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

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) :	MELISSA CHISHOLM (188)
Inspection No. / No de l'inspection :	2012_099188_0025
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Jul 3, 4, 5, 19, 20, 25, 2012
Licensee / Titulaire de permis :	~~Sault Area Hospital~~ → Extendicare (Canada) Inc. ~~969 Queen St. East, SAULT STE. MARIE, ON, P6A-2C4~~ → 3000 Steeles Avenue East, Suite 700, Markham, ON L3R 9W2
LTC Home / Foyer de SLD :	GREAT NORTHERN NURSING CENTRE LIMITED 860 Great Northern Road, Sault Ste Marie, ON, P6A-5K7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JACK WILLET

To ~~Sault Area Hospital~~, you are hereby required to comply with the following order(s) by the date(s) set out below:
Extendicare (Canada) Inc.

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA 2007, S.O. 2007, c.8, s.6. This plan shall identify how the licensee will ensure that residents' plans of care will provide clear direction to staff and that residents are assessed and the written plan of care reviewed and revised at any time when the residents' condition changes. This plan shall also identify how the licensee will ensure that staff provide care as specified in the plan of care.

This plan is to be submitted in writing to Long Term Care Homes Inspector, Melissa Chisholm, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603, Sudbury, ON, P3E 6A5 by August 3, 2012 and fully implemented by September 10, 2012.

Grounds / Motifs :

1. Inspector reviewed the health care record including the written plan of care for resident #0690. Inspector noted the resident experienced increased pain. Inspector noted the health care record indicated that the resident had a change in condition. Inspector noted that the resident's written plan of care was not reviewed and revised until seven days after the change in condition. The licensee failed to ensure that the resident is assessed and the written plan of care reviewed and revised at any time when the resident's condition changes. [LTCHA 2007, S.O. 2007, c.8, s.6(10)(b)] (188)
2. Inspector reviewed the health care record including the written plan of care for resident #0690. Inspector noted the resident experienced increased pain. Inspector noted that the written plan of care was not updated to reflect this change in the resident's condition and provided direct care staff with clear direction on the resident's transferring abilities. Inspector noted that the resident's plan of care was not updated to provide new direction to staff until seven days after the initial change in condition. The licensee failed to ensure the plan of care provided clear direction to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)] (188)
3. Inspector reviewed the plan of care for resident #0013 . Inspector noted the plan of care indicated that staff are to follow the resident's routine related to a smoking preference. It identified the resident is at risk for falling if staff do not follow this routine. Inspector observed the established routine was not followed. The resident was not assisted as specified in the plan of care. The licensee failed to ensure the care is provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)] (188)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 10, 2012

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

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~~
~~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~~

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance 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

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

Director

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.

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

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 recommand~~

~~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~~

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto 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
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 25th day of July, 2012

Signature of inspector / Signature de l'inspecteur :

Name of inspector / Nom de l'inspecteur : MELISSA CHISHOLM

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue 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
Jul 3, 4, 5, 19, 20, 25, 2012	2012_099188_0025	Complaint

Licensee/Titulaire de permis

~~Sault Area Hospital~~ Extendicare (Canada) Inc. 3000 steeles Avenue East, Suite 700, Markham, ON L3R 9W2
~~969 Queen St. East, SAULT STE. MARIE, ON, P6A-2G4~~

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

GREAT NORTHERN NURSING CENTRE LIMITED
860 Great Northern Road, Sault Ste Marie, ON, P6A-5K7

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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Care (ADOC), Registered Nursing Staff (RN/RPN), Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, reviewed resident health care records, reviewed abuse investigation notes and review various policies and procedures.

The following inspection Protocols were used during this inspection:

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

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

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Inspector reviewed the plan of care for resident #0013 . Inspector noted the plan of care indicated that staff are to follow the resident's routine related to a smoking preference. It identified the resident is at risk for falling if staff do not follow this routine. Inspector observed the established routine was not followed. The resident was not assisted as specified in the plan of care. The licensee failed to ensure the care is provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s.6(7)]
2. Inspector reviewed the health care record including the written plan of care for resident #0690. Inspector noted the resident experienced increased pain. Inspector noted that the written plan of care was not updated to reflect this change in the resident's condition and provided direct care staff with clear direction on the resident's transferring abilities. Inspector noted that the resident's plan of care was not updated to provide new direction to staff until seven days after the initial change in condition. The licensee failed to ensure the plan of care provided clear direction to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)]
3. Inspector reviewed the health care record including the written plan of care for resident #0690. Inspector noted the resident experienced increased pain. Inspector noted the health care record indicated that the resident had a change in condition. Inspector noted that the resident's written plan of care was not reviewed and revised until seven days after the change in condition. The licensee failed to ensure that the resident is assessed and the written plan of care reviewed and revised at any time when the resident's condition changes. [LTCHA 2007, S.O. 2007, c.8, s.6(10)(b)]

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. 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. Inspector reviewed a critical incident regarding allegations of abuse, brought forward to the home's charge nurse by the resident's substitute decision-maker. These allegations of abuse were reported to the Director outside of the immediate reporting time frame. The licensee failed to ensure that the Director is immediately informed of abuse of a resident by anyone that resulted in harm or risk of harm to the resident. [LTCHA 2007, S.O. 2007, c.8, s.24(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 ensuring that Director is immediately informed of abuse of a resident by anyone that resulted in harm or risk of harm to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following subsections:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. Inspector reviewed the health care record for resident #0616. Inspector noted the resident experienced reoccurring pain. Inspector noted a progress note entry identifying that a note was placed in the MD book to report the resident's increased pain over the previous 2 weeks. Inspector noted that several progress notes identified the resident's continued pain prior to and after note and changes to the resident's analgesics ordered by the physician. Inspector noted that the resident continued to experience pain and receive PRN pain medications. Inspector was unable to locate a pain assessment completed using a clinically appropriate instrument specifically designed for this purpose. The licensee failed to ensure that when a resident's pain is not relieved by initial interventions that the resident is assessed using a clinically appropriate instrument specifically designed for this purpose. [O.Reg. 79/10, s.52(2)]
2. Inspector reviewed the health care record of resident #0690. Progress notes identify the resident experienced increased pain. This increased pain was assessed by the RN on duty and by the RN(EC) and these assessments were documented in the resident's progress notes. Inspector noted the resident continued to complain of pain. Inspector was unable to locate a pain assessment, using a clinically appropriate instrument specifically designed for this purpose, completed while the resident continued to experience pain. The licensee failed to ensure that when a resident's pain is not relieved by initial interventions that the resident is assessed using a clinically appropriate instrument specifically designed for this purpose. [O.Reg. 79/10, s.52(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 ensuring that when a resident's pain is not relieved by initial interventions that the resident is assessed using a clinically appropriate instrument specifically designed for this purpose, to be implemented voluntarily.

WN #4: 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. Inspector reviewed the health care record for resident #0690 . Inspector noted the resident experienced increased pain. Inspector noted that the resident was scheduled for additional assessment due to the continued pain and change in the resident's condition. Although versions of the events reported by staff differ, it was identified by staff members that the resident yelled out during the care and transfers prior to the additional assessment. At no time during the care was the resident assessed by a member of the registered nursing staff. The licensee failed to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with her needs was fully respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3(1)(4)]

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 ensuring that residents' right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs is fully respected and promoted, to be implemented voluntarily.

WN #5: 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 subsections:

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;
(b) appropriate action is taken in response to every such incident; and
(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. Inspector reviewed a critical incident which identifies allegations of abuse. The allegations of abuse were reported to the home's charge nurse (RN) by the resident's substitute decision-maker. The investigation of these allegations and reported incident did not begin until several days after the home was made aware of the allegations. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone is immediately investigated. [LTCHA 2007, S.O. 2007, c.8, s.23(1)(a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Inspector spoke with the Administrator related to a critical incident. It was reported by the Administrator that the investigation into the allegations of abuse had concluded however the results of the investigation had not been shared with the resident's substitute decision-maker. This was confirmed to the inspector by the resident's substitute decision-maker who identified the results of the investigation had not been shared. The licensee failed to ensure that the resident's substitute decision-maker is notified of the results of the alleged abuse investigation immediately upon its completion. [O.Reg. 79/10, s.97(2)]

Issued on this 25th day of July, 2012

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