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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 28, 2018	2018_657681_0006	004562-18	Resident Quality Inspection

Licensee/Titulaire de permis

St. Joseph's Health Centre of Sudbury
1140 South Bay Road SUDBURY ON P3E 0B6

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

St. Gabriel's Villa of Sudbury
4690 Municipal Road 15 Chelmsford ON P0M 1L0

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

STEPHANIE DONI (681), JENNIFER LAURICELLA (542), LISA MOORE (613)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): March 26-29, 2018, April 3-6, 2018, and April 9-10, 2018.

The following intakes were inspected during this Resident Quality Inspection:

-One intake related to CO #001 from Inspection report #2017_668543_0004, s. 8 (1) of the Ontario Regulation 79/10, specific to ensuring that inter-professional team reviews/team conferences are initiated as indicated in the home's "Fall Prevention and Management Program".

-One intake related to CO #002 from Inspection report #2017_668543_0004, s. 6 (7) of the Long-Term Care Homes Act (LTCHA),2007, specific to ensuring that care set out in the plan of care is provided as specified in the plan.

-One intake related to CO #003 from Inspection report #2017_668543_0004, s. 6 (10) (b) of the LTCHA, 2007, specific to ensuring that resident are reassessed and their plan of care are reviewed and revised whenever the residents' care needs change or the care set out in the plan is no longer necessary.

-One intake related to a complaint submitted to the Director regarding an allegation of resident to resident abuse that resulted in injury.

-Two intakes related to falls that resulted in injury to residents.

-Three intakes related to allegations of staff to resident abuse.

-Two intakes related to allegations of resident to resident abuse.

-One intake related to an allegation of visitor to resident abuse.

-One intake related to a medication incident that altered a resident's health status.

-One intake related to a disease outbreak in the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Cook, Receptionist, family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, personnel files and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **5 WN(s)**
- **1 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #003	2017_668543_0004	681
O.Reg 79/10 s. 8. (1)	CO #001	2017_668543_0004	613

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During Inspection #2017_668543_0004, compliance order (CO) #002 was issued to the home to address the licensee's failure to comply with s. 6 (7) of the Long Term Care Homes Act (LTCHA), 2007.

The CO indicated that the licensee shall:

a) Develop and implement a process to ensure that for residents #002 and #008 the care set out in the plan of care is provided as specified in the plan,

b) Develop and implement a process to ensure that all direct care staff involved in the care of residents in the home, review the residents' plans of care and are kept aware of every residents' most up to date plans of care as changes occur.

The compliance due date of this order was November 30, 2017.

While the licensee complied sections "a" and "b", non-compliance continued to be identified with s. 6 (7) of the LTCHA.

A Critical Incident System (CIS) report was submitted to the Director which identified that resident #010 had sustained a fall.

Inspector #613 reviewed resident #010's care plan, which indicated that a specific fall prevention intervention was to be implemented.

A review of the home's investigation file identified that PSW #111 found resident #010 on the floor and that PSW #111 immediately reported the fall to RN #114. RN #114 informed PSW #111 that resident #010's specified fall prevention intervention was not in place.

During an interview with PSW #111, they stated that resident #010's care plan indicated that a specific fall prevention intervention was to be implemented.

During an interview with the DOC, they confirmed that RN #114 did not follow resident #010's care plan. [s. 6. (7)]

2. Resident #018 was identified as having altered skin integrity through a record review completed by Inspector #613.

Inspector #542 completed a health care record review for resident #018. A physician's order indicated that a specified treatment was to be applied for resident #018's altered skin integrity.

On a particular day, Inspector #542 observed resident #018 in their room without the specified treatment applied.

Inspector #542 interviewed RPN #108, who verified that resident #018 was to have a specified treatment applied.

On the following day, the Inspector reviewed resident #018's progress notes and noted that RPN #108 documented that a specified treatment had been applied because it had not previously been completed. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Resident #022 was identified as having experienced a change in their continence status since their admission through an Minimum Data Set (MDS) assessment.

Inspector #681 reviewed the progress notes in resident #022's electronic medical record,

which included a progress note entered by RPN #118. The progress note indicated that a referral had been received for resident #022 related to a change in their continence status and that a specified document was to be completed. A second progress note entered by RN #123 indicated that the specified document had been completed and was forwarded to a Nursing Restorative designate for review and assessment.

The Inspector was unable to locate documentation related to the review and assessment of resident #022's completed document.

During an interview with RPN #118, they stated that a progress note had not been completed when resident #022's specified document was reviewed. However, RPN #118 showed the Inspector that an entry had been made in an excel spreadsheet, which indicated that resident #022's document had been reviewed and assessed on a particular date.

During an interview with Inspector #681, the ADOC stated that the review and assessment of the specified document should have been charted in resident #022's medical record and that the excel spreadsheet was just a tracking tool used by the nursing restorative RPNs. The ADOC verified that resident care was provided to resident #022 but was not documented. [s. 6. (9) 1.]

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. 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 has failed to ensure that the home's written policy to promote zero

tolerance of abuse and neglect of residents was complied with.

The Ontario Regulation 79/10 (O. Reg. 79/10) 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.

A CIS report was submitted to the Director related to allegations of staff to resident verbal abuse that occurred in a specified home area. The CIS report identified that PSW #116 reported that PSW #124 made inappropriate comments to residents #007, #008, and #009.

a) Inspector #681 reviewed the home' investigation notes, which indicated that PSW #116 reported to RPN #118 that PSW #124 made inappropriate comments to residents #007, #008, and #009. The home's investigation notes also indicated that the inappropriate comments directed to resident #008 occurred a week before the incidents were reported. PSW #124 subsequently received disciplinary action related to the incidents.

During an interview with Inspector #681, PSW #116 stated that they brought forth concerns about PSW #124 speaking inappropriately to residents. PSW #116 stated that they reported the concerns the day after the incidents occurred.

Inspector #681 reviewed the home's "Zero Tolerance for Abuse and Neglect" policy, which indicated that residents within the facility were to be treated with dignity and respect and were to live free from abuse and neglect. The home's policy also indicated that staff were to immediately report any alleged or witnessed incidents of resident abuse or neglect to a supervisor.

During an interview with Inspector #681, the ADOC stated that the allegation of verbal abuse was substantiated and that PSW #124 received disciplinary action related to the incident. The ADOC also stated that PSW #116 should have reported the allegations of resident abuse immediately.

b) Inspector #681 reviewed the home's PSW schedule, which indicated that PSW #124 was regularly scheduled to work in a specified home area.

The home's "Zero Tolerance for Abuse and Neglect" policy, indicated that if resident

abuse was suspected but could not be proven, the Site Administrator/designate would take steps to prevent further abuse by re-assigning the staff member to another unit.

During an interview with the Inspector, the DOC verified that PSW #124 "owned a posting" in the specified home area.

During an interview with the Administrator, they indicated that they intended to move PSW #124 to another home area, but that there was not an equal position open at that time. However, the Administrator stated that the home should have attempted to switch PSW #124 with another employee who was in a "similar posting" on another unit. The Administrator verified that the home's abuse policy was not complied with. [s. 20. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, any person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or

staff had occurred, immediately reported the suspicion and information upon which it was based to the Director.

Inspector #542 reviewed the home’s complaint files and noted a complaint from resident #028's family member, which indicated that they had concerns regarding resident #028’s skin integrity and continence status. The family member also indicated in their complaint that resident #028 could not participate in a specified activity because of their altered skin integrity.

Inspector #542 reviewed resident #028’s electronic medical record and located a progress note which indicated that the resident's family member requested that the resident's incontinence product be changed. It was noted that the resident still had their continence product on from the previous shift and that they had experienced altered skin integrity.

A review of the home’s investigation file, concluded that PSW #125 had neglected resident care and had falsely documented that care was provided. PSW #125 received disciplinary action as a result of this incident.

Inspector #542 interviewed the ADOC who verified that the complaint was not submitted to the Director and that it should have been. [s. 24. (1)]

2. A CIS report was submitted to the Director, related to allegations of staff to resident verbal abuse that occurred in a specified home area. The CIS report indicated that PSW #116 reported that PSW #124 made inappropriate comments to residents #007, #008, and #009.

Inspector #681 reviewed the home’ investigation notes, which included an email addressed to the DOC and ADOC from RN #115. The email indicated that PSW #120 had reported to RN #115 that they witnessed PSW #124 make inappropriate comments to resident #010.

The CIS report submitted by the home to the Director did not include the allegation of abuse involving resident #010.

During an interview with the ADOC, they stated that they did not believe the CIS report was updated to reflect the allegation of verbal abuse that involved resident #010. [s. 24. (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 O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #022 was identified as having experienced a change in their continence status since admission through a MDS assessment.

Inspector #681 reviewed resident #022’s admission MDS assessment, which indicated that the resident had a specified continence status. Inspector #681 also reviewed resident #022's 90 day post admission MDS assessment, which identified that the resident #022's continence status had changed.

During an interview with the Inspector, PSW #122 stated that resident #022's continence status had changed since their admission to the home and that the resident now required a specified continence intervention.

The Inspector reviewed resident #022’s electronic medical record and was unable to locate a continence assessment that was completed when resident #022’s continence status changed.

During an interview with the Inspector, RPN #104 stated that resident #022's continence status had changed. RPN #104 stated that a continence assessment should have been completed when resident #022’s continence status changed and that this was not done.

Inspector #681 reviewed the home’s policy titled “Continence Care Program”, which indicated that a Bowel and Bladder Continence Assessment was to be completed on admission and with any change that may affect continence.

During an interview with the ADOC, they stated that a continence assessment was not completed when the continence status of this resident changed and that, as per current policy, this should have been completed. [s. 51. (2) (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 each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that the resident's substitute decision-maker, if any, and any other person specified by the resident, were notified within 12 hours of the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

A CIS report was submitted to the Director, related to allegations of staff to resident verbal abuse that occurred in a specified home area. The CIS report indicated that PSW #116 reported that PSW #124 made inappropriate comments to residents #007, #008, and #009.

Inspector #681 reviewed the home' investigation notes, which included an email sent to the DOC and ADOC from RN #115. The email indicated that PSW #120 had reported to RN #115 that they witnessed PSW #124 make inappropriate comments to resident #010. The home's investigation notes did not include any documentation to support that resident #010's SDM had been notified about the allegation of verbal abuse.

During an interview with the ADOC, they stated that they did not contact resident #010's SDM and that there was no documentation to support that another staff member had notified resident #010's SDM about the allegation of verbal abuse. [s. 97. (1) (b)]

Issued on this 1st day of June, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STEPHANIE DONI (681), JENNIFER LAURICELLA (542), LISA MOORE (613)
Inspection No. / No de l'inspection :	2018_657681_0006
Log No. / No de registre :	004562-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 28, 2018
Licensee / Titulaire de permis :	St. Joseph's Health Centre of Sudbury 1140 South Bay Road, SUDBURY, ON, P3E-0B6
LTC Home / Foyer de SLD :	St. Gabriel's Villa of Sudbury 4690 Municipal Road 15, Chelmsford, ON, P0M-1L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ray Ingriselli

To St. Joseph's Health Centre of Sudbury, 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)

Linked to Existing Order / Lien vers ordre existant: 2017_668543_0004, CO #002;

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 must be compliant with s. 6. (7) of the Long-Term Care Homes Act (LTCHA).

The licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

a) how the licensee will ensure that care is provided to resident #010 as specified in the resident's plan of care, specifically related to falls prevention.

b) how the licensee will ensure that care is provided to resident #018 as specified in the resident's plan of care, specifically related to wound care.

Please submit the written plan, quoting Inspection #2018_657681_0006 and Inspector, Stephanie Doni, by email to SudburySAO.moh@ontario.ca by June 8, 2018.

Please ensure that the submitted written plan does not contain any Personal Information and/or Personal Health Information.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During Inspection #2017_668543_0004, compliance order (CO) #002 was issued to the home to address the licensee's failure to comply with s. 6 (7) of the Long Term Care Homes Act (LTCHA), 2007.

The CO indicated that the licensee shall:

a) Develop and implement a process to ensure that for residents #002 and #008 the care set out in the plan of care is provided as specified in the plan,

b) Develop and implement a process to ensure that all direct care staff involved in the care of residents in the home, review the residents' plans of care and are kept aware of every residents' most up to date plans of care as changes occur.

The compliance due date of this order was November 30, 2017.

While the licensee complied sections "a" and "b", non-compliance continued to be identified with s. 6 (7) of the LTCHA.

A Critical Incident System (CIS) report was submitted to the Director which identified that resident #010 had sustained a fall.

Inspector #613 reviewed resident #010's care plan, which indicated that a specific fall prevention intervention was to be implemented.

A review of the home's investigation file identified that PSW #111 found resident #010 on the floor and that PSW #111 immediately reported the fall to RN #114. RN #114 informed PSW #111 that resident #010's specified fall prevention intervention was not in place.

During an interview with PSW #111, they stated that resident #010's care plan indicated that a specific fall prevention intervention was to be implemented.

During an interview with the DOC, they confirmed that RN #114 did not follow resident #010's care plan.

2. Resident #018 was identified as having altered skin integrity through a record review completed by Inspector #613.

Inspector #542 completed a health care record review for resident #018. A

physician's order indicated that a specified treatment was to be applied for resident #018's altered skin integrity.

On a particular day, Inspector #542 observed resident #018 in their room without the specified treatment applied.

Inspector #542 interviewed RPN #108, who verified that resident #018 was to have a specified treatment applied.

On the following day, the Inspector reviewed resident #018's progress notes and noted that RPN #108 documented that a specified treatment had been applied because it had not previously been completed.

The severity of this issue was determined to be a level two, as there was minimal harm or potential for actual harm to the residents of the home. The scope of the issue was a level one, as it only related to two residents reviewed during the RQI. The home had a level four compliance history, as they had ongoing non-compliance with this section of the LTCHA that included:

-written notification (WN) issued July 21, 2015, (#2015_380593_0015);

-voluntary plan of correction (VPC) issued November 3, 2015, (#2015_282543_0023

-compliance order (CO) issued May 31, 2016, with a compliance due date (CDD) of July 12, 2016, (#2016_320612_0007).

-CO issued November 7, 2017, with a compliance due date of November 30, 2017. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 22, 2018

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. 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 must be compliant with s. 20. (1) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee must

a) ensure that all employees who witness or suspect that a resident is being abused or neglected immediately report the allegations as per the home's policy.

b) develop and implement a process to ensure that staff are aware of what constitutes resident abuse and neglect and that they are aware of the appropriate process for reporting these allegations.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The Ontario Regulation 79/10 (O. Reg. 79/10) 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.

A CIS report was submitted to the Director related to allegations of staff to resident verbal abuse that occurred in a specified home area. The CIS report identified that PSW #116 reported that PSW #124 made inappropriate

comments to residents #007, #008, and #009.

a) Inspector #681 reviewed the home' investigation notes, which indicated that PSW #116 reported to RPN #118 that PSW #124 made inappropriate comments to residents #007, #008, and #009. The home's investigation notes also indicated that the inappropriate comments directed to resident #008 occurred a week before the incidents were reported. PSW #124 subsequently received disciplinary action related to the incidents.

During an interview with Inspector #681, PSW #116 stated that they brought forth concerns about PSW #124 speaking inappropriately to residents. PSW #116 stated that they reported the concerns the day after the incidents occurred.

Inspector #681 reviewed the home's "Zero Tolerance for Abuse and Neglect" policy, which indicated that residents within the facility were to be treated with dignity and respect and were to live free from abuse and neglect. The home's policy also indicated that staff were to immediately report any alleged or witnessed incidents of resident abuse or neglect to a supervisor.

During an interview with Inspector #681, the ADOC stated that the allegation of verbal abuse was substantiated and that PSW #124 received disciplinary action related to the incident. The ADOC also stated that PSW #116 should have reported the allegations of resident abuse immediately.

b) Inspector #681 reviewed the home's PSW schedule, which indicated that PSW #124 was regularly scheduled to work in a specified home area.

The home's "Zero Tolerance for Abuse and Neglect" policy, indicated that if resident abuse was suspected but could not be proven, the Site Administrator/designate would take steps to prevent further abuse by re-assigning the staff member to another unit.

During an interview with the Inspector, the DOC verified that PSW #124 "owned a posting" in the specified home area.

During an interview with the Administrator, they indicated that they intended to move PSW #124 to another home area, but that there was not an equal position open at that time. However, the Administrator stated that the home should have attempted to switch PSW #124 with another employee who was in a "similar

posting" on another unit. The Administrator verified that the home's abuse policy was not complied with.

The severity of this issue was determined to be a level two, as there was minimal harm or potential for actual harm to the residents of the home. The scope of the issue was a level one, as it only related to one resident reviewed. The home had a level four compliance history, as they had ongoing non-compliance with this section of the LTCHA that included:

- written notification (WN) issued April 30, 2015, (#2015_380593_0006);

- WN issued July 21, 2015, (#2015_380593_0015);

- voluntary plan of correction (VPC) issued February 9, 2017, (#2017_615638_0004);

- VPC issued July 4, 2017, (#2017_668543_0004). (681)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 29, 2018

Order # / Ordre no : 003

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 must be compliant with s. 24 (1) of the Long-Term Care Homes Act (LTCHA).

Specifically, any person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff has occurred, immediately report the suspicion and information upon which it was based to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that, any person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff had occurred, immediately reported the suspicion and information upon which it was based to the Director.

Inspector #542 reviewed the home's complaint files and noted a complaint from resident #028's family member, which indicated that they had concerns regarding resident #028's skin integrity and continence status. The family member also indicated in their complaint that resident #028 could not participate in a specified activity because of their altered skin integrity.

Inspector #542 reviewed resident #028's electronic medical record and located a progress note which indicated that the resident's family member requested that the resident's incontinence product be changed. It was noted that the resident still had their continence product on from the previous shift and that they had experienced altered skin integrity.

A review of the home's investigation file, concluded that PSW #125 had neglected resident care and had falsely documented that care was provided. PSW #125 received disciplinary action as a result of this incident.

Inspector #542 interviewed the ADOC who verified that the complaint was not submitted to the Director and that it should have been.

2. A CIS report was submitted to the Director, related to allegations of staff to resident verbal abuse that occurred in a specified home area. The CIS report indicated that PSW #116 reported that PSW #124 made inappropriate comments to residents #007, #008, and #009.

Inspector #681 reviewed the home' investigation notes, which included an email addressed to the DOC and ADOC from RN #115. The email indicated that PSW #120 had reported to RN #115 that they witnessed PSW #124 make inappropriate comments to resident #010.

The CIS report submitted by the home to the Director did not include the allegation of abuse involving resident #010.

During an interview with the ADOC, they stated that they did not believe the CIS report was updated to reflect the allegation of verbal abuse that involved resident #010.

The severity of this issue was determined to be a level two, as there was minimal harm or potential actual harm to the residents of the home. The scope of the issue was a level one, as it only related to two residents reviewed. The home had a level four compliance history, as they had ongoing non-compliance with this section of the LTCHA that included:

- voluntary plan of correction (VPC) issued April 30, 2015, (#2015_380593_0006);

- VPC issued January 22, 2016, (#2015_264609_0059);

- VPC issued February 9, 2017, (#2017_615638_0004);

- VPC issued July 4, 2017, (#2017_668543_0004); (681)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 22, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 28th day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Stephanie Doni

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