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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 22, 2016	2016_463616_0013	008121-16	Complaint

Licensee/Titulaire de permis

AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
130 ELM STREET SUDBURY ON P3C 1T6

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

CEDARWOOD LODGE
860 GREAT NORTHERN ROAD SAULT STE. MARIE ON P6A 5K7

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

JENNIFER KOSS (616), SHEILA CLARK (617)

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): May 16-19, 2016

This Complaint inspection is related to issues raised at a meeting in the home that included the licensee's responsibility to post the home's license, and a suspected health hazard concern related to air quality in the basement of the home. Additional Complaint logs were also inspected related to the improper care of a resident which resulted in injury, and posting of the home's license and accommodation charges.

Concurrent inspections included Follow Up inspection #2016_463616_0012, Critical Incident inspection #2016_339617_0019, and Other inspection #2016_339617_0020.

Observations were made of the home areas, including the basement, and the provision of care and services to residents during the inspection. Many of the home's policies and procedures, and resident health records were reviewed.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care (DOC), the Resident Quality Manager (RQM), the Director of Support Services (DSS), maintenance staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members, and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Admission and Discharge
Prevention of Abuse, Neglect and Retaliation

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.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 a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) in February 2016, regarding an injury sustained by resident #012 during a service received from a contracted service provider.

During Inspector #616's interview with the complainant, they stated that their concern was related to the skill and competency level of the home's contracted service provider. They stated that this concern had been raised at a recent meeting at the home when the Director of Care was present, but they were unable to confirm the date of the meeting.

During an interview with the Director of Care (DOC), they stated to Inspector #616 that they had no knowledge of this resident's injury.

A review of progress notes in resident #012's health record revealed an incident in January 2016. Registered Nurse (RN) #100 had documented that the resident had reported to them that during an appointment with the contracted service provider, they sustained an injury. The RN documented that the contracted service provider had not

reported the resident's injury to staff. Further review of the progress notes documented that the resident had received an analgesic this same day related to pain from the injury, and an order was obtained the following day for treatment to the area.

The Inspector reviewed the home's policy titled "Prevention of Abuse & Neglect of a Resident", #VII-G-10.00, last revised January 2015, which for reporting purposes defined abuse as, but not limited to: "improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident".

During an interview with the Resident Quality Manager, they stated that the contracted service provider should have reported this incident to registered staff if they were aware of the injury. They stated that the RN should have reported the incident to the DOC when they became aware of it.

During an interview with the DOC, they stated the registered staff should have immediately reported this injury as improper or incompetent care which resulted in harm to resident #012. [s. 24. (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. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written response was provided to the Family Council within 10 days of receiving concerns or recommendations under either paragraph 8 or 9 of subsection (1).

A complaint was received by the MOHLTC on March 7, 2016, related to a suspected potential health hazard posed by air quality in the basement of the building, and the licensee not posting the home's long-term care license as required.

A review of minutes from a Family Council meeting dated March 3, 2016, included these two issues raised during the meeting.

During a meeting with the DOC, they stated they had not provided a response to Family Council within 10 days, but did so on March 31, 2016, 20 days after the concerns were raised. [s. 60. (2)]

Issued on this 10th day of August, 2016

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) :	JENNIFER KOSS (616), SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2016_463616_0013
Log No. / Registre no:	008121-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 22, 2016
Licensee / Titulaire de permis :	AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC. 130 ELM STREET, SUDBURY, ON, P3C-1T6
LTC Home / Foyer de SLD :	CEDARWOOD LODGE 860 GREAT NORTHERN ROAD, SAULT STE. MARIE, ON, P6A-5K7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rudy Putton

To AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 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. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall:

a) Ensure that all staff members, volunteers, agency staff, private duty caregivers, contracted service providers, leadership team, and all others who provide care to residents are trained and retrained on zero tolerance of abuse and neglect of residents. This includes the home's current policy titled "Prevention of Abuse and Neglect of a Resident", #VII-G-10.00.

b) Ensure training records are maintained of the participants, as well as the content of the training.

Grounds / Motifs :

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 harm or a risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) in February 2016, regarding an injury sustained by resident #012 during a service received from a contracted service provider.

During Inspector #616's interview with the complainant, they stated that their concern was related to the skill and competency level of the home's contracted service provider. They stated that this concern had been raised at a recent meeting at the home when the Director of Care was present, but they were unable to confirm the date of the meeting.

During an interview with the Director of Care (DOC), they stated to Inspector #616 that they had no knowledge of this resident's injury.

A review of progress notes in resident #012's health record revealed an incident in January 2016. Registered Nurse (RN) #100 had documented that the resident had reported to them that during an appointment with the contracted service provider, they sustained an injury. The RN documented that the contracted service provider had not reported the resident's injury to staff. Further review of the progress notes documented that the resident had received an analgesic this same day related to pain from the injury, and an order was obtained the following day for treatment to the area.

The Inspector reviewed the home's policy titled "Prevention of Abuse & Neglect of a Resident", #VII-G-10.00, last revised January 2015, which for reporting purposes defined abuse as, but not limited to: "improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident".

During an interview with the Resident Quality Manager, they stated that the contracted service provider should have reported this incident to registered staff if they were aware of the injury. They stated that the RN should have reported the incident to the DOC when they became aware of it.

During an interview with the DOC, they stated the registered staff should have immediately reported this injury as improper or incompetent care which resulted in harm to resident #012.

The decision to issue an order was based on the actual harm of resident #012. Although the scope was isolated, there was a history of previous non-compliance specific to LTCHA 2007, S.O. 2007, c. 8, s. 24 (1) identified during the following inspections:

-A voluntary plan of correction (VPC) was issued in Critical Incident System Inspection #2015_395613_0022, served to the home on February 4, 2016,

-A written notification (WN) was issued in 2015_281542_0021 served to the home on December 22, 2015. (616)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 07, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Koss

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