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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 28, 2019	2019_793743_0009	020640-18, 027378-18, 031073-18, 031333-18, 032321-18, 004111-19, 010251-19	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Arthur Nursing Home
215 Eliza Street P.O. Box 700 ARTHUR ON N0G 1A0

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

KIYOMI KORNETSKY (743), JANET GROUX (606), KRISTAL PITTER (735)

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): May 14-17, 21-24, 27-31 and June 3-6, 2019.

The following intakes were completed in this critical incident inspection:
Log #020640-18, Log#027378-18, Log#031333-18, Log#032321-18 and Log #010251-19, related to alleged resident to resident sexual abuse
Log #031073-18 and Log #004111-19 related to resident falls.

PLEASE NOTE: Written Notifications and Compliance Orders related to O.Reg. 79/10, s.8(1), O.Reg.79/10, s.131(2), and a Written Notification and Voluntary Plan of Correction, related to O.Reg. s.50(2)(b)(IV), were identified in this inspection and have been issued in Inspection Report 2019_793743_0008, dated June 28, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director or Care (DOC), the Assistant Director of Care (ADOC), the Resident Assessment Instrument Coordinator (RAI-C), the Ward Clerk (WC), the Behavioral Supports Ontario (BSO), Registered Practical Nurses (RPN), Registered Nurses (RN), Personal Support Workers (PSW), Housekeeping, and the Pharmacist.

The inspector(s) reviewed clinical records, plans of care for relevant residents, pertinent policies and procedures, the home's documentation related to relevant investigations, completed observations and interviewed residents and staff.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **2 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents were protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The Home's policy "Abuse and Neglect – Staff to Resident, Family to resident, Resident to Resident, Resident and/or Family to Staff Abuse Policy" effective date August 2018, last reviewed September 2018; promoted zero tolerance of abuse and neglect of residents.

A) A Critical incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), reporting resident to resident sexual abuse. The CI stated that staff witnessed resident #024 touching resident #026.

Resident #024's progress notes documented that Personal Support Worker (PSW) #124 witnessed resident #024 touching resident #026.

Resident #026's plan of care identified the resident with cognitive loss of intellectual functioning characterized by a deficit in memory, judgment, decision making, thought process. The resident also had impaired impaired mobility.

Resident #024's clinical records, including progress notes, and plan of care stated the resident was cognitively intact.

PSW #124 stated that resident #026 was cognitively impaired and was not able to move

due to their medical diagnoses. They told the Inspector that resident #024 had a history of sexually inappropriate behaviors. PSW #124 stated that they witnessed resident #024 touching #026, and reported the incident to the registered staff.

Registered Nurse (RN) #111 stated that PSW #124 reported to them about the incident between resident #024 and #026.

B) Multiple CI reports were submitted to the MOHLTC related to incidents of alleged sexual abuse involving resident #021. Resident #021 was alleged to have sexually abused residents #022, #023 and #27 over a nine-month period.

Resident #021's MDS, care plan and documentation in PCC were reviewed. The resident had a progressive decline in intellectual functioning, including alteration of thought process, and a deficit in memory, judgment and decision making.

At the time of the incidents, resident #021 was independent with mobility, had a history of wandering and sexually responsive behaviors.

i) A record review was completed and documentation in Point Click Care (PCC) indicated that resident #021 was witnessed touching resident #023. PSW #123 said they witnessed resident #021 touching resident #23 and that resident #023 was crying during the incident.

Resident #023 had moderate cognitive impairment, were usually able to make themselves understood, were usually able to understand others, and had clear speech.

ii) PSW #124 said they heard resident #022 screaming from their room and observed resident #022 trying to push resident #021 away. RN #111 said they observed resident #021 touching resident #022.

According to resident #022's MDS assessment, their mode of expression was through signs, gestures or sounds.

iii) Documentation in PCC recorded that PSW #117 witnessed resident #021 touching #027. PSW #117 confirmed that they saw resident #021 touching resident #027.

According to their MDS Assessment, resident #027's cognitive skills for daily decision-making were severely impaired. ADOC #102 said that resident #027 would not have

been able to give informed consent to allow resident #021 to touch them.

The licensee failed to ensure that residents #022, #023, #026 and #027 were protected from sexual abuse by residents #021 and #024. (743)

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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

A CI reported resident to resident sexual abuse.

Resident #025 stated they told the staff that they did not want resident #024 in their room and did not want resident #024 to touch them.

Progress notes were reviewed, and documentation stated that there had been previous incidents involving these two residents over a two-month period.

Resident #024's progress notes identified that they had also had several incidents with

resident #030. It was reported that resident #024 was witnessed touching resident #030.

Resident #024's clinical records including the progress notes, plan of care, physician orders, and assessments stated that the following interventions were initiated to respond to resident #024's behaviours. Resident #024 continued to be monitored and was spoken to by staff and told not to go near resident #025.

Review of resident #024's plan of care did not show that a follow up was completed after two incidents, to address resident #024's responsive behaviours.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #024 and resident #025 and other residents, including identifying and implementing interventions.

2. A CI reported that PSW #124 witnessed resident #024 touching resident #026.

The plan of care for resident #024 was to increase monitoring to ensure that there were no further incidents. Resident #026's plan of care directed the staff to follow a number of interventions.

Progress notes documented another incident where PSW #124 witnessed resident #024's hand on resident #026. Resident #024 was redirected back to their room and documentation stated that the resident would be monitored.

Resident #024's plan of care was reviewed and identified them to express inappropriate sexual behaviour of a verbal and physical nature, towards residents and staff.

PSW #124 stated they witnessed resident #024 touching resident #026 inappropriately and removed resident #024 out of resident #026's room.

PSW #124, Registered Practical Nurse (RPN) #107 and RN #111 stated that resident #024 had been identified with inappropriate responsive behaviours. They stated that they managed resident #024's behaviours through monitoring. They stated that after the incident with resident #026, the home initiated additional interventions to further manage resident #024's responsive behaviours, but not before the incident.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #024, and resident

#026 and other residents, including identifying and implementing interventions.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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 :

The licensee failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director.

A) A CI reported resident to resident sexual abuse.

RN #111 stated they were informed about the incident between resident #012 and resident #026, but did not report it immediately to the Director.

DOC #101 acknowledged that the incident between resident #024 and resident #026 was not reported immediately as required.

B) A CI documented an incident of sexual abuse.

Documentation in the progress notes in PCC indicated that resident #021 was witnessed touching resident #023.

ADOC #102 acknowledged that the incident between resident #021 and #023 was not reported immediately as required.

C) A CI documented an incident of sexual abuse.

Documentation in the progress notes recorded that resident #021 was found touching resident #022 by RN #111.

ADOC #102 said the nurse who reported the incident did not immediately report it to the Director.

The licensee failed to ensure that the witnessed sexual abuse of residents #022, #023 and #026 was immediately reported to the Director. (743)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone, immediately reports the suspicion and the information which it is based to the Director, to be implemented voluntarily.

WN #4: 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 :

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

A CI was submitted to the MOHLTC documenting that resident #021 exhibited responsive behaviours towards resident #023. The home failed to reassess resident #021's behaviors after the incident and failed to trial new interventions.

Resident #021's MDS, care plan and documentation in PCC were reviewed. The resident had a progressive decline in intellectual functioning, including alteration of thought process, as well as a deficit in memory, judgment and decision making.

At the time of the incident, resident #021 was independent with mobility, had a history of wandering and responsive behaviours.

Documentation in the progress notes in PCC indicated resident #021 exhibited responsive behaviors towards resident #023.

As per the risk assessment documentation in PCC, the on-call Administrator Staff #100 was notified about the incident and staff were advised to place resident #021 on safety checks at specific intervals. ADOC #102 said that it did not appear the safety checks were added to the plan of care.

Review of the resident #021's plan of care found no new interventions were added after the incident to address their responsive behaviour. ADOC #102 said no new interventions were added to the plan of care after the incident, and according to BSO #106, resident #021 was not referred to the BSO program to re-assess their behaviours.

Progress notes documented that resident #021 subsequently exhibited behaviours towards resident #022.

The licensee failed to ensure that when resident #021 exhibited responsive behaviours, that actions were taken, including reassessment of the behavior and interventions; and that the resident #021's responses to the interventions were documented.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that actions are taken to respond to the needs of a resident demonstrating responsive behaviours, including reassessments, interventions, and that the resident's responses are documented, to be implemented voluntarily.

Issued on this 5th day of July, 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) :	KIYOMI KORNETSKY (743), JANET GROUX (606), KRISTAL PITTER (735)
Inspection No. / No de l'inspection :	2019_793743_0009
Log No. / No de registre :	020640-18, 027378-18, 031073-18, 031333-18, 032321-18, 004111-19, 010251-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 28, 2019
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Arthur Nursing Home 215 Eliza Street, P.O. Box 700, ARTHUR, ON, N0G-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lindsay Ross

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 Caressant-Care Nursing and Retirement Homes Limited, 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s.19 (1) of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must:

a) Ensure that residents #022, #023, #025, #026, #027, or any other resident, are not abused by resident #21 or resident #024.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The Home's policy "Abuse and Neglect – Staff to Resident, Family to resident, Resident to Resident, Resident and/or Family to Staff Abuse Policy" effective date August 2018, last reviewed September 2018; promoted zero tolerance of abuse and neglect of residents.

A) A Critical incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), reporting resident to resident sexual abuse. The CI stated that staff witnessed resident #024 touching resident #026.

Resident #024's progress notes documented that Personal Support Worker

(PSW) #124 witnessed resident #024 touching resident #026.

Resident #026's plan of care identified the resident with cognitive loss of intellectual functioning characterized by a deficit in memory, judgment, decision making, thought process. The resident also had impaired impaired mobility.

Resident #024's clinical records, including progress notes, and plan of care stated the resident was cognitively intact.

PSW #124 stated that resident #026 was cognitively impaired and was not able to move due to their medical diagnoses. They told the Inspector that resident #024 had a history of sexually inappropriate behavior. PSW #124 stated that they witnessed resident #024 touching #026, and reported the incident to the registered staff.

Registered Nurse (RN) #111 stated that PSW #124 reported to them about the incident between resident #024, and #026.

B) Multiple CI reports were submitted to the MOHLTC related to incidents of alleged sexual abuse involving resident #021. Resident #021 was alleged to have sexually abused residents #022, #023 and #27 over a nine-month period.

Resident #021's MDS, care plan and documentation in PCC were reviewed. The resident had a progressive decline in intellectual functioning, including alteration of thought process, and a deficit in memory, judgment and decision making.

At the time of the incidents, resident #021 was independent with mobility, had a history of wandering and sexually responsive behaviors.

i) A record review was completed and documentation in Point Click Care (PCC) indicated that resident #021 was witnessed touching resident #023. PSW #123 said they witnessed resident #021 touching resident #23 and that resident #023 was crying during the incident.

Resident #023 had moderate cognitive impairment, were usually able to make themselves understood, were usually able to understand others, and had clear

speech.

ii) PSW #124 said they heard resident #022 screaming from their room and observed resident #022 trying to push resident #021 away. RN #111 said they observed resident #021 touching resident #022.

According to resident #022's MDS assessment, their mode of expression was through signs, gestures or sounds.

iii) Documentation in PCC recorded that PSW #117 witnessed resident #021 touching #027. PSW #117 confirmed that they saw resident #021 touching resident #027.

According to their MDS Assessment, resident #027's cognitive skills for daily decision-making were severely impaired. ADOC #102 said that resident #027 would not have been able to give informed consent to allow resident #021 to touch them.

The licensee failed to ensure that residents #022, #023, #026 and #027 were protected from sexual abuse by residents #021 and #024. (743)

The severity level of this issue was determined to be a level 2, as there was minimal harm to the residents. The scope of the issue was a level 3 as it related to five out of five residents reviewed. The home had a level 2 compliance history as there was previous non-compliance to a different subsection.

(606)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 19, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee must be compliant with s.54(b) of O.Reg 79/10.

Specifically, the licensee must:

1) Ensure that interventions are identified and implemented to minimize the risk of altercations and potentially harmful interactions between resident #024 and resident #25, resident #26 and any other resident.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

A CI reported resident to resident sexual abuse.

Resident #025 stated they told the staff that they did not want resident #024 in their room and did not want resident #024 to touch them.

Progress notes were reviewed, and documentation stated that there had been previous incidents involving these two residents over a two-month period.

Resident #024's progress notes identified that they had also had several

incidents with resident #030. It was reported that resident #024 was witnessed touching resident #030.

Resident #024's clinical records including the progress notes, plan of care, physician orders, and assessments stated that the following interventions were initiated to respond to resident #024's behaviours. Resident #024 continued to be monitored and was spoken to by staff and told not to go near resident #025.

Review of resident #024's plan of care did not show that a follow up was completed after two incidents, to address resident #024's responsive behaviours.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #024 and resident #025 and other residents, including identifying and implementing interventions.

2. A CI reported that PSW #124 witnessed resident #024 touching resident #026.

The plan of care for resident #024 was to increase monitoring to ensure that there were no further incidents. Resident #026's plan of care directed the staff to follow a number of interventions.

Progress notes documented another incident where PSW #124 witnessed resident #024's hand on resident #026. Resident #024 was redirected back to their room and documentation stated that the resident would be monitored.

Resident #024's plan of care was reviewed and identified them to express inappropriate sexual behaviour of a verbal and physical nature, towards residents and staff.

PSW #124 stated they witnessed resident #024 touching resident #026 inappropriately and removed resident #024 out of resident #026's room.

PSW #124, Registered Practical Nurse (RPN) #107 and RN #111 stated that resident #024 had been identified with inappropriate responsive behaviours.

They stated that they managed resident #024's behaviours through monitoring. They stated that after the incident with resident #026, the home initiated additional interventions to further manage resident #024's responsive behaviours, but not before the incident.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #024, and resident #026 and other residents, including identifying and implementing interventions.

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 2 as it related to two out of three residents reviewed. The home had a level 2 compliance history as they had previous non-compliance to a different subsection. (606)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 19, 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 28th day of June, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kiyomi Kornetsky

Service Area Office /
Bureau régional de services : Central West Service Area Office