 9 (1).
(b) where relevant to the resident's assessed care needs, includes, but is not limited to, physiotherapy and other therapy services which may be either arranged or provided by the licensee. 2007, c. 8, s. 9 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is an organized interdisciplinary program with a restorative care philosophy that,(a) promotes and maximizes independence; and (b) where relevant to the resident's assessed care needs, includes, but is not limited to, physiotherapy and other therapy services which may be either arranged or provided by the licensee.

The home currently does not have a written description for an interdisciplinary restorative care program.

Interview with the administrator confirmed that the program is not in place in the home. [s. 9. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that written complaints about the care of a resident or the operation of the long-term care home shall immediately be forwarded to the Director.

On a specified date a written complaint about verbal abuse toward a resident was received by the licensee alleging a staff member to have yelled at the resident and the resident believes that the staff member has a personal vendetta against him/her.

On a specified date a written complaint was received by the home from a family member regarding the rough handling of the resident which caused pain. The complainant named the caregiver and described her as being disrespectful of the resident's condition and abusive.

Record review and staff interview reveal that neither of these written complaints concerning the care of a resident was forwarded to the Director. [s. 22. (1)]

WN #10: 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 failed to immediately report suspected verbal abuse of a resident and the information upon which it was based to the Director.

Record review and staff interview revealed resident #11 wrote a complaint form to the management alleging that a specific staff member had yelled at him/her and the resident believed the staff member had a personal vendetta against him/her.

The administrator confirmed that all complaints are reviewed by the administrator.

Staff interview and record review reveal the alleged verbal abuse was not reported to the Director. [s. 24. (1)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Residents' Council advise related to concerns or recommendations.

Review of Residents' Council minutes indicate on April 24, 2014 the Council provided a written recommendation to a manager requesting a large print thermometer and large print documents for the residents. The response was not made to the Residents' Council until June 5, 2014 in an email message.

Interview with the manager indicates that previously the home was not responding to resident recommendations in writing and within 10 days. [s. 57. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint; and where the complaint alleges harm or risk of harm to one or more residents an investigation is commenced immediately.

Resident #11 submitted a written complaint to the licensee alleging a staff member verbally abused him/her.

Staff interview confirmed the licensee did not investigate this complaint. [s. 101. (1) 1.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. Record review and staff interview reveal the direct care staff have not been provided any annual training in pain management including recognition of specific and non-specific signs of pain.

This was confirmed by a manager. [s. 221. (1) 4.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's quality improvement and utilization review system ensure that improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents are communicated to the Residents' Council on an ongoing basis.

Record review of the homes quality improvement projects indicate that there are a large number of quality improvement initiatives currently in place at the home. Staff and resident interview reveal that the home currently only communicates a small segment of the quality improvements made with the Residents' Council.

A manager stated that the decision had been made to share a small selection of quality indicators with the Residents' Council. [s. 228. 3.]

Issued on this 8th day of October, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN SQUIRES (109), ALEX MCWILLIAM (212)
Inspection No. / No de l'inspection :	2014_163109_0023
Log No. / Registre no:	T-698-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 3, 2014
Licensee / Titulaire de permis :	REGIONAL MUNICIPALITY OF YORK 17250 Yonge Street, NEWMARKET, ON, L3Y-6Z1
LTC Home / Foyer de SLD :	YORK REGION NEWMARKET HEALTH CENTRE 194 EAGLE STREET, NEWMARKET, ON, L3Y-1J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Salonen Mackay

To REGIONAL MUNICIPALITY OF YORK, 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.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 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 prepare, submit and implement a plan outlining how the licensee will ensure that the following resident rights are fully respected and promoted.

Resident #1's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects his/her dignity.

Residents' right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to a government official without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else.

Resident #1's right to form friendships and relationships and to participate in the life of the Long-term care home

Please submit compliance plan to susan.squires@ontario.ca by September 19, 2014.

Grounds / Motifs :

1. 1. The licensee failed to fully respect resident #1's right to be treated with courtesy and respect and in a way that fully recognizes his/her individuality and respects his/her dignity.

Resident and staff interviews revealed that on an unspecified date approximately

one year ago resident #1 was spoken to by a manager in a rude and loud voice causing the resident to feel infantilized. The witness to the conversation stated that he/she was shocked at the manner in which the manager spoke to the resident and told inspectors that the residents' rights were violated.

Interview with an OARC representative indicated that during a meeting with the President of the Resident's Council and the home's management in March 2014 she observed a manager using a condescending tone of voice on resident #1 and changing the wording of resident #1's sentence around causing the resident to get flustered.

Staff and resident interview reveal resident #1 was observed by several other persons including other supervisors and volunteers to be upset and crying after having conversations with management.

Inspectors observed resident #1 to become visibly upset and crying every time he/she discussed the relationship with management. On one occasion the resident was crying because he/she had been told by management to change the minutes of a meeting and he/she disagreed with the management's request and stated that he/she did not know what to do. [s. 3. (1) 1.]
(109)

2. 2. The licensee failed to promote and respect the resident's right to raise concerns or recommend changes in policies and services on behalf of themselves or others to a government official without interference and without fear of coercion, discrimination or reprisal, whether directed at the residents or anyone else.

On June 5, 2014, inspectors entered the home and conducted private interviews with several residents. According to an identified resident, the management of the home questioned the residents on the following day to determine what the purpose of the inspectors visit was and what the residents had told the inspectors.

An identified resident who was questioned by the management of the home confirmed that he/she had been questioned about the inspectors' visit. The resident further stated that he/she felt very uncomfortable and was concerned about retaliation against his/her family by the management. As a result of this, the resident told the inspector that he/she did not want to speak further with the

inspectors.

Two other identified residents confirmed the management was questioning the residents about their interviews with the Ministry of Health and Long-term Care home inspectors. [s. 3. (1) 17. v.]
(109)

3. 3. The licensee failed to fully respect and promote resident #1's right to form friendships and relationships and to participate in the life of the long-term care home.
Resident, staff and volunteer interviews revealed that staff and volunteers were instructed by the manager not to speak with resident # 1. Staff and volunteers told inspectors that they were afraid to speak to resident #1 due to a perceived fear of reprisal from management. [s. 3. (1) 18.]

(109)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 28, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 65. A licensee of a long-term care home,
(a) shall not interfere with the meetings or operation of the Residents' Council or the Family Council;
(b) shall not prevent a member of the Residents' Council or Family Council from entering the long-term care home to attend a meeting of the Council or to perform any functions as a member of the Council and shall not otherwise hinder, obstruct or interfere with such a member carrying out those functions;
(c) shall not prevent a Residents' Council assistant or a Family Council assistant from entering the long-term care home to carry out his or her duties or otherwise hinder, obstruct or interfere with such an assistant carrying out those duties; and
(d) shall ensure that no staff member, including the Administrator or other person involved in the management or operation of the home, does anything that the licensee is forbidden to do under clauses (a) to (c). 2007, c. 8, s. 65.

Order / Ordre :

The licensee shall refrain from interfering with the meetings or operation of the Residents' Council.

The licensee shall refrain from requiring approval of the Residents' Council's meeting minutes.

The licensee shall train staff, including the management team on how not to interfere and on the powers of Residents' Council.

Grounds / Motifs :

1. 1. The licensee failed to ensure that the meetings or operation of the Residents' Council are not interfered with.

Over the past 3 years the Newmarket Health Center has undergone senior management changes with subsequent staffing and policy changes within the

home. Prior to this, the Residents' Council played a strong and active role in organizing, funding and executing resident social programs and other activities within the home.

According to staff, volunteers and other managers that were interviewed during the inspection process, there is a prevailing culture in the home which enforces the chain of command to such an extent that there is constant conflict between the management and the Residents' Council as the Residents' Council attempts to exercise the powers of the Residents' Council.

On a specified date an email from a manager was sent to the President of the Residents' Council asking him/her to revise the minutes from April 30, 2014.

On a specified date an email from a manager was sent to the President of the Residents' Council questioning why the Residents' Council meeting minutes had been posted before he/she and others at the meeting had approved them.

On a specified date a meeting was held between the management and the Residents' Council. During this meeting a manager told the President of the Residents' Council that technically he/she is in charge of the building and everything in the building has to be approved by the manager before being posted to the public.

On a specified date after the final minutes had been sent from the Residents' Council meeting of May 28, 2013, an email from a manager was sent to the President of the Residents' Council questioning why the revisions that he/she had made were not reflected on the final minutes.

Staff opined that the Council is like a thorn in the management's side. The management gives very limited information to the Residents' Council and there is a lack of transparency. A staff member further stated that it is not a good working relationship in that management does not work with the Council and communications are described as tense. [s. 65. (a),s. 65. (b),s. 65. (c),s. 65. (d)]

(109)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 28, 2014

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

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

and the Director

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.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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 3rd day of September, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SUSAN SQUIRES

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