Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 20, 2021	2021_879621_0007 (A1)	006062-21, 007200-21, 007912-21	Complaint

Licensee/Titulaire de permis

Riverside Health Care Facilities Inc.
110 Victoria Avenue Fort Frances ON P9A 2B7

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

Rainycrest
550 Osborne Street Fort Frances ON P9A 3T2

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

Amended by JULIE KUORIKOSKI (621) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home requested an extension from October 25, 2021, Compliance Due Date (CDD), to allow time to complete the sensitivity training, as ordered. Enrollment in the training has occurred, however it does not take place until after October 25, 2021. An extension until November 19, 2021, to complete the training has been granted.

Issued on this 20th day of October, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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Long-Term Care Inspections Branch

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

Amended by JULIE KUORIKOSKI (621) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 12 - 15, 2021.

The follow intakes were inspected upon during this Complaint Inspection:

- One intake related to Residents' Council, and menu and dining service; and

- Two intakes related to alleged staff to resident abuse, personal support services and medication management.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Clinical Manager (CM), the Infection Prevention and Control (IPAC) Lead, a Physician, the Food Services Supervisor (FSS), the Residents' Council Assistant (RCA), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), an Activity Assistant, the Maintenance Clerk, a Physiotherapy Assistant (PTA), the Residents' Council President and residents.

The Inspectors also completed daily tours of the resident care areas, observed the provision of care and services to residents, observed staff-to-resident and resident-to-resident interactions, reviewed relevant resident healthcare records, home's investigation records, complaint records, meeting minutes, and applicable policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Dining Observation
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.
- **8 WN(s)**
- **5 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the right of a resident to participate fully in making any decision concerning any aspect of their care, and the right to obtain an independent opinion with regard to any of those matters, was fully respected and promoted.

A resident was admitted to the home on a day in August 2020. A number of days later, a staff member discontinued a specific medication without informing the resident or discussing this change with them. Following the discontinuation of this medication, the resident reported experiencing symptoms, that negatively impacted their level of health and well-being. The resident indicated that they were not aware that a specific medication had been discontinued until they started to experience these symptoms. On a date in November 2020, the resident expressed to staff that they were having similar symptoms to what they had in the past, and that a certain medication had been the only thing that helped. Despite the staff member being made aware of these concerns, and the resident repeatedly requesting the medication be added back to their medication regimen, the medication was not restarted again until six months later.

Additionally, the resident was seen by a certain licensed medical professional prior to their admission to the home. A physician's letter related to the Long-Term Care placement of the resident, identified that the resident required attendance with this type of medical professional related to a medical condition. The resident asked a staff member to submit a referral to the medical professional, however, this request was refused. In November 2020, when the resident was unwell, they were provided with an emergency appointment with a community healthcare provider, who supported them seeing the medical professional. The resident again requested to be seen by this type of medical professional, however no referral was made by the staff member. A referral to the specified medical professional was not made until six months after the request.

The DOC indicated that the resident’s right to participate in the decision to discontinue a specified medication, and the decision regarding consultation with another medical professional to obtain an independent opinion regarding their care, was not respected by the staff member.

Sources: Healthcare records of the resident, a referral; a physician's letter; and interviews with the resident, DOC, and the staff member. [s. 3. (1) 11. iii.] (757)

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from verbal abuse by a staff member.

Ontario Regulation (O. Reg.) 79/10, s. 2. (1), defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

In April 2021, a meeting was held with an RN, the resident, and a staff member in attendance. The resident indicated that the staff member was verbally abusive during the meeting. The home's investigation confirmed the verbal abuse. The investigation also identified that other staff in attendance should have intervened to stop the verbal abuse.

The resident said that comments made by the staff member during the meeting were very upsetting and caused them to feel belittled and a diminished sense of well-being, dignity, and self-worth.

Following the meeting, an Activity Assistant reported that the resident met with them to discuss the incident, and was upset and fearful. Additionally, the resident's healthcare record identified that on the day of the meeting, the resident did not attend meal service as they were too upset to eat.

The DOC confirmed that the incident constituted verbal abuse.

Sources: Healthcare records of the resident; the home's investigation; a CIS report; and interviews with the resident, the RN, an Activity Assistant, the DOC, and the staff member. [s. 19. (1)] (757)

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

In accordance with COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, effective June 9, 2021, it identified that all staff were required to wear appropriate eye protection (eg., googles or face shield), when they were within two meters of a resident(s) as part of provision of direct care, and/or when they interacted with a resident(s) in an indoor area.

During the July inspection, the inspector observed staff not wearing goggles or face shields as part of required eye protection during meal service.

During an interview with the home's Infection, Prevention and Control (IPAC) Lead, they identified that as part of COVID-19 IPAC measures for resident safety, staff were required to wear eye protection when performing direct care with residents.

Together with the Inspector, the IPAC Lead observed and confirmed that staff were providing direct care to residents, and not wearing required eye protection during meal service.

Sources: Observations of meal service; Interviews with the IPAC Lead, an RN and other relevant staff; COVID-19 Directive #3 effective at the time of inspection. [s. 5.] (621)

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 is a safe and secure environment for its residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21. (1).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

The home's temperature logs for July 2021 identified that 36 out of 44 (82 per cent) of temperatures taken in the home, were at 20 and 21 degrees Celsius. The maintenance clerk confirmed that the temperatures were below the minimum requirements.

Sources: The home's temperature logs; and interviews with the DOC and maintenance clerk. [s. 21. (1)] (621)

2. The licensee has failed to ensure that temperatures were measured and documented in writing, at a minimum, in at least two resident bedrooms in different parts of the home; one resident common area on every floor of the home, which may include a lounge, dining area or corridor; and every designated cooling area, if there were any in the home.

The home's temperature logs for July 2021 identified that recorded temperatures were only taken in a common area for each unit in the home. The maintenance clerk confirmed that temperatures were not measured in all required areas.

Sources: The home's temperature logs; and interviews with the DOC and maintenance clerk. [s. 21. (2)] (621)

3. The licensee has failed to ensure that temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The home's temperature logs for July 2021 identified the recorded temperatures were taken only once a day, in the afternoon. The maintenance clerk confirmed that the temperatures were not measured at the required times.

Sources: The home's temperature logs; and interviews with the DOC and maintenance clerk. [s. 21. (3)] (621)

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 was maintained at a minimum temperature of 22 degrees Celsius; the temperature was measured in writing at a minimum in the following areas of the home: at least two resident bedrooms in different parts of the home, one resident common area on every floor of the home, and every designated cooling area if there are any in the home; and the temperature was documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #5: 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.
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, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in a risk of harm to the resident, was immediately reported to the Director with the information upon which the suspicion was based.

A resident brought concerns to the DOC regarding possible medication administration errors made by an RPN. The DOC indicated that while an internal investigation into the matter had been conducted by the home, the suspicion and the information upon which it was based had not been reported to the Director.

Sources: Review of Critical Incident System (CIS) reports submitted by the home; and an interview with the DOC. [s. 24. (1) 1.] (757)

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 a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident, that resulted in a risk of harm to the resident, was immediately reported to the Director with the information upon which the suspicion was based, to be implemented voluntarily.

WN #6: 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 has failed to ensure that if the Residents' Council advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee within 10 days of receiving the advice, responded to the Residents' Council in writing.

In a complaint made to the Director, it was identified that concerns made at Residents' Council (RC) meetings were not followed up by the home, by way of a written response, within 10 days of the meeting.

During a review of minutes for the April, May and June 2021 RC meetings, it was identified that concerns from the April meeting were followed up in writing by the home's Administrator 19 days after the meeting, and at of the time of inspection, no written response from the home's Administrator, was found for the documented concerns from the May and June meetings.

An interview with the RC Assistant reported that they were unaware the the home's management were to provide a written response to concerns brought forward at the RC meeting within 10 days of the meeting, and verified that the written response from the Administrator for the April 2021 RC meeting was late, and there was no written response for either the May or June 2021 meetings.

Sources: Meeting minutes of RC; Administrator's letter of response; and interviews with current and former RC Presidents, the RC Assistant, and other relevant staff. [s. 57. (2)] (621)

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 if the Residents' Council advises the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee within 10 days of receiving the advice, responds to the Resident's Council in writing, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement entered into in accordance with section 20 of the Local Health System Integration Act, 2006 or section 22 of the Connecting Care Act, 2019;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term

care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council, were posted in the home, in a conspicuous and easily accessible location.

In follow up to a complaint made to the Director, it was identified that Residents' Council (RC) had meetings over the previous quarter.

On review of the RC communication board in the home, only minutes from meetings in 2019 were found.

During an interview with the RC Assistant, they reported that meetings of RC were held as recently as June 2021. They confirmed that as of the time of inspection, minutes of this meeting had not yet been posted on the RC communication board in the home, and should have been.

Sources: Observations of RC postings; review of RC minutes; and interviews with the RC Assistant, DOC, RC President and other residents in the home. [s. 79. (3) (n)] (621)

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 most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council, are posted in the home, in a conspicuous and easily accessible location, to be implemented voluntarily.

WN #8: 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:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident a response shall be made to the person who made the complaint indicating that the licensee believes the complaint to be unfounded and the reasons for the belief.

A Critical Incident System (CIS) report was made to the Director for alleged staff to resident abuse. The CIS identified that a resident made a complaint alleging verbal abuse by a staff person during a meeting. An investigation was conducted, however, the DOC identified that a response had not been provided to the resident, indicating the outcome of the complaint, and the reasons for that belief.

Sources: A CIS report; and interviews with the resident and DOC. [s. 101. (1) 3.] (757)

Issued on this 20th day of October, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JULIE KUORIKOSKI (621) - (A1)
Inspection No. / No de l'inspection :	2021_879621_0007 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	006062-21, 007200-21, 007912-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 20, 2021(A1)
Licensee / Titulaire de permis :	Riverside Health Care Facilities Inc. 110 Victoria Avenue, Fort Frances, ON, P9A-2B7
LTC Home / Foyer de SLD :	Rainycrest 550 Osborne Street, Fort Frances, ON, P9A-3T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Taralee Morelli

To Riverside Health Care Facilities Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 must comply with s. 3 (1) 11. iii of the LTCHA, 2007. Specifically, the licensee must ensure that:

1) The identified staff member completes training provided by the licensee related to the residents' bill of rights, and signs off that they have read and understand it; and

2) Records are kept of the required training.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the right of a resident to participate fully in making any decision concerning any aspect of their care, and the right to obtain an independent opinion with regard to any of those matters, was fully respected and promoted.

A resident was admitted to the home on a day in August 2020. A number of days later, a staff member discontinued a specific medication without informing the

resident or discussing this change with them. Following the discontinuation of this medication, the resident reported experiencing symptoms, that negatively impacted their level of health and well-being. The resident indicated that they were not aware that a specific medication had been discontinued until they started to experience these symptoms. On a date in November 2020, the resident expressed to staff that they were having similar symptoms to what they had in the past, and that a certain medication had been the only thing that helped. Despite the staff member being made aware of these concerns, and the resident repeatedly requesting the medication be added back to their medication regimen, the medication was not restarted again until six months later.

Additionally, the resident was seen by a certain licensed medical professional prior to their admission to the home. A physician's letter related to the Long-Term Care placement of the resident, identified that the resident required attendance with this type of medical professional related to a medical condition. The resident asked a staff member to submit a referral to the medical professional, however, this request was refused. In November 2020, when the resident was unwell, they were provided with an emergency appointment with a community healthcare provider, who supported them seeing the medical professional. The resident again requested to be seen by this type of medical professional; however no referral was made by the staff member. A referral to the specified medical professional was not made until six months after the request.

The DOC indicated that the resident's right to participate in the decision to discontinue a specified medication, and the decision regarding consultation with another medical professional to obtain an independent opinion regarding their care, was not respected by the staff member.

Sources: Healthcare records of the resident, a referral; a physician's letter; and interviews with the resident, DOC, and the staff member. [s. 3. (1) 11. iii.] (757)

An order was made by taking the following factors into account.

Severity: There was actual risk to a resident, with discontinuation of a medication without their knowledge and consent, and failure to respect the resident's request for referral for independent opinion regarding their health and medication management.

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Scope: The scope of this non-compliance was isolated, with non-compliance identified for one out of three residents reviewed during this inspection.

Compliance History: The home’s compliance history over the past 36 months identified non-compliance with the same subsection as follows: a Voluntary Plan of Correction (VPC) during inspections #2021_841679_0013, and #2021_783742_0001. (757) (757)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Aug 06, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must comply with s. 19 (1) of the Long-Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee must ensure that:

1) The staff member reviews the home's Zero Tolerance of Abuse and Neglect policy and signs off that they have read and understand it;

2) The staff member is enrolled and completes a training program provided by the licensee. The licensee must obtain documentation of its completion;

3) A plan is developed and implemented to secure alternate services to care for the resident. The plan must be discussed with the resident, and the resident updated as to the plan's status, at specified intervals, until alternate services are secured;

4) The resident is permitted to have a support person of their choosing, present during all interactions with the staff member, until alternate services for the resident are secured; and

5) Records are kept of all of the above actions.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that a resident was protected from verbal abuse by a staff member.

Ontario Regulation (O. Reg.) 79/10, s. 2. (1), defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

In April 2021, a meeting was held with an RN, the resident, and a staff member in attendance. The resident indicated that the staff member was verbally abusive during the meeting. The home's investigation confirmed the verbal abuse. The investigation also identified that other staff in attendance should have intervened to stop the verbal abuse.

The resident said that comments made by the staff member during the meeting were very upsetting and caused them to feel belittled and a diminished sense of well-being, dignity, and self-worth.

Following the meeting, an Activity Assistant reported that the resident met with them to discuss the incident, and was upset and fearful. Additionally, the resident's healthcare record identified that on the day of the meeting, the resident did not attend meal service as they were too upset to eat.

The DOC confirmed that the incident constituted verbal abuse.

Sources: Healthcare records of the resident; the home's investigation; a CIS report; and interviews with the resident, the RN, an Activity Assistant, the DOC, and the staff member. [s. 19. (1)] (757)

An order was made by taking the following factors into account:

Severity: There was actual harm to the resident, with findings of abuse of the resident by a the staff member, and actual risk with the continued involvement of the staff member in the resident's care.

Scope: The scope of this non-compliance was isolated, as abuse was identified in one out of three residents reviewed during this inspection.

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Compliance History: The home’s compliance history over the past 36 months identified non-compliance with the same subsection as follows: a CO during inspection #2020_829757_0017, a Voluntary Plan of Correction (VPC) during inspection #2018_509617_0004, and a CO during inspections #2017_624196_0016, and #2017_463616_0011. (757) (757)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 19, 2021(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

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

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

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

Issued on this 20th day of October, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by JULIE KUORIKOSKI (621) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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Ordre(s) de l'inspecteur

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

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