



**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

**Ministère 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

**Health System Accountability and Performance Division
Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité**

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2011_054133_0030
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Dec 6, 7, 13, 15, 20, 22, 2011
Licensee / Titulaire de permis :	F. J. DAVEY HOME 733 Third Line East, Box 9600, Sault Ste Marie, ON, P6A-7C1
LTC Home / Foyer de SLD :	F. J. DAVEY HOME 733 Third Line East, Sault Ste Marie, ON, P6A-7C1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PETER J. MACLEAN

To F. J. DAVEY HOME, you are hereby required to comply with the following order(s) by the date(s) set out below:



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Order # /	Order Type /
Ordre no : 001	Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
 - i. participate fully in the development, implementation, review and revision of his or her plan of care,
 - ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
 - iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
 - iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
 - i. the Residents' Council,
 - ii. the Family Council,
 - iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
 - iv. staff members,
 - v. government officials,



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vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with the requirement that residents' right to be protected from abuse is fully respected and promoted. The plan is to be submitted in writing to Long Term Care Homes Inspector Jessica Lapensee, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 347 Preston street, 4th floor, Ottawa, ON, K1S-3J4 by January 5th, 2012.

Grounds / Motifs :

1. Related to Log # S-001387-11: An incident of staff to resident abuse occurred in June 2011. The abuse was perpetrated by a Personal Support Worker (PSW).

As reported by the resident who experienced the abuse, the PSW was rough and impatient during the provision of evening care, hurting their nose during the removal of their sweater, grabbing them in a rough manner and holding their arms too tightly. The resident also reported that the PSW made an offensive comment that was very upsetting to them.

The resident's right to be protected from abuse was not fully respected and promoted [LTCHA 2007, S.O. 2007, c.8, s.3(2)]

Related to Log # S-001480-11: A second incident of staff to resident abuse occurred in June 2011. The abuse was perpetrated by a Personal Support Worker (PSW).

Two PSWs were providing care to a resident. As one of the PSWs began undressing the resident, the resident became agitated, verbally resisted care and started slapping out at the PSW. The second PSW then witnessed the PSW attempting to undress the resident, slap the resident on the arm. The resident stated that they were going to call the police and the PSW responded that they were going to call the police as well.

The resident's right to be protected from abuse was not fully respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3(2)] (133)



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**Ministère 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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2012



**Ministry of Health and
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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

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the

Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.



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RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 December, 2011

**Signature of Inspector /
Signature de l'inspecteur :**

Jessica Lapensee

**Name of Inspector /
Nom de l'inspecteur :**

JESSICA LAPENSEE

Service Area Office /

Bureau régional de services : Sudbury Service Area Office



**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
prévus le Loi de 2007 les
foyers de soins de longue**

Health System Accountability and Performance
Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la performance et de la
conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Dec 6, 7, 13, 15, 20, 22, 2011	2011_054133_0030	Critical Incident

Licensee/Titulaire de permis

F. J. DAVEY HOME
733 Third Line East, Box 9600, Sault Ste Marie, ON, P6A-7C1

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

F. J. DAVEY HOME
733 Third Line East, Sault Ste Marie, ON, P6A-7C1

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the CEO/Administrator, the Executive Manager of Nursing Services, the Directors of Nursing, Registered Nursing staff, Personal Support Workers and Residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas and reviewed the following: two Critical Incident Reports, documents related to the home's investigation into these reported incidents, a resident's health care record and the licensee's policy to promote zero tolerance of abuse and neglect entitled "Resident Abuse" (review date April 2004).

This Critical Incident inspection addressed Log # S-001480-11 and Log # S-001387-11.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



**Ministry of Health and
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**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection
prévus le Loi de 2007 les
foyers de soins de longue**

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

- 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.**
- 2. Every resident has the right to be protected from abuse.**
- 3. Every resident has the right not to be neglected by the licensee or staff.**
- 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.**
- 5. Every resident has the right to live in a safe and clean environment.**
- 6. Every resident has the right to exercise the rights of a citizen.**
- 7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.**
- 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.**
- 9. Every resident has the right to have his or her participation in decision-making respected.**
- 10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.**
- 11. Every resident has the right to,**
 - i. participate fully in the development, implementation, review and revision of his or her plan of care,**
 - ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
 - iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
 - iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.**
- 12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.**
- 13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.**
- 14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.**
- 15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.**
- 16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.**
- 17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,**
 - i. the Residents' Council,**
 - ii. the Family Council,**
 - iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,**
 - iv. staff members,**
 - v. government officials,**
 - vi. any other person inside or outside the long-term care home.**
- 18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.**
- 19. Every resident has the right to have his or her lifestyle and choices respected.**
- 20. Every resident has the right to participate in the Residents' Council.**
- 21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.**

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Related to Log # S-001387-11: An incident of staff to resident abuse occurred in June 2011. The abuse was perpetrated by a Personal Support Worker (PSW).

As reported by the resident who experienced the abuse, the PSW was rough and impatient during the provision of evening care, hurting their nose during the removal of their sweater, grabbing them in a rough manner and holding their arms too tightly. The resident also reported that the PSW made an offensive comment that was very upsetting to them.

The resident's right to be protected from abuse was not fully respected and promoted [LTCHA 2007, S.O. 2007, c.8, s.3 (2)]

Related to Log # S-001480-11: A second incident of staff to resident abuse occurred in June 2011. The abuse was perpetrated by a Personal Support Worker (PSW) and witnessed by another PSW.

Two PSWs were providing care to a resident. As one of the PSWs began undressing the resident, the resident became agitated, verbally resisted care and started slapping out at the PSW. The second PSW then witnessed the PSW attempting to undress the resident, slap the resident on the arm. The resident stated that they were going to call the police and the PSW responded that they were going to call the police as well.

The resident's right to be protected from abuse was not fully respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3 (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

- s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
- (a) shall provide that abuse and neglect are not to be tolerated;
 - (b) shall clearly set out what constitutes abuse and neglect;
 - (c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
 - (d) shall contain an explanation of the duty under section 24 to make mandatory reports;
 - (e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
 - (f) shall set out the consequences for those who abuse or neglect residents;
 - (g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
 - (h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).
-

Findings/Faits saillants :

1. The licensee's policy to promote zero tolerance of abuse and neglect of residents, entitled Resident Abuse (review date April 2004), does not contain an explanation of the duty under section 24 of the Act to make mandatory reports. [LTCHA 2007, c.8, s.20(2)d]

The licensee's policy to promote zero tolerance of abuse and neglect of residents, entitled Resident Abuse (review date April 2004), does not set out consequences for those who abuse or neglect residents. [LTCHA 2007, c.8, s.20(2)f]

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 with the requirement that the policy to promote zero tolerance of abuse and neglect contains an explanation of the duty under section 24 of the Act to make mandatory reports and sets out consequences for those who abuse or neglect residents, to be implemented voluntarily.

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 subsections:

- 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, ss. 24 (1), 195 (2).
-

Findings/Faits saillants :

1. Related to Log # S-001387-11: On a day in June 2011, a resident reported to a Personal Support Worker (PSW) that another PSW was rough with them during the provision of care and also made a comment that was offensive to them.

The PSW who received this report of abuse from the resident immediately reported it to a Registered Practical Nurse (RPN). The Director of Care for the area in which the resident resides became aware of this incident of abuse on the following day.

The Director was notified of this incident two days after it occurred, by way of a Critical Incident Report.

The licensee failed to ensure the Director was immediately informed of the suspected abuse of a resident. [LTCHA 2007, S.O 2007, c.8, s24(1)2]

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 with the requirement that any person who has reasonable grounds to suspect abuse of a resident by anyone reports the suspicion and the information upon which it is based immediately to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records
Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. As per s.20 of LTCHA 2007, c.8, the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents. The licensee's policy to promote zero tolerance of abuse and neglect of residents is entitled "Resident Abuse" with a review date of April 2004.

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect is in compliance with the Act.

The policy describes sexual abuse as "any sexual behavior, assault or harassment directed toward a person without his or her consent". This definition is not in line with the definition of sexual abuse in O. Reg 79/10, s (2)1, specifically with regards to the concept of consent and the distinction between actions of the licensee or staff member and actions by persons other than a licensee or staff member. [O. Reg 79/10, s. 8(1)a]

The policy describes physical abuse as "any act of violence or rough handling that may or may not result in physical injury includes but is not limited to.....". This definition is not in line with the definition of physical abuse in O. Reg 79/10, s.(2)1, specifically with regards to the distinction between what constitutes resident to resident physical abuse and what constitutes physical abuse of a resident by anyone other than a resident. [O. Reg 79/10, s. 8(1)a]

The policy fails to reflect the distinction between emotional abuse of a resident by another resident and emotional abuse of a resident by anyone other than a resident, as is defined in O. Reg 79/10, s(2)1. [O. Reg 79/10, s. 8(1)a]

The policy fails to explicitly describe what constitutes verbal abuse and does not reflect the distinction between verbal abuse of a resident by another resident and verbal abuse of a resident by anyone other than a resident, as is defined in O. Reg 79/10, s(2)1. [O. Reg 79/10, s. 8(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 with the requirement that the policy to promote zero tolerance of abuse and neglect of residents is in compliance with the Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following subsections:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

2. A description of the individuals involved in the incident, including,

i. names of all residents involved in the incident,

ii. names of any staff members or other persons who were present at or discovered the incident, and

iii. names of staff members who responded or are responding to the incident.

3. Actions taken in response to the incident, including,

i. what care was given or action taken as a result of the incident, and by whom,

ii. whether a physician or registered nurse in the extended class was contacted,

iii. what other authorities were contacted about the incident, if any,

iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and

v. the outcome or current status of the individual or individuals who were involved in the incident.

4. Analysis and follow-up action, including,

i. the immediate actions that have been taken to prevent recurrence, and

ii. the long-term actions planned to correct the situation and prevent recurrence.

5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. Related to log S-001387-11: The Critical Incident report submitted to the Director about the alleged abuse of a resident did not contain the name of the staff person who was the alleged abuser. [O. Reg 79/10, s. 104(1)2ii]

Issued on this 12th day of January, 2012



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
prévue le Loi de 2007 les
foyers de soins de longue

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

Jessica Lapensée