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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 6, 2014	2014_205129_0014	H-000846-13/H-000861-13	Critical Incident System

Licensee/Titulaire de permis

ST. PETER'S CARE CENTRES
125 Redfern Ave, HAMILTON, ON, L9C-7W9

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

ST. PETER'S RESIDENCE AT CHEDOKE
125 Redfern Avenue, HAMILTON, ON, L9C-7W9

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 11, 14, 15, 16, and 17, 2014

During the course of the inspection, the inspector(s) spoke with residents, registered and unregulated nursing staff, both Directors of Care and the Administrator in relation to Log #H-000846-13, H-000861-13 and H-00046-14.

During the course of the inspection, the inspector(s) reviewed clinical documents and computerized records, investigative notes written by leadership staff, staff employment files and the home's policies and procedures [Non-Abuse of Residents, Duty to Report/Whistle Blowing Protection and Responsive Behaviour]

**The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation**

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

Findings/Faits saillants :

1. The licensee did not ensure that the right of residents to be protected from abuse was fully respected and promoted, in relation to the following: [3(1)2]
1. Resident #005's right to be protected from abuse was not fully respected and promoted, when on an identified date a co-resident was observed to enter resident #005's room and touch the resident in a sexual manner. The co-resident was known to staff to frequently exhibit sexually responsive behaviours towards both staff and residents; however, the co-resident was not being monitored to a degree that prevented this resident from wandering in resident #005's room and engaging in non-consensual touching of a sexual nature.
2. Resident #002's right to be protected from abuse was not fully respected and promoted on the evening shift of an identified date when two PSWs were observed to force resident #002, who at the time was only partially clothed, to walk down a public hallway while the resident was resisting this care by loud vocalizations and physically responsive behaviours. A witness reported that the PSWs took the resident into the shower room, where the resident continued to vocalize resistance to care and one of the PSWs was heard to respond inappropriately. Resident #002's right to be protected from abuse continued to be in jeopardy at the time of this inspection when staff involved in this incident confirmed they felt they knew the resident well enough to know what care the resident required and following disciplinary action the two staff involved in this incident continued to provide care to resident #005 without a plan to monitor the care these staff were providing.
3. Resident #003's right to be protected from abuse was not fully respected and promoted when on an identified date a PSW providing care was heard to yell at this resident because the PSW thought the resident was using the nurse call bell too much. Witness statements indicated that the resident looked shocked, confused and distraught as a result of this verbal abuse. The following day witness statements indicated that the same PSW was observed to be aggressive and overly rough while assisting the resident to dress, causing the resident to state "stop, you are hurting me". [s. 3. (1) 2.]

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. 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 did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care, in relation to the following: [6(7)]
Personal Support Workers providing care to resident #002 confirmed that the resident was not provided with care as specified in the resident’s plan of care. The plan of care directed that if the resident demonstrated resistance to care staff were to leave the resident and return in five to ten minutes. On an identified date in 2013 two PSWs were observed to continue to force the resident to receive care despite the resident demonstrating their opposition to this care by loud vocalizations and physically responsive behaviours. The resident’s plan of care also directed that the resident required the assistance of one staff to assist with bathing; however, the same two PSWs proceeded to provide a shower to resident #002. At the time of this inspection the PSWs involved in the above noted incidents confirmed during an interview that they were unaware of the directions in the plan of care to leave and return to the resident if the resident was demonstrating resistance to care and felt that they knew the resident well enough to know that the resident required two staff for bathing. [s. 6. (7)]

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect was complied with, in relation to the following: [20(1)]
Staff in the home did not comply with the home's policy [Non-Abuse of Residents] identified as # 2-60 and revised in January 2014, in relation to the following:
1. The policy directed that in all incidents of alleged, suspected or witnessed resident abuse or neglect the Registered Nurse (RN) or Nurse in Charge must immediately report to a member of the leadership team.
-Incident investigative notes written by the DOC confirmed that a Registered Nurse (RN) in charge did not immediate report to a member of the leadership team when it was reported by a RPN that a PSW was overheard yelling at resident #003 for using the nurse call bell too much and the same PSW was observed to be rough while assisting the resident to dress which visibly upset the resident.
2. The policy directed that any staff member must immediately report all incidents of alleged, suspected or witnessed resident abuse or neglect to the nurse in charge.
- A RPN who was informed that a PSW was overheard yelling at resident #003 for using the nurse call bell too much confirmed that she did not immediately report this information to the Nurse in charge. This information was reported to the Nurse in Charge the following day.
3. The policy directed that the RN or the Nurse in charge was to immediately assess the resident for physical harm or emotional distress.
-Clinical documentation confirmed a RN who received information that resident #003 had been yelled at and treated roughly while care was being provided did not assess resident #003 for physical harm or emotional distress.
-A DOC who received information that resident #002 was being forcibly walked down the hall by two PSW's while appearing to be unclothed on the bottom half of the body confirmed that the resident was not immediately assess the resident for physical harm. [s. 20. (1)]

Additional Required Actions:

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

WN #4: 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. Registered staff in the home who had reasonable grounds to suspect that abuse of a resident had occurred did not immediately report this information to the Director, in relation to the following: [24(1)2]
1. Clinical documentation and information forwarded to the Ministry on a Critical Incident Report indicated that there were reasonable grounds to suspect that resident #005 was the victim of non-consensual sexually touching by resident #001. On an identified date in 2013 it was documented in the clinical record that a Personal Support Worker (PSW) observed resident #001 standing at the bedside of resident #005 with their hands on the resident's chest. This incident was reported to registered staff and documented in the resident's computerized progress notes. It was also documented that at the time of this incident resident #005 told the PSW that they wanted that to stop. This incident of non-consensual touching of a sexual nature was not reported to the Director for a period of time in excess of 17 hours when a Critical Incident report was submitted to the Hamilton Service Area Office.
2. Clinical documentation, staff and information forwarded to the Ministry on a Critical Incident Report indicated that there were reasonable grounds to suspect that resident #003 was verbally abused by staff providing care. A PSW reported that they overheard a second PSW yelling at resident #003 for using the nurse call bell too much. The above noted incident was reported to the Registered Practical Nurse who at the time of this inspection confirmed that this would be considered abusive behaviour. The same PSW reported, on another day, that the same PSW who allegedly yelled at resident #003 the previous day was rough when assisting the resident to dress and visible upset the resident with this care. The RPN who received the reports on these two days reported this information to the Registered Nurse Supervisor. These incidents of alleged abusive behaviour were not reported to the Director for two days after the first incident and a day after the second incident when a Critical Incident Report was submitted to the Hamilton Service Area Office. [s. 24. (1) 2.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee’s written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee did not ensure that the written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents identified measures and strategies to prevent abuse and neglect, in relation to the following: [96(c)]
At the time of this inspection the home provided two policies that provided direction to staff in the home related to zero tolerance of abuse and neglect of residents. The policies were identified as [Non-Abuse of Residents] identified as # 2-60 last revised in January 2014 and [Duty to Report/Whistle Blowing Protection] identified as # 2-65 dated July 2012. The Director of Care (DOC) confirmed that these polices did not identify measures and strategies to prevent abuse and neglect. [s. 96. (c)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee did not ensure that a written record of the annual evaluation of the effectiveness of the home's policy under section 20 of the Act to promote zero tolerance of abuse contained an analysis of every incident of abuse or neglect, what changes and improvements were required to prevent further occurrences, the date the evaluation was completed, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented was promptly prepared, in relation to the following: [99(e)]
The Administrator confirmed that a written record of a 2013 annual evaluation of the effectiveness of the home's policy to promote zero tolerance of abuse and neglect of residents was not prepared in accordance with the requirements identified in the Regulation and was not available at the time of this inspection. [s. 99. (e)]

Issued on this 12th day of September, 2014

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

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) :	PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2014_205129_0014
Log No. / Registre no:	H-000846-13/H-000861-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 6, 2014
Licensee / Titulaire de permis :	ST. PETER'S CARE CENTRES 125 Redfern Ave, HAMILTON, ON, L9C-7W9
LTC Home / Foyer de SLD :	ST. PETER'S RESIDENCE AT CHEDOKE 125 Redfern Avenue, HAMILTON, ON, L9C-7W9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Renee Guder

To ST. PETER'S CARE CENTRES, 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: 2013_215123_0020, CO #001;

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 ensure that the right of all residents to be protected from abuse is fully respected and promoted.

Grounds / Motifs :

1. Previously identified non-compliant on June 17, 2013 as a VPC and on November 13, 2013 as a CO.
2. In three of three situations reviewed the right of the resident to be protected from abuse was not fully respected or promoted.
3. Resident #005's right to be protected from abuse was not fully respected and promoted, when on October 9, 2013 a co-resident was observed to enter resident #005's room, pull the resident's bed sheets down and rub the resident's chest. The co-resident was known to staff to frequently exhibit sexually responsive behaviours towards both staff and residents; however, the co-resident was not being monitored to a degree that prevented this resident from wandering in resident #005's room and engaging in non-consensual touching of a sexual nature.
4. Resident #002's right to be protected from abuse was not fully respected and promoted on the evening shift of December 4, 2013. On this date, two PSWs were observed to force resident #002, who at the time was only partially clothed, to walk down a public hallway while the resident was resisting this care by loud vocalizations and physically responsive behaviours. A witness reported that the PSWs took the resident into the shower room, where the resident continued to vocalize resistance to care and one of the PSWs was heard to tell the resident to "shut up". Resident #002's right to be protected from abuse continued to be in jeopardy at the time of this inspection when staff involved in this incident confirmed they felt they knew the resident well enough to know what care the resident required and following disciplinary action the two staff involved in this incident continued to provide care to resident #005 without a plan to monitor the care these staff were providing.
5. Resident #003's right to be protected from abuse was not fully respected and promoted when on January 4, 2014 a PSW providing care was heard to yell at this resident because the PSW thought the resident was using the nurse call bell too much. Witness statements indicated that the resident looked shocked, confused and distraught as a result of this verbal abuse. The following day, January 5, 2013 witness statements indicated that the same PSW was observed to be aggressive and overly rough while assisting the resident to dress, causing the resident to state "stop, you are hurting me". (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 05, 2014

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

Order / Ordre :

The licensee shall ensure that staff provide care to residents as specified in the resident's plan of care.

Grounds / Motifs :

1. Previously identified non-compliant on August 16, 2011 as a WN, on May 16, 2012 as a VPC and on June 17, 2013 as a VPC.
2. Personal Support Workers providing care to resident #002 on the evening of December 4, 2013 confirmed that the resident was not provided with care as specified in the resident's plan of care. The plan of care in place on this date directed that if the resident demonstrated resistance to care staff were to leave the resident and return in five to ten minutes. On December 4, 2013 two male PSWs were observed to continue to force the resident to receive care despite the resident demonstrating their opposition to this care by loud vocalizations and physically responsive behaviours. The resident's plan of care also directed that the resident required the assistance of one staff to assist with bathing; however, the same two PSWs proceeded to provide a shower to resident #002. At the time of this inspection the PSWs involved in the above noted incidents confirmed during an interview that they were unaware of the directions in the plan of care to leave and return to the resident if the resident was demonstrating resistance to care and felt that they knew the resident well enough to know that the resident required two staff for bathing. (129)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 05, 2014

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2013_215123_0020, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall ensure that staff comply with the written policies related to the promotion of zero tolerance of abuse and neglect of residents.

Grounds / Motifs :

1. Previously identified non-compliant on July13, 2011 as a WN and on November 11, 2013 as a CO.
2. The policy directed that in all incidents of alleged, suspected or witnessed resident abuse or neglect the Registered Nurse (RN) or Nurse in Charge must immediately report to a member of the leadership team.
-Incident investigative notes written by the DOC confirmed that a Registered Nurse (RN) in charge did not immediate report to a member of the leadership team when it was reported to her by a RPN that a PSW was overheard yelling at resident #003 for using the nurse call bell too much and the same PSW was observed to be rough while assisting the resident to dress which visibly upset the resident.
3. The policy directed that any staff member must immediately report all incidents of alleged, suspected or witnessed resident abuse or neglect to the Nurse in charge.
- A RPN who was informed that a PSW was overheard yelling at resident #003 for using the nurse call bell too much confirmed that she did not immediately report this information to the Nurse in charge. This information was reported to the Nurse in Charge the following day.
4. The policy directed that the RN or the Nurse in charge was to immediately assess the resident for physical harm or emotional distress.
-Clinical documentation confirmed a RN who received information that resident #003 had been yelled and treated roughly while care was being provided did not assess resident #003 for physical harm or emotional distress.
-A DOC who received information that resident #002 was being forcibly walked down the hall by two PSW's while appearing to be unclothed on the bottom half of the body confirmed that she did not immediately assess the resident for physical harm.
(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 05, 2014

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

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 ensure that person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

1. Previously identified as non-compliant on July 13, 2011 as a WN, on August 16, 2011 as a WN and on November 13, 2013 as a VPC.
2. In two of three situations of suspected abuse of residents the Director was not immediately notified.
3.Clinical documentation and information forwarded to the Ministry on a Critical Incident Report indicated that there were reasonable grounds to suspect that resident #005 was the victim of non-consensual sexually touching by resident #001. On October 9, 2013 at 2153hrs. it was documented in the clinical record that a Personal Support Worker (PSW) observed resident #001 standing at the bedside of resident #005, resident #005's bed sheets had been pulled down and resident #001 was fondling the breasts of resident #005. This incident was reported to registered staff and documented in the resident's computerized progress notes. It was also documented that at the time of this incident resident #005 told the PSW that she wanted that to stop. This incident of non-consensual touching of a sexual nature was not reported to the Director for a period of time in excess of 17 hours when on October 10, 2013 at 1547hrs a Critical Incident report was submitted to the Hamilton Service Area Office.
4. Clinical documentation, staff and information forwarded to the Ministry on a Critical Incident Report indicated that there were reasonable grounds to suspect that resident #003 was verbally abused by staff providing care on January 4, 2014. A PSW reported that they overheard a second PSW yelling at resident #003 for using the nurse call bell too much. The above noted incident was reported to the Registered Practical Nurse who at the time of this inspection confirmed that this would be considered abusive behaviour. On January 5, 2014 the same PSW reported that the same PSW who allegedly yelled at resident #003 the previous day was rough when assisting the resident to dress and visible upset the resident with this care. The RPN who received these reports on these two days reported this information to the Registered Nurse Supervisor. These incidents of alleged abusive behaviour were not reported to the Director for two days after the first incident and a day after the second incident when on January 6, 2014 at 2028hrs a Critical Incident Report was submitted to the Hamilton Service Area Office. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 05, 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 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 6th day of August, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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