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

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Public Copy/Copie 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
Jan 5, 2022	2021_678577_0006	013707-21, 013763-21	Complaint

Licensee/Titulaire de permis

Chartwell Master Care LP
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

Chartwell Parkhill Long Term Care Residence
250 Tain Street P.O. Box 129 Parkhill ON N0M 2K0

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

DEBBIE WARPULA (577)

Inspection Summary/Résumé de l'inspection

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

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

This inspection was conducted on the following date(s): November 25, 26 and 29, 2021.

The following intakes were inspected on during this Complaint inspection:
-two logs related to alleged employee theft from the residents and the home.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Services Manager/Food Services Manager (ESM/FSM), a Constable with the Ontario Provincial Police (OPP), Registered Nurse (RN), Registered Practical Nurses (RPNs), Dietary Aides (DAs), Housekeeping Aides (HAs), Laundry Aides (LAs), Maintenance Aide (MA), Personal Support Workers (PSWs), residents and a family member.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, Infection Prevention and Control (IPAC) practices, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 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	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. 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 residents were protected from financial abuse

by a Housekeeping Aide (HA).

Two complaints were received by the Director on an identified date, which outlined allegations of theft of resident's belongings and items from the home. The report indicated that the allegations of theft by a HA were substantiated, theft had been occurring over a specified time, it had been reported to a Manager on several occasions and nothing was done. Additionally, the thefts were never reported to the Ministry.

O. Reg. 79/10 defines financial abuse as any misappropriation or misuse of a resident's money or property.

A review of the home's policy "Abuse Allegations and Follow-Up -LTC-CA-WQ-100-05-02" effective December 2021, indicated that the home had a zero tolerance of abuse of any type and defined financial abuse as any misappropriation or misuse of a resident's money or property. If the alleged abuser was an employee, they were to be removed to an alternative area and/or may be sent home pending completion of the investigation based on the situation.

A review of the home's policy "Theft – ALL-CA-ALL-600-03-10", effective May 2007, indicated that theft of any kind would not be tolerated and defined it as taking or consuming food or supplies; use or theft of property belonging to residents.

A review of the investigation file which contained staff interviews and handwritten notes from staff, indicated that the HA had been stealing specified items from the home and residents belongings over a specified time period.

During an interview with a Laundry Aide (LA), they showed Inspector #577 a text message received from the HA on a specified date, which indicated that they had a garbage bag that contained specified items and stated, "the sun room was full of goodies when you could get in there and not get caught and that they could find a lot of goodies".

During staff interviews with two LA's and a Maintenance Aide (MA), they reported that the HA had been stealing resident belongings and items from the home over a specified time period.

During an interview with the MA, they showed a letter of meeting notes from a specified date, which was a written statement of events from a specified date, that was reported to the Assistant Director of Care (ADOC). The letter indicated that on a specified date, they

entered the HA's housekeeping room and found two garbage bags full of specified items from the home and residents. Advised that they reported it to the ADOC. During an interview with the ADOC, they reported that the statement taken on an identified date was not investigated.

During an interview with the DOC they reported that on an identified date, the MA had reported that staff had observed items from the home in the HA's housekeeping room and were concerned of theft. The investigation confirmed that the allegations of theft were substantiated and that they had removed items from the home that belonged to residents and items that belonged to the home over a specified time period. They advised it was financial abuse. They further reported that staff had reported to them that they had been reporting allegations of theft to a Manager and nothing was being done. They further advised that the Manager had never advised them of any concerns of theft.

Sources: two complaints, the home's policy Abuse Allegations and Follow-Up (LTC-CA-WQ-100-05-02 effective December 2021), Theft (ALL-CA-ALL-600-03-10 effective May 2007), Abuse Free Communities-Prevention, Education and Analysis (LTC-CA-WQ-100-05-18 effective December 2021), review of the home's investigation file, review of abuse training records and interviews with the DOC and other staff. [s. 19. (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 staff complied with the home's zero tolerance of abuse of residents policy in regard to investigating financial abuse of residents.

A review of the home's policy "Abuse Allegations and Follow-Up – LTC-CA-WQ-100-05-02" effective December 2021, indicated that if the employee was the alleged abuser, the employee was to be removed to an alternative area and/or may be sent home pending completion of the investigation.

A review of the home's policy "Theft - ALL-CA-ALL-600-03-10" effective May 2007, indicated that employees suspected of theft would be relieved from duty with pay pending the outcome of the investigation.

During an interview with the DOC, they reported to Inspector #577 that on an identified date, a MA had reported that staff had observed items from the home in a HA's housekeeping room and were concerned of theft. They advised that they had not immediately suspended the HA, when they were made aware of the allegations of theft.

Sources: two complaints, the home's policy Abuse Allegations and Follow-Up (LTC-CA-WQ-100-05-02 effective December 2021), Theft (ALL-CA-ALL-600-03-10 effective May 2007), review of the home's investigation file, and an interview with the DOC. [s. 20. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by the licensee or staff, that the licensee knew of, or that was reported to the licensee, was immediately investigated.

Two complaints were received by the Director on an identified date, which outlined allegations of theft of resident's belongings and items from the home. The report indicated that the allegations of theft by a HA were substantiated, theft had been occurring over a specified time period, it had been reported to a Manager on several occasions and nothing was done.

O. Reg. 79/10 defines financial abuse as any misappropriation or misuse of a resident's money or property.

a) A review of policy ""Theft - ALL-CA-ALL-600-03-10" revised May 2007, indicated that theft of any kind would not be tolerated; including taking or consuming food or supplies and the use or theft of property belonging to residents. Theft was defined as the unauthorized use or possession of property, money and/or time that does not belong to the employee. Any theft must be reported immediately to the Manager/Administrator. Allegations of theft would be investigated immediately.

During staff interviews, they advised that they had been reporting theft of resident belongings and items from the home by a HA over a specified time period, to a Manager

and nothing was done.

A review of the home’s investigation notes indicated that staff had previously reported allegations of theft to the Manager and nothing was done.

During an interview with the DOC they reported that on an identified date, a MA had reported that staff had observed items from the home in HA’s housekeeping room and were concerned of theft. The investigation confirmed that the allegations of theft were substantiated and that they had removed items from the home that belonged to residents and items that belonged to the home over a specified time period. They advised it was financial abuse. They further reported that staff had reported to them that they had been reporting allegations of theft to a Manager and nothing was being done. They further advised that the Manager had never advised them of any concerns of theft.

b) During an interview with the MA, they showed a letter of meeting notes on an identified date, which was a written statement of events from an identified date, that was reported to the ADOC. The letter indicated that on an identified date, they entered the HA’s housekeeping room and found two garbage bags full of specified items of the home and of resident's items. Advised that they reported it to the ADOC.

During an interview with the ADOC they reported that the statement taken on an identified date was not investigated.

Sources: two complaints, the home's policy Theft (ALL-CA-ALL-600-03-10 effective May 2007), Abuse Allegations and Follow-Up (LTC-CA-WQ-100-05-02 effective December 2021), review of the home's investigation file, and an interview with the ADOC and other staff. [s. 23. (1) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had 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: Abuse of a resident by the licensee or staff that resulted in harm or a risk of harm to the residents.

Two complaints were received by the Director on an identified date, which outlined allegations of theft of resident's belongings and items from the home. The report indicated that the allegations of theft by a HA were substantiated, theft had occurred over a specified time period, it had been reported to a Manager on several occasions and nothing was done. Additionally, the thefts were never reported to the Ministry.

O. Reg. 79/10 defines financial abuse as any misappropriation or misuse of a resident's money or property.

A review of the home's policy "Critical Incidents/Reportable Incidents - LTC-CA-WQ-100-05-04" effective December 2021, indicated that financial abuse was the misuse of the funds and assets of a person in care by a person not in care, or the obtaining of the property and funds of a person in care by a person not in care without the knowledge and full consent of the person in care or his or her parent or representative. The Director of Care /designate or the Administrator was responsible to notify the Director via the Critical Incident System.

A review of the home's policy "Abuse Free Communities-Prevention, Education and Analysis – LTC-CA-WQ-100-05-18" effective December 2021, indicated that the home had zero tolerance of abuse of any type. Furthermore they had a zero tolerance with respect to failure to report abuse of any kind.

During an interview with the DOC, they advised that they had not reported theft of resident's belongings and items from the home as a Critical Incident to the Ministry. They also advised that during the investigation, staff had reported that they had been reporting suspected theft to a Manager and nothing was being done.

Sources: two complaints, the home's policy Abuse Free Communities-Prevention, Education and Analysis (LTC-CA-WQ-100-05-18 effective December 2021), Critical Incidents/Reportable Incidents (LTC-CA-WQ-100-05-04 effective December 2021), review of the home's investigation file, and an interview with the DOC. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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: Abuse of a resident by the licensee or staff that resulted in harm or a risk of harm to the residents, 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 failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Two complaints were received by the Director on an identified date, which outlined allegations of theft of resident's belongings and items from the home. The report indicated that the allegations of theft by a HA were substantiated, theft had been occurring over a specified time period, it had been reported to a Manager on several occasions and nothing was done. Additionally, the thefts were never reported to the Ministry.

During an interview with the DOC, they advised that the allegations of theft from residents and from the home over a specified time period by the HA was substantiated. They further confirmed that it was financial abuse and they had not notified any resident's substitute decision-makers.

Sources: two complaints, the home's policy Abuse Free Communities-Prevention, Education and Analysis (LTC-CA-WQ-100-05-18 effective December 2021), and an interview with the DOC. [s. 97. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse of a resident that the licensee suspected may have constituted a criminal offence.

Two complaints were received by the Director on an identified date, which outlined allegations of theft of resident's belongings and items from the home. The report indicated that the allegations of theft by a HA were substantiated and theft had been occurring over a specified time period.

A review of the home's policy "Abuse Allegations and Follow-Up – LTC-CA-WQ-100-05-02" effective December 2021, indicated that the home was to immediately report to police all allegations of financial abuse of a resident, either monetary or personal property.

During an interview with the DOC, they reported to Inspector #577 that their investigation had confirmed theft of resident's belongings and items from the home by the HA, and they had not notified the police.

Sources: two complaints, the home's policy Abuse Allegations and Follow-Up (LTC-CA-WQ-100-05-02 effective December 2021), and an interview with a Constable with the Ontario Provincial Police (OPP) and the DOC. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

Issued on this 6th day of January, 2022

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBBIE WARPULA (577)
Inspection No. / No de l'inspection :	2021_678577_0006
Log No. / No de registre :	013707-21, 013763-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 5, 2022
Licensee / Titulaire de permis :	Chartwell Master Care LP 7070 Derrycrest Drive, Mississauga, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Parkhill Long Term Care Residence 250 Tain Street, P.O. Box 129, Parkhill, ON, N0M-2K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tania Taylor

To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 : 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. 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 be compliant with s. 19 (1) of O. Reg. 79/10.

Specifically the licensee must:
a) Ensure all residents are protected from abuse and neglect
b) Ensure that every alleged, suspected or witnessed incident of abuse and neglect of a resident is immediately investigated, and appropriate action is taken in response to every such incident
c) Train all staff on the abuse and neglect policies, specifically related to abuse prevention, recognition, response, and reporting requirements as identified in the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10
d) Maintain records of training
e) Immediately report to the Director all incidents of alleged, suspected or witnessed abuse
f) Develop and implement a monitoring system to ensure that abuse and neglect is reported as required by this section
g) Develop and implement a system to monitor compliance with the home's abuse and neglect policies
h) Notify the resident's SDM immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident within 12 hours
i) Immediately notify the appropriate police force of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from financial abuse by a Housekeeping Aide (HA).

Two complaints were received by the Director on an identified date, which outlined allegations of theft of resident's belongings and items from the home. The report indicated that the allegations of theft by a HA were substantiated, theft had been occurring over a specified time, it had been reported to a Manager on several occasions and nothing was done. Additionally, the thefts were never reported to the Ministry.

O. Reg. 79/10 defines financial abuse as any misappropriation or misuse of a resident's money or property.

A review of the home's policy "Abuse Allegations and Follow-Up -LTC-CA-WQ-100-05-02" effective December 2021, indicated that the home had a zero tolerance of abuse of any type and defined financial abuse as any misappropriation or misuse of a resident's money or property. If the alleged abuser was an employee, they were to be removed to an alternative area and/or may be sent home pending completion of the investigation based on the situation.

A review of the home's policy "Theft – ALL-CA-ALL-600-03-10", effective May 2007, indicated that theft of any kind would not be tolerated and defined it as taking or consuming food or supplies; use or theft of property belonging to residents.

A review of the investigation file which contained staff interviews and handwritten notes from staff, indicated that the HA had been stealing specified items from the home and residents belongings over a specified time period.

During an interview with a Laundry Aide (LA), they showed Inspector #577 a text message received from the HA on a specified date, which indicated that they had a garbage bag that contained specified items and stated, "the sun room was full of goodies when you could get in there and not get caught and that they could find a lot of goodies".

During staff interviews with two LA's and a Maintenance Aide (MA), they reported that the HA had been stealing resident belongings and items from the home over a specified time period.

During an interview with the MA, they showed a letter of meeting notes from a specified date, which was a written statement of events from a specified date, that was reported to the Assistant Director of Care (ADOC). The letter indicated that on a specified date, they entered the HA's housekeeping room and found two garbage bags full of specified items from the home and residents. Advised that they reported it to the ADOC. During an interview with the ADOC, they reported that the statement taken on an identified date was not investigated.

During an interview with the DOC they reported that on an identified date, the MA had reported that staff had observed items from the home in the HA's housekeeping room and were concerned of theft. The investigation confirmed that the allegations of theft were substantiated and that they had removed items from the home that belonged to residents and items that belonged to the home over a specified time period. They advised it was financial abuse. They further reported that staff had reported to them that they had been reporting allegations of theft to a Manager and nothing was being done. They further advised that the Manager had never advised them of any concerns of theft.

Sources: two complaints, the home's policy Abuse Allegations and Follow-Up (LTC-CA-WQ-100-05-02 effective December 2021), Theft (ALL-CA-ALL-600-03-10 effective May 2007), Abuse Free Communities-Prevention, Education and Analysis (LTC-CA-WQ-100-05-18 effective December 2021), review of the home's investigation file, review of abuse training records and interviews with the DOC and other staff. [s. 19. (1)]

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

Severity: There was minimal harm to residents

Scope: The scope of this non-compliance was widespread

Compliance history: The licensee was found to be non-compliant with different sections of the legislation in the last 36 months.

(577)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 16, 2022

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:

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

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 5th day of January, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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