Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 13, 2019	2019_624196_0010	007366-18, 022192-18, 026875-18, 029574-18, 030196-18, 002078-19, 002175-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 2) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Birchwood Terrace
237 Lakeview Drive, R.R. #1 KENORA ON P9N 4J7

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

LAUREN TENHUNEN (196), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621), LOVIRIZA CALUZA (687)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 1 - 5, 2019.

The following intakes were inspected during this Critical Incident System (CIS) inspection:

One intake related to staff to resident verbal abuse;

Two intakes related to resident to resident physical abuse;

One intake related to alleged financial abuse and staff to resident abuse and neglect;

Two intakes related to residents' falls that resulted in a significant change to their health condition; and

One intake related to a resident's hospitalization.

Follow Up inspection #2019_624196_0011 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapist (PT), Physiotherapy Assistant (PTA), Program Manager, Office Manager, Staff Scheduler, Personal Support Workers (PSWs), Resident Assessment Instrument (RAI) coordinator and residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident, and resident to resident interactions, reviewed relevant health care records, home's investigation records, employee files, staff education records, staff schedules, Critical Incident System (CIS) reports, and applicable licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **8 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A CIS report was submitted to the Director on a specific date in 2017, which identified a physical altercation between resident #006 and #007. The report indicated that resident #007 asked resident #006 to do something to which resident #006 responded, "No" and pushed resident #007 onto the floor.

Another CIS report was submitted to the Director on another date in 2018, which identified a physical altercation that resulted in an injury between resident #006 and #008. The report indicated that resident #008 was yelling in the hallway and made a statement that alleged an injury. Resident #006 was seen heading towards their bedroom.

Inspector #687 conducted a review of resident #006's health care records which indicated that resident #006 had seven incidents of physical aggression towards other residents that were documented in the e-notes, over an approximate four month

consecutive time period in 2018, as follows:

- Resident #006 pushed resident #007 onto the floor in the dining room. No injury sustained;
- Resident #006's physical altercation with resident #010 in the hallway. No injury sustained;
- Resident #006's physical altercation with resident #010 in the lounge. No injury sustained;
- Resident #006's physical altercation with resident #010 in the bedroom. Resident #010 sustained a specific injury;
- Resident #006's physical altercation with unknown resident in the dining room. No injury sustained;
- Resident #006's physical altercation with resident #008 along the hallway. Resident #008 sustained a specific injury; and
- Resident #006's physical altercation with resident #010. No injury sustained.

In a record review of the physician's note dated in 2018, the physician wrote that resident #006 had numerous incidents of violence against other residents and towards staff members.

In an interview with PSW #113 they stated that resident #006 had responsive behaviours towards staff and residents. The PSW stated that the resident had not seen Psychogeriatric or Behaviour Outreach Support to assist resident #006 with their responsive behaviour in 2018.

In an interview with RPN #115, they stated that since a specific month in 2018, there was no Psychogeriatric or Behaviour Outreach Support to assist resident #006 with their responsive behaviour.

In an interview with RN #100, they stated that since a specific month in 2017, there was no further Psychogeriatric or Behaviour Outreach Support for resident #006's escalating responsive behaviours.

In an interview with the DOC, they stated that they recognized that resident #006's responsive behaviours continued to escalate starting in 2018, and that a referral should have been in place for Psychogeriatric Support or the Behaviour Outreach Support but there was no follow-up. [s. 53. (4) (c)]

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were 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.

A CIS report was received by the Director on a specific date in 2018, regarding an allegation of improper/incompetent treatment of resident #001. The CIS report identified resident #001 met with RPN #111 and reported that PSW #123 had spoken to them, "in an angry tone" after attending to the resident's care needs, during a particular shift.

During a review of the home's investigation notes, a letter directed from the Director of Care (DOC) #124 to PSW #123 dated on a specific date in 2018, identified that PSW #123 was found in violation of the resident's rights involving two residents during a particular shift on a date in 2018, when they approached the residents in a disrespectful manner. The letter indicated that based on the results of the investigation, PSW #123 was disciplined.

During an interview with the Administrator, they identified that resident #001, as well as resident #003 were the two residents identified in the letter of discipline issued to PSW #123 as a consequence of their approach with both residents on a shift in 2018, while attending to their care needs. The Administrator reported that a separate CIS report had been submitted for resident #003 for their allegations towards PSW #123, with the same disciplinary outcome identified.

During an interview with resident #001, they reported to Inspector #621 that they recalled the incident where PSW #123 had been on shift on a specific date in 2018; where they responded to the resident's call bell in an angry tone, and made a particular statement to the resident.

During an interview with DOC #117, they confirmed that based on the home's CIS investigation and subsequent letter of discipline to PSW #123, that resident #001 had not been treated with dignity and respect, consistent with their rights as a resident on the specific shift on a date in 2018, by PSW #123, and should have been. [s. 3. (1) 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 that ensures 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the goals the care was intended to achieve.

A Critical Incident System (CIS) report was submitted to the Director on a specific date in 2019, which indicated that resident #005 had a fall which resulted in an injury and required treatment.

During a record review of resident #005's most current care, the plan of care identified, under the heading "PASD" (Personal Assistive Services Device), the specifics of the use of the PASD. There were no listed goals or interventions.

The home's policy titled, "Care Planning - RC-05-01-01", last updated April 2017, indicated that the care plan was a guide that directed care that was provided to the resident. Resident care plans were to reflect specific information about a resident which included their expected outcomes and interventions required to produce expected outcomes.

During an interview with the Resident Assessment Instrument (RAI) Coordinator #111, together with Inspector #577, the care plan specific to Personal Assistive Services Device (PASD) and Restraints was reviewed. They confirmed with Inspector #577 that the PASD foci did not indicate any goals or interventions, and they updated the care plan to include goals and interventions related to the PASD falls prevention device. [s. 6. (1) (b)]

2. The licensee has failed to ensure that there was a written plan of care for each resident which set out clear directions to staff and others who provided direct care to the resident.

A CIS report was submitted to the Director on a specific date in 2019, which indicated that resident #009 had displayed a specific responsive behaviour.

The home's policy titled, "Care Planning - RC-05-01-01" last updated April 2017, indicated, "The resident plan of care, which includes the care plan, serves as a communication tool which enhances provision of individualized care and assists in provision of continuity of care as all team members were aware of the individualized plan".

A review of resident #009's care plan indicated that for the focus, of a specific responsive behaviour, the intervention was to, "Provide One-on-One", care.

During an interview with RN #100, they stated that resident #009 had moments of a specific responsive behaviour and recognized that the care plan stated to, "Provide One-on-One", care. However, the RN stated that resident #009 did not always exhibit a specific responsive behaviour and did not require, "One-on-One", care from staff at all times. The RN further stated that the specific responsive behaviour intervention pertaining to, "One-on-One", care was not very clear.

During an interview with the DOC, they stated that resident #009 had moments of a specific responsive behaviour but did not require, "One-on-One", care all the time. The DOC acknowledged that the intervention in resident #009's care plan did not provide clear direction to staff members. [s. 6. (1) (c)]

3. A CIS report was submitted to the Director on a specific date in 2019, which indicated that resident #005 had a fall which resulted in an injury and required treatment.

On three consecutive dates in 2019, Inspector #577 observed resident #005 self-propelling in a mobility aide, wearing a fall prevention device.

During an interview with resident #005, Inspector #577 prompted the resident to unfasten their fall prevention device. The Inspector observed resident #005 unfasten and fasten their fall prevention device.

A record review of the physician's orders dated on a specific date in 2019, indicated an order for resident #005 to have had a fall prevention device applied while in their mobility aide for safety.

During a record review of resident #005's most current care plan, the plan of care identified, under the heading of PASD, the specific details of the use of the fall prevention device. There were no listed goals or interventions. In contrast, the plan of care also identified, under the heading, restraint, and the specifics of the use of the fall prevention device; with numerous interventions listed to manage the fall prevention device.

A review of the home's policy titled, "Care Planning - RC-05-01-01", last updated April 2017, indicated that members of the interdisciplinary team were to update the plan of

care so that at any point in time, the care plan continued to be reflective of the current needs and preferences of the resident. The policy outlined that registered staff and interdisciplinary team members should have ensured that the care plan was revised when appropriate to reflect the resident's current needs.

During an interview with RAI coordinator #111, together with Inspector #577, the care plan specific to PASD and Restraints was reviewed. RAI Coordinator #111, confirmed it was unclear and that the fall prevention device was listed as both a restraint and as a PASD. They further confirmed that the fall prevention device was not considered a restraint, and removed the Restraint focus from the care plan. Additionally, they included goals and interventions related to the PASD fall prevention device. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A CIS report was submitted to the Director on a specific date in 2019, which indicated that resident #009 had displayed a specific type of responsive behaviour.

In a record review of the resident's electronic progress notes (e-notes) from a date in 2019, it was documented that resident #009 had displayed a particular behaviour. The resident had made a statement that provided an explanation as to why the particular behaviour was displayed. RPN #104 informed a PSW to provide one-on-one care until the end of the shift and would notify the oncoming staff to closely monitor the resident until they fell asleep.

In an interview with RPN #104, they stated that they initiated, "one-on-one" care due to resident #009's verbalization of a concern on a specific date in 2019. The RPN stated that PSW #103 was assigned to provide one-on-one care to resident #009 for the remainder of the shift.

In an interview with RN #101, they informed Inspector #687 that they were working a shift on a specific date in 2019, and that one-on-one staff was assigned to monitor resident #009 due to the resident's verbalization of a concern. The RN stated they had PSW #102 as one-on-one staff to monitor the resident.

In an interview with PSW #102, they verified that they were working a shift on a specific

date in 2019, but they were not assigned as, "one-on-one" staff. They further stated that they had not seen any staff assigned as "one-on-one" for the resident. The PSW further informed the Inspector that they were the staff who found resident #009 when they displayed a particular responsive behaviour and had called the registered staff to respond immediately.

In an interview conducted by Inspector #687 with the Ward Clerk/Staff Scheduler #124, they stated that on a specific date in 2019, their staffing schedule showed that there were six (6) PSWs on a particular shift which indicated a full complement of staff. The staff schedule had not indicated any one-on-one staffing on that particular shift. On the following date in 2019, their staffing schedule indicated that there were four (4 PSWs) on a particular shift which also indicated a full complement of PSW staffing on the floor but did not indicate any one-on-one staff.

In an interview conducted by Inspector #687 with the Administrator, they stated that they were made aware of the incident and that they had, "one-on-one" staff for resident #009 on a specific date in 2019, and into the following shift. The Administrator further stated that the registered staff provided direction to the PSWs and that their expectation was for the PSWs to adhere with the registered staff's direction. [s. 6. (4) (b)]

5. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the care set out in the plan had not been effective.

A CIS report was submitted to the Director on a specific date in 2019, which indicated that resident #005 had a fall which resulted in an injury and required treatment.

Inspector #577 reviewed resident #005's most current care plan, which identified interventions specifically related to three different care areas.

During observations on three consecutive dates in 2019, Inspector #577 observed resident #005 self propelling in their mobility aide, wearing a falls prevention device. They did not have an fall prevention device on their chair or bed. Their bedside transfer logo indicated a specific type of transfer with staff with the aid of a device.

During an interview with RN #118, they reported to Inspector #577 that resident #005 used a mobility aide for ambulation and required a specific type of transfer with staff to transfer them for an activity of daily living.

During an interview with RPN #119, they reported that resident #005 used a mobility aide to prevent falls and required a specific type of transfer with staff with transferring to perform an activity of daily living.

During an interview with PSW #120, they reported that after resident #005 sustained an injury, they had a change in their ambulation and used a mobility aide. They further reported that the resident required a specific type of transfer with staff.

In an interview with PTA #121, they reported that resident #005 self propelled in their mobility aide for ambulation and required a specific type of transfer with staff with a device. They further reported that they discontinued the use of the specific device for ambulation in a month of 2018, due to the residents unsafe practice.

In an interview with the previous PT #122, they reported that the resident was only to use their mobility aide for mobility due to their unsafe practices with their device.

During an interview with RAI Coordinator #111, together with Inspector #577, reviewed resident #005's care plan interventions. They confirmed that the interventions related to three specific care areas were not revised to reflect resident #005's current needs. They further confirmed that the resident often disabled the falls prevention devices.

A review of the home's policy titled, "Care Planning - RC-05-01-01", last updated April 2017, indicated that members of the interdisciplinary team were to update the plan of care so that at any point in time, the care plan continued to be reflective of the current needs and preferences of the resident. The policy outlined that registered staff and interdisciplinary team members should have ensured that the care plan was revised when appropriate to reflect the resident's current needs.

During interviews with RN #118 and RPN #119, they both confirmed that all registered staff were responsible to update care plans.

During an interview with Resident Assessment Instrument (RAI) Coordinator #111, they reported that all registered staff were responsible to update care plans.

During an interview with the Administrator, together with Inspector #577, resident #005's care plan interventions related to the three different care areas were reviewed. They confirmed that the interventions were not revised to reflect resident #005's current needs

and that all registered staff were responsible to update care plans. [s. 6. (10) (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 that ensures that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, 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 has failed to ensure that a person who had reasonable ground to suspect that any of the following has occurred, or may occur, immediately reported the suspicion and information upon which it was based to the Director: 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.

A CIS report was received by the Director on a date in 2018, regarding a suspected case of misuse/misappropriation of resident #002's money by a particular person. As part of the CIS, the home had also submitted a written letter of complaint from a particular person, on this same date in 2018, which alleged staff to resident abuse and neglect of resident #002, and their roommate. The letter of complaint was stamped as, "received" on a specific date in 2018, by the home and submitted as part of a CIS report amendment to the Director.

During a review of resident #002's electronic health care record, including progress notes, Inspector #621 identified in an entry from a date in 2018, made by the former Registered Social Worker (RSW), which outlined a complaint from a family member of resident #002, regarding interaction of staff with the resident.

During an interview with the Administrator, they reported to the Inspector that it was their expectation that when there was an allegation of abuse or neglect made by anyone including a resident or family member, that the home's follow their mandatory reporting policy and processes, and report the allegation to the Director immediately.

During a review of the CIS report, the letter of complaint and resident #002's progress notes, the Administrator confirmed to Inspector #621 that in conversation with the complainant on a date in 2018, the complainant alleged staff to resident mistreatment of resident #003. The Administrator confirmed that they did not report the allegations immediately to the Director, but instead waited until they received a written letter from the complainant three days later. [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 that ensures 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: 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: 1. The complaint was investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk or harm to one or more residents, the investigation commenced immediately.

A CIS report was received by the Director on a specific date in 2018, regarding an allegation of improper/incompetent treatment of resident #001 by PSW #123. The CIS report identified that a verbal complaint was made by resident #001 to RPN #111 on a date in 2018 concerning PSW #123, and their approach with the resident during care, on a particular shift on a date in 2018. Additionally, the CIS included a letter of complaint from resident #001 to the home, dated the following day in 2018, concerning PSW #123 and their response to them and their care needs during a shift.

During an interview with resident #001, they informed the Inspector that they had made a written complaint to the home in the spring of 2018, concerning PSW #123 and the PSWs approach to their care on a particular shift. Resident #001 reported that they had spoken with RPN #111 about the same incident, and were encouraged at that time to also put forth a written complaint to the home. Resident #001 identified that they brought forward their written complaint to the former DOC #124, who indicated that they would be meeting with management to discuss further. When the Inspector inquired whether they heard back from DOC #124 or any other management of the home about the outcome of the investigation of their complaint, resident #001 reported that they had not. Resident #001 further identified that, soon after they submitted their complaint to the DOC, they noticed PSW #123 was no longer on the unit. The resident reported that only after asking unit staff as to what happened to PSW #123, did they find out the PSW was assigned to work on the other unit in the home, and would no longer be providing care to them.

During a review of the home's policy titled, "Complaints and Customer Service – RC-09-01-04", last updated April 2017, it identified that the Administrator/designate was to: initiate an investigation into the circumstances leading to the complaint within 24 hours; keep all material related to the investigation together in one file for future retrieval and quality improvement auditing purposes; complete the investigation within 10 days, and if the investigation was not completed within 10 days, contact the complainant to indicate the investigation is ongoing and provide an estimated date of completion; provide a

written response to the complainant/resident/SDM/family/staff at the conclusion of the investigation, with the written response including: what the home did to resolve the complaint, and if the complaint was unfounded, the reasons why this conclusion was reached.

Inspector #621 obtained the home's complaint documentation from DOC #117 for a particular month in 2018, and found no documented record of an investigation being completed for resident #001's written complaint.

During an interview with DOC #117, they identified to Inspector #621, that although an investigation was completed as part of the CIS report submitted to the Director, on review of the home's complaint records documentation, they were unable to locate any record that an investigation was done specific to the resident's written complaint or that a response was made to the resident indicating what was done to resolve the complaint.

During an interview with the Administrator, they reported that it was their expectation that the home's complaint reporting process was followed for each written complaint received by the home, so that reporting, investigation, documentation, and follow up with the complainant within required timelines could be made. [s. 101. (1) 1.]

2. A CIS report was received by the Director on a date in 2018, regarding a suspected case of misuse/misappropriation of resident #002's money by a particular person. As part of the CIS, the home had also submitted a written letter of complaint from a particular person, on this same date in 2018, which alleged staff to resident abuse and neglect of resident #002 and their roommate.

During a review of resident #002's electronic health care record, including progress notes, Inspector #621 identified in an entry from a date in 2018, made by the former Registered Social Worker (RSW), which outlined a complaint from a family member of resident #002, regarding interaction of staff with the resident.

Inspector #621 obtained the home's complaint's documentation from DOC #117 for a specific month in 2018, and found no documentation that an investigation had been completed into the allegations made in the written complaint from resident #002's family member, or that a response to the complainant was made at any time to notify them as to what was done to resolve the complaint, or that the home determined the complaint to be unfounded, and the home's reason's for their belief.

During an interview with the Administrator, they reported that it was their expectation that the home's complaint reporting policy and process was followed for each written complaint received by the home, so that reporting, investigation, documentation, and follow up with the complainant within required timelines could be made. The Administrator confirmed that they had met with the complainant on a date in 2018, and at that time were told by the complainant about the interaction of staff with the resident. They confirmed that that the home received the complainant's written complaint on a particular date in 2018, and that it had been submitted as part of an active CIS report for resident #002 related to the misuse and misappropriation of residents money, instead of reporting the incident under a separate CIS report to the Director. Additionally, the Administrator confirmed that they had not completed an investigation of the written complaint, nor had they followed up with the complainant thereafter. [s. 101. (1) 1.]

3. The licensee has failed to ensure that a documented record was kept in the home that included: a) the nature of each verbal or written complaint; b) the date the complaint was received; c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; d) the final resolution, if any; e) every date on which any response was provided to the complainant and a description of the response; and f) any response made in turn by the complainant.

Inspector #621 obtained the home's complaint documentation from DOC #117 for a particular month in 2018, and found no documented record of an investigation being completed for resident #001's written complaint.

During an interview with DOC #117, they identified to Inspector #621, that a complaint investigation form was to be completed for all written complaints, and filed in the home's Complaint's Binder. The DOC reviewed the Complaint's Binder for 2018, as well as other potential areas where complaints investigations were temporarily filed in the home, any found no record of resident #001's complaint being investigated by the home.

During an interview with the Administrator, they reported that it was their expectation that the home's complaint reporting process was followed for each written complaint received by the home, so that reporting, investigation, documentation, and follow up with the complainant within required timelines could be made. [s. 101. (2)]

4. A CIS report was received by the Director on a date in 2018, regarding a suspected case of misuse/misappropriation of resident #002's money by a particular person.

Inspector #621 obtained the home's complaint documentation from DOC #117, for a particular month in 2018, and found no documented record that an investigation was completed by the home into the written letter of complaint from the resident #002's family member.

During a review of the home's policy titled, "Complaints and Customer Service – RC-09-01-04", last updated April 2017, it identified that the Administrator/designate was to: initiate an investigation into the circumstances leading to the complaint within 24 hours; keep all material related to the investigation together in one file for future retrieval and quality improvement auditing purposes.

During an interview with DOC #117, they identified to Inspector #621, that a complaint investigation form was to be completed for all written complaints, and filed in the home's Complaint's Binder. The DOC reviewed the Complaint's Binder for 2018, as well as other potential areas where complaints investigations were temporarily filed in the home, and found no record the written complaint from resident #002's family member being investigated by the home.

During an interview with the Administrator, they reported that it was their expectation that the home's complaint reporting policy and processes were followed for each written complaint received by the home, so that reporting, investigation, documentation, and follow up with the complainant within required timelines could be made. The Administrator reviewed the home's documentation and confirmed that they had not completed an investigation into the written complaint by resident #002's family member as per legislative requirements. [s. 101. (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 that ensures every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately and ensures that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect 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. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident 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.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to 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.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to 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.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. Subject to subsection (3.1), an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

During a review of a CIS report that was received by the Director on a date in 2018, the report indicated that resident #004 had fallen on a specific date, sustained an injury and

was transferred to the hospital for further assessment. The report further indicated a history of falls, whereby the day before, the resident had fallen, and sustained an injury and was transferred to a hospital for further assessment.

A record review of resident #004's progress notes indicated that on the day before the CIS had been submitted, the resident was found on the floor with an injury and was transferred to a hospital.

A review of the home's policy titled, "Mandatory and Critical Incident Reporting (ON) - RC-09-01-06", revised April 2017, indicated that the home was required to inform the Director no later than one business after the occurrence of the incident that causes an injury to a resident that resulted in a significant change in the resident's health condition for which the resident was taken to a hospital.

During an interview with the Administrator, they confirmed with Inspector #577 that the home had not submitted a CIS report for resident #004's fall with transfer to hospital which had occurred the day previous. [s. 107. (3) 4.]

2. The licensee failed to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: Actions taken in response to the incident, including, the outcome or current status of the individual or individuals who were involved in the incident.

A CIS report was received by the Director on a date in 2018, which indicated that resident #004 had fallen. The report indicated the fall details, the injury sustained and that the resident was transferred to the hospital for further assessment and had been hospitalized.

During a review of the CIS report, Inspector #577 noted that on a specific date in 2019, the Director had requested information to be provided to include, the date and status of the resident upon return from the hospital.

During a further review of the CIS, Inspector #577 found that there were no amendments made.

A review of the home's policy titled, "Mandatory and Critical Incident Reporting (ON) – RC-09-01-06", revised April 2017, indicated that where there was an incident that caused

an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital, the critical incident report had to include the following:
- the outcome or current status of the individual or individuals who were involved in the incident.

During an interview with the Administrator, they confirmed with Inspector #577 that they had not documented any amendments to the CIS report. [s. 107. (4) 3. v.]

3. A CIS report was received by the Director on a date in 2019, which indicated that resident #005 had a fall, had sustained an injury which required intervention.

During a review of the CIS report, Inspector #577 noted that on a further date in 2019, the Director had requested information to be provided to include, specific information regarding the date and status of the resident upon their return from the hospital.

During a further review of the amended CIS report, Inspector #577 found that there were no amendments made to include the date when the resident had returned to the home, or their status upon return.

During an interview with the Administrator, they confirmed with Inspector #577 that they had not documented any amendments to the CIS report. [s. 107. (4) 3. v.]

4. The licensee failed to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 4. Analysis and follow-up action, including, the immediate actions that had been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.

A CIS report was submitted to the Director on a date in 2019, which indicated that resident #009 had displayed a specific responsive behaviour.

A review of the CIS report submitted by the home, identified that the analysis and the follow-up information from the home's internal investigation was not updated.

A review of resident #009's e-notes indicated that they resident was sent to the hospital and was admitted on a date in 2019. The resident had returned to the home the following

day with no further intervention.

In an interview with the Administrator, they acknowledged that they did not amend the CIS report. The Administrator further stated that they would immediately amend the report to reflect the analysis and the follow-up actions of the home to prevent recurrence. [s. 107. (4) 4.]

5. A CIS report was received by the Director on a date in 2018, which indicated that resident #004 had fallen and was transferred to the hospital for further assessment and had been hospitalized.

During a review of the CIS report, Inspector #577 noted that on a date in 2019, the Director had requested information to be provided to include, long-term actions planned to prevent recurrence.

During a further review of the CIS, Inspector #577 found that there were no amendments made.

During an interview with the Administrator, they confirmed to Inspector #577 that they had not amended the CIS report to have included the follow-up action, which should have included, the long-term actions planned to prevent recurrence. [s. 107. (4) 4. ii.]

6. A CIS report was received by the Director on a date in 2019, which indicated that resident #005 had a fall, sustained an injury and required intervention.

During a review of the CIS report, Inspector #577 noted that on a date in 2019, the Director had requested information to be provided to include, specific information regarding interventions in place to prevent recurrence.

During a further review of the amended CIS report, Inspector #577 found that there were no amendments made to include long-term actions to prevent recurrence.

During an interview with the Administrator, they confirmed to Inspector #577 that they had not amended the CIS report to have included the follow-up action, which should have included, the long-term actions planned to prevent recurrence. [s. 107. (4) 4. ii.]

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 that ensures a licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Findings/Faits saillants :

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

A CIS report was submitted to the Director on a date in 2018, which identified a physical altercation between resident #006 and #008 that resulted in an injury.

Inspector #687 reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect" last updated April 2017, which indicated that, "Immediately respond to any form of alleged, potential, suspected or witnessed abuse. For resident to resident incidents, separate residents and move to another room or unit if appropriate".

Inspector #687 reviewed resident #006's e-notes and identified the following additional altercations over an approximate five week time period, involving another resident:
- Resident #006's physical altercation with resident #010 in the hallway. No injury sustained;
- Resident #006's physical altercation with resident #010 in the lounge. No injury sustained;
- Resident #006's physical altercation with resident #010 in the bedroom. Resident #010

sustained an injury; and
- Resident #006's physical altercation with resident #010. No injury sustained.

Inspector #687 conducted an observation and noted that resident #006 and resident #010 shared the same room despite the listed altercations between both residents in 2018.

In an interview with PSW #113, they stated that due to the nature of resident #006's unpredictable responsive behaviour, they stated that it was not safe for resident #006 and #010 to be in the same room and hallway.

In an interview with RN #100, they stated that the home did not provide a safe environment for resident #010 after the physical altercation between resident #006 and #010 on a date in 2018, which resulted in an injury to resident #010. The RN further stated that currently the two residents remained in the same room.

In an interview with the DOC, they reviewed the incidents on three dates in 2018, and recognized that they should have looked into the policy and provided safety to both resident #006 and #010. The DOC further stated that resident #006 and #010 should have been separated or moved to another room but the residents were not and therefore, the policy was not followed. [s. 20.]

WN #8: 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:

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:
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.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under subsection 23(1) of the Act, the licensee included 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: 4. Analysis and follow-up action, including, i) the immediate actions that had been taken to prevent recurrence, and ii) the long-term actions planned to correct the situation and prevent recurrence.

A CIS report was received by the Director on a date in 2018, regarding a suspected case of misuse/misappropriation of resident #002's money by a particular person.

During a review of the amended CIS report, Inspector #621 identified that information provided by the home for their immediate and long-term actions plans to prevent recurrence of the incident still required updates. Specifically, under the "Analysis and follow-up" section of the CIS report no specific information was identified.

During an interview with the Administrator, they confirmed that they had initiated the CIS report for resident #002 on a date in 2018, and that the CIS report had not been updated after the amendment was completed three days later, to include further relevant updates pertaining to "Analysis and follow-up" section of the report. [s. 104. (1) 4.]

Issued on this 14th day of May, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621), LOVIRIZA CALUZA (687)
Inspection No. / No de l'inspection :	2019_624196_0010
Log No. / No de registre :	007366-18, 022192-18, 026875-18, 029574-18, 030196-18, 002078-19, 002175-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 13, 2019
Licensee / Titulaire de permis :	CVH (No. 2) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Birchwood Terrace 237 Lakeview Drive, R.R. #1, KENORA, ON, P9N-4J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pat Stephenson

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

To CVH (No. 2) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee must be compliant with r. 53. (4) of the Ontario Regulations 79/10.

The licensee shall ensure that, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Specifically the licensee must:

(a) Ensure that resident #006 is reassessed with regard to their demonstrated responsive behaviours.
(b) Implement strategies based upon the reassessment of resident #006, in order to minimize the demonstrated responsive behaviours and to ensure safety of other residents within the home.
(c) Maintain records of the responsive behaviour reassessment of resident #006, the strategies implemented into this resident's plan of care, and the process in which the the plan of care was communicated to both direct care and nursing staff.

Grounds / Motifs :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the

resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A CIS report was submitted to the Director on a specific date in 2017, which identified a physical altercation between resident #006 and #007. The report indicated that resident #007 asked resident #006 to do something to which resident #006 responded, "No" and pushed resident #007 onto the floor.

Another CIS report was submitted to the Director on another date in 2018, which identified a physical altercation that resulted in an injury between resident #006 and #008. The report indicated that resident #008 was yelling in the hallway and made a statement that alleged an injury. Resident #006 was seen heading towards their bedroom.

Inspector #687 conducted a review of resident #006's health care records which indicated that resident #006 had seven incidents of physical aggression towards other residents that were documented in the e-notes, over an approximate four month consecutive time period in 2018, as follows:

- Resident #006 pushed resident #007 onto the floor in the dining room. No injury sustained;
- Resident #006's physical altercation with resident #010 in the hallway. No injury sustained;
- Resident #006's physical altercation with resident #010 in the lounge. No injury sustained;
- Resident #006's physical altercation with resident #010 in the bedroom. Resident #010 sustained a specific injury;
- Resident #006's physical altercation with unknown resident in the dining room. No injury sustained;
- Resident #006's physical altercation with resident #008 along the hallway. Resident #008 sustained a specific injury; and
- Resident #006's physical altercation with resident #010. No injury sustained.

In a record review of the physician's note dated in 2018, the physician wrote that resident #006 had numerous incidents of violence against other residents and towards staff members.

In an interview with PSW #113 they stated that resident #006 had responsive behaviours towards staff and residents. The PSW stated that the resident had not seen Psychogeriatric or Behaviour Outreach Support to assist resident #006 with their responsive behaviour in 2018.

In an interview with RPN #115, they stated that since a specific month in 2018, there was no Psychogeriatric or Behaviour Outreach Support to assist resident #006 with their responsive behaviour.

In an interview with RN #100, they stated that since a specific month in 2017, there was no further Psychogeriatric or Behaviour Outreach Support for resident #006's escalating responsive behaviours.

In an interview with the DOC, they stated that they recognized that resident #006's responsive behaviours continued to escalate starting in 2018, and that a referral should have been in place for Psychogeriatric Support or the Behaviour Outreach Support but there was no follow-up. [s. 53. (4) (c)]

The decision to issue this compliance order was based on the severity which was a level two as there was minimal harm or a potential for actual harm to the residents. The scope was a level two as there was a pattern of residents that were affected by resident #006's responsive behaviours. The compliance history was a level three as there was one or more related non-compliance with this area of legislation which included the following:
- a Compliance Order (CO) was issued under r. 53.(4) of the O.Reg 79/10, on January 10, 2017, in report #2016_512196_0015. (687)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 11, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 13th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

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