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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 18, 2017	2017_595604_0009	031508-16, 007072-17	Critical Incident System

Licensee/Titulaire de permis

Downsview Long Term Care Centre Limited
3595 Keele Street NORTH YORK ON M3J 1M7

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

Downsview Long Term Care Centre
3595 Keele Street NORTH YORK ON M3J 1M7

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

SHIHANA RUMZI (604), JOY IERACI (665)

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 6, 7, 10, and 11, 2017.

The following intakes were inspected related to unlawful conducted that resulted in harm/risk to a resident, log #031508-16, and #007072-17.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Recreational Assistant (RA), and residents.

During the course of the inspection, the inspectors made observations of staff to resident interactions, resident to resident interaction, provision of care, conducted reviews of health records, homes complaints and critical incident logs, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted an identified Critical Incident System (CIS) report on an identified date to the Ministry of Health and Long Term Care (MOHLTC), Director. The CIS report indicated a PSW found resident #003 laying on the floor complaining of pain in resident #001's room. When resident #001 was asked about what had occurred, the resident indicated to a PSW that resident #003 was in his/her room and had exhibited an identified responsive behaviour towards resident #001. The CIS indicated resident #003 sustained injuries and was transferred to hospital for further assessment.

A record review of resident #003's clinical records indicated that the resident had identified responsive behaviours. A review of the written plan of care for an identified time period, which had been signed as reviewed by a registered staff two weeks later, confirmed the identified plan of care was in place at the time of the incident. The written plan of care indicated that resident #003 had identified responsive behaviours and the goal is to ensure the resident was safe. The written plan of care and the Kardex directed staff to provide an identified intervention.

During an interview with PSW #104, it was stated that he/she was assigned to an identified shift on an identified unit in the home and was providing nourishment in the hall when he/she heard a noise come from resident #001's room. When the PSW entered resident #001's room he/she stated he/she saw resident #003 laying on the floor. The PSW stated resident #001 told him/her that resident #003 was in his/her room and had exhibited an identified responsive behaviour towards resident #003. Resident #003 was transferred to hospital for further assessment.

Interviews with PSWs #105 and #109 indicated that resident #003 had identified responsive behaviours. PSWs #105 and #109 indicated the resident was not being provided the identified intervention.

Interviews with RPNs #102 and #103 indicated that it was the home's expectation for registered staff to ensure interventions in a resident's written plan of care are implemented and delegate interventions to the PSWs . The RPN's stated that resident #003 had identified responsive behaviours and the written plan of care directs staff to provide an identified intervention. RPN#102 indicated that PSWs are to document the identified intervention on monitoring sheets. RPN #102 indicated he/she was unable to locate the monitoring sheets for the resident and that PSW staff have been directed to provide the identified intervention to resident #003. The RPN further confirmed that staff had not been documenting the residents' identified intervention on the his/her identified responsive behaviour monitoring sheets and the written plan of care was not followed for

resident #003.

An interview with the Assistant Director of Care (ADOC) indicated PSWs were to have documented the identified intervention on the flow sheets located in block binders in the nursing station and further stated it is the home's expectation for interventions in the plan of care to be followed. The ADOC confirmed that the plan of care directed staff to provide an identified intervention and the staff are expected follow the plan of care set out for the resident.

An interview with the Director of Care (DOC) indicated resident #003 was identified with responsive behaviours. The DOC stated it is the home's expectation for staff to follow the plan of care and confirmed that staff had not been following what they were expected to do.

The severity of the non-compliance and the severity of harm and risk was actual. On an identified date, resident #003 who had identified responsive behaviours went into resident #001's room, and was subsequently injured resulting in a transfer to hospital for further assessment. Resident #003's written plan of care directed staff to provide identified interventions. Interview with RPNs, PSWs, ADOC, and DOC confirmed the home did not follow the care set out in the plan of care for resident #003.

The scope of the non-compliance was isolated to resident #003.

A review of the home's compliance history revealed previous non-compliance related to the Long-Term Care Homes Act, Or.Reg c. 8, s. 6 (7), was issued. The Non-compliances are as follows:
-Inspection #2016_420643_0007, Resident Quality Inspection - VPC was issued.
-Inspection #2014_321501_0021, Resident Quality Inspection – VPC was issued.
-Inspection #2014_163019_0021, Complaint Inspection – VPC was issued.

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. 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 where protect from abuse by anyone in the home.

The home submitted two CIS reports to the MOHLTC, Director. The CIS reports were as follows:
1) The CIS report submitted on an identified date indicated resident #001 exhibited an identified responsive behaviour towards resident #002. Resident #001 and resident #002 sustained injuries further assessment and was transferred to hospital.

2) The CIS report submitted on an identified date indicated a PSW found resident #003 laying on the floor beside the bed complaining of pain in resident #001's room. When resident #001 was asked as to what had occurred resident #001 had indicated to the PSW that he/she exhibited an identified responsive behaviour toward the resident. The CIS indicated resident #003 sustained injuries requiring further assessment and was transferred to hospital.

A review of resident #001's written plan of care for two identified dates indicated the resident had identified responsive behaviours towards others in the home. Goals indicated to reduce incidents of the identified responsive behaviours. Identified interventions were in place to respond to the resident's identified responsive behaviours. The resident was seen by psychogeriatric community resources.

An interview with RPN #101 indicated he/she knows resident #001 well and that the resident presented with identified responsive behaviours and is aware of identified triggers.

Further interview with RPN #101 indicated he/she witnessed resident #001 exhibiting identified responsive behaviours towards resident #002. The RPN stated resident #002 was assessed at the time of the incident and the resident had sustained injuries and was transferred to hospital for further assessment. A week later with further complaints of

pain by resident #002 revealed further injuries sustained by the encounter with resident #001. The RPN indicated he/she viewed this incident to be abuse from resident #001 to resident #002 as there was injuries sustained by resident #002.

An interview with PSW #104 stated he/she was assigned on the an identified shift on an identified unit in the home and was assigned to provide nourishment, the PSW indicated as he/she was providing nourishment in the hall close to resident #001's room, he/she heard a noise come from resident #001's room. When the PSW entered the room he/she stated he/she saw resident #003 laying on the floor and asked resident #001 what had occurred. The PSW stated resident #001 told him/her that resident #003 was in his/her room and had exhibited identified responsive behaviours towards the resident. The PSW further stated he/she requested RPN #103's assistance and the resident was transferred to hospital and stated the incident constituted as abuse.

An interview with RPN #103 confirmed the above incident occurred and that he/she assisted in assessing resident #003 and indicated resident #003 had sustained injuries which needed further assessment and was transferred to hospital. The RPN further stated he/she identified this incident to be abuse towards resident #003 by resident #001.

A record review of resident #003's clinical records indicated that the resident had been identified with responsive behaviours. A review of the written plan of care for an identified date and subsequent review, indicated that resident #003 had identified responsive behaviours. The written plan of care and Kardex directed staff to provide identified interventions.

An interview with PSWs #105 and #109 indicated that resident #003 will wander into other residents' room. PSWs #105 and #109 indicated resident was not being provided the identified intervention.

Interviews with RPNs #102 and #103 indicated resident #003 has the tendency to go to other residents' room's and the written plan of care directed staff to provide an identified intervention. RPN#102 indicated that PSWs are to document the identified intervention on the monitoring sheets. RPN #102 stated he/she was unable to locate the monitoring sheets for the resident and stated that staff have been directed to provide the identified intervention and confirmed that staff had not been documenting the identified intervention on the monitoring sheets.

An interview with resident #001 revealed he/she was able to recall both incidence involving resident #002 and #003, and stated he/she gets confused and unsure as to why he/she reacted the way he/she did. Resident #001 stated he/she was told by the home to ring the bell if he/she has a problem or concern but did not ring the bell.

An interview with the home's DOC indicated he/she was aware of both incidents as he/she submitted the CIS reports. The DOC confirmed resident #002 and #003 sustained injuries in both incidents and considered the incidents to be abuse by resident #001 towards resident #002 and #003.

The severity of the non-compliance and the severity of harm and risk were actual. On an identified date resident #002 sustained injuries which required further assessment and was transferred to hospital. On a subsequent identified date, resident #003 entered into resident #001's room and resident #001 exhibited identified responsive behaviours towards resident #003. Resident #003 sustained injuries which required further assessment and was transferred to hospital. Resident #003 was not provided the identified intervention as directed in the plan of care and the home failed to ensure that resident #003 was safe therefore the home is being served an order.

The scope of the non-compliance is isolated to resident #002 and #003.

A review of the home's compliance history revealed previous non-compliance related to the Long-Term Care Homes Act, O.Reg. c. 8, s. 19 (1). The Non-compliances are as follows:
-Inspection #2016_420643_0007, Resident Quality Inspection – CO was issued specifically related to the home's abuse and neglect policy.
-Inspection #2014_321501_0021, Resident Quality Inspection – CO was issued.

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 has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion upon which it was based to the Director.

The home submitted a CIS report on an identified date to the MOHLTC Director, which indicated resident #001 exhibited identified responsive behaviours toward resident #002. Resident #001 and resident #002 sustained injuries requiring further assessment and was transferred to hospital.

A review of the amended CIS report indicated the incident occurred on an identified date, and a CIS report was submitted to the MOHLTC, Director on an identified date, the CIS report was four days late.

An interview with the home's DOC indicated the Administrator and the DOC are the only individuals in the home who are able to complete CIS reports. The DOC confirmed the above incident which occurred with resident #001 and #002 was reported late.

Issued on this 9th day of June, 2017

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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) :	SHIHANA RUMZI (604), JOY IERACI (665)
Inspection No. / No de l'inspection :	2017_595604_0009
Log No. / Registre no:	031508-16, 007072-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 18, 2017
Licensee / Titulaire de permis :	Downsview Long Term Care Centre Limited 3595 Keele Street, NORTH YORK, ON, M3J-1M7
LTC Home / Foyer de SLD :	Downsview Long Term Care Centre 3595 Keele Street, NORTH YORK, ON, M3J-1M7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Christiana Burns

To Downsview Long Term Care Centre Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that front line staff are aware of resident #003's written plan of care.

The plan shall include but is not limited to the following areas:
1) A process to ensure front line staff review the written plan of care for resident #003.

2) A process to ensure front line staff conduct and the identified intervention for resident #003 as directed in the written plan of care.

The plan shall be submitted by May 29, 2017, to shihana.rumzi@ontario.ca.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted an identified Critical Incident System (CIS) report on an identified date to the Ministry of Health and Long Term Care (MOHLTC), Director. The CIS report indicated a PSW found resident #003 laying on the floor complaining of pain in resident #001's room. When resident #001 was asked about what had occurred, the resident indicated to a PSW that resident #003 was in his/her room and had exhibited an identified responsive behaviour towards resident #001. The CIS indicated resident #003 sustained injuries and was transferred to hospital for further assessment.

A record review of resident #003's clinical records indicated that the resident had identified responsive behaviours. A review of the written plan of care for an

identified time period, which had been signed as reviewed by a registered staff two weeks later, confirmed the identified plan of care was in place at the time of the incident. The written plan of care indicated that resident #003 had identified responsive behaviours and the goal is to ensure the resident was safe. The written plan of care and the Kardex directed staff to provide an identified intervention.

During an interview with PSW #104, it was stated that he/she was assigned to an identified shift on an identified unit in the home and was providing nourishment in the hall when he/she heard a noise come from resident #001's room. When the PSW entered resident #001's room he/she stated he/she saw resident #003 laying on the floor. The PSW stated resident #001 told him/her that resident #003 was in his/her room and had exhibited an identified responsive behaviour towards resident #003. Resident #003 was transferred to hospital for further assessment.

Interviews with PSWs #105 and #109 indicated that resident #003 had identified responsive behaviours. PSWs #105 and #109 indicated the resident was not being provided the identified intervention.

Interviews with RPNs #102 and #103 indicated that it was the home's expectation for registered staff to ensure interventions in a resident's written plan of care are implemented and delegate interventions to the PSWs . The RPN's stated that resident #003 had identified responsive behaviours and the written plan of care directs staff to provide an identified intervention. RPN#102 indicated that PSWs are to document the identified intervention on monitoring sheets. RPN #102 indicated he/she was unable to locate the monitoring sheets for the resident and that PSW staff have been directed to provide the identified intervention to resident #003. The RPN further confirmed that staff had not been documenting the residents' identified intervention on the his/her identified responsive behaviour monitoring sheets and the written plan of care was not followed for resident #003.

An interview with the Assistant Director of Care (ADOC) indicated PSWs were to have documented the identified intervention on the flow sheets located in block binders in the nursing station and further stated it is the home's expectation for interventions in the plan of care to be followed. The ADOC confirmed that the plan of care directed staff to provide an identified intervention and the staff are expected follow the plan of care set out for the resident.

An interview with the Director of Care (DOC) indicated resident #003 was identified with responsive behaviours. The DOC stated it is the home's expectation for staff to follow the plan of care and confirmed that staff had not been following what they were expected to do.

The severity of the non-compliance and the severity of harm and risk was actual. On an identified date, resident #003 who had identified responsive behaviours went into resident #001's room, and was subsequently injured resulting in a transfer to hospital for further assessment. Resident #003's written plan of care directed staff to provide identified interventions. Interview with RPNs, PSWs, ADOC, and DOC confirmed the home did not follow the care set out in the plan of care for resident #003.

The scope of the non-compliance was isolated to resident #003.

A review of the home's compliance history revealed previous non-compliance related to the Long-Term Care Homes Act, Or.Reg c.8, s. 6 (7), was issued. The Non-compliances are as follows:
-Inspection #2016_420643_0007, Resident Quality Inspection - VPC was issued.
-Inspection #2014_321501_0021, Resident Quality Inspection – VPC was issued.
-Inspection #2014_163019_0021, Complaint Inspection – VPC was issued.
(665)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 01, 2017

Order # / Ordre no : 002

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 shall prepare, submit and implement a plan to ensure that residents in the home are protected from abuse by resident #001.

The plan shall include but is not be limited to the following:
1) Training to all staff on the risks associated with residents identified with responsive behaviours.

2) Develop and implement interventions to ensure residents who have been identified with responsive behaviours on the identified home area are wanderers on home area are monitored as directed in the plan of care.

3) Process to ensure all front line staff are aware of all residents on the identified home area with the identified responsive behaviours.

The plan shall be submitted by May 29, 2017, to shihana.rumzi@ontario.ca.

Grounds / Motifs :

1. The licensee has failed to ensure that residents where protect from abuse by anyone in the home.

The home submitted two CIS reports to the MOHLTC, Director. The CIS reports were as follows:
1) The CIS report submitted on an identified date indicated resident #001 exhibited an identified responsive behaviour towards resident #002. Resident #001 and resident #002 sustained injuries further assessment and was transferred to hospital.

2) The CIS report submitted on an identified date indicated a PSW found resident #003 laying on the floor beside the bed complaining of pain in resident #001's room. When resident #001 was asked as to what had occurred resident #001 had indicated to the PSW that he/she exhibited an identified responsive behaviour toward the resident. The CIS indicated resident #003 sustained injuries requiring further assessment and was transferred to hospital.

A review of resident #001's written plan of care for two identified dates indicated the resident had identified responsive behaviours towards others in the home. Goals indicated to reduce incidents of the identified responsive behaviours. Identified interventions were in place to respond to the resident's identified responsive behaviours. The resident was seen by psychogeriatric community resources.

An interview with RPN #101 indicated he/she knows resident #001 well and that the resident presented with identified responsive behaviours and is aware of identified triggers.

Further interview with RPN #101 indicated he/she witnessed resident #001 exhibiting identified responsive behaviours towards resident #002. The RPN stated resident #002 was assessed at the time of the incident and the resident had sustained injuries and was transferred to hospital for further assessment. A week later with further complaints of pain by resident #002 revealed further injuries sustained by the encounter with resident #001. The RPN indicated he/she viewed this incident to be abuse from resident #001 to resident #002 as there was injuries sustained by resident #002.

An interview with PSW #104 stated he/she was assigned on the an identified shift on an identified unit in the home and was assigned to provide nourishment, the PSW indicated as he/she was providing nourishment in the hall close to resident #001's room, he/she heard a noise come from resident #001's room. When the PSW entered the room he/she stated he/she saw resident #003 laying on the floor and asked resident #001 what had occurred. The PSW stated resident #001 told him/her that resident #003 was in his/her room and had exhibited identified responsive behaviours towards the resident. The PSW further stated he/she requested RPN #103's assistance and the resident was transferred to hospital and stated the incident constituted as abuse.

An interview with RPN #103 confirmed the above incident occurred and that

he/she assisted in assessing resident #003 and indicated resident #003 had sustained injuries which needed further assessment and was transferred to hospital. The RPN further stated he/she identified this incident to be abuse towards resident #003 by resident #001.

A record review of resident #003's clinical records indicated that the resident had been identified with responsive behaviours. A review of the written plan of care for an identified date and subsequent review, indicated that resident #003 had identified responsive behaviours. The written plan of care and Kardex directed staff to provide identified interventions.

An interview with PSWs #105 and #109 indicated that resident #003 will wander into other residents' room. PSWs #105 and #109 indicated resident was not being provided the identified intervention.

Interviews with RPNs #102 and #103 indicated resident #003 has the tendency to go to other residents' room's and the written plan of care directed staff to provide an identified intervention. RPN#102 indicated that PSWs are to document the identified intervention on the monitoring sheets. RPN #102 stated he/she was unable to locate the monitoring sheets for the resident and stated that staff have been directed to provide the identified intervention and confirmed that staff had not been documenting the identified intervention on the monitoring sheets.

An interview with resident #001 revealed he/she was able to recall both incidence involving resident #002 and #003, and stated he/she gets confused and unsure as to why he/she reacted the way he/she did. Resident #001 stated he/she was told by the home to ring the bell if he/she has a problem or concern but did not ring the bell.

An interview with the home's DOC indicated he/she was aware of both incidents as he/she submitted the CIS reports. The DOC confirmed resident #002 and #003 sustained injuries in both incidents and considered the incidents to be abuse by resident #001 towards resident #002 and #003.

The severity of the non-compliance and the severity of harm and risk were actual. On an identified date resident #002 sustained injuries which required further assessment and was transferred to hospital. On a subsequent identified date, resident #003 entered into resident #001's room and resident #001

exhibited identified responsive behaviours towards resident #003. Resident #003 sustained injuries which required further assessment and was transferred to hospital. Resident #003 was not provided the identified intervention as directed in the plan of care and the home failed to ensure that resident #003 was safe therefore the home is being served an order.

The scope of the non-compliance is isolated to resident #002 and #003.

A review of the home's compliance history revealed previous non-compliance related to the Long-Term Care Homes Act, O.Reg. c. 8, s. 19 (1). The Non-compliances are as follows:
-Inspection #2016_420643_0007, Resident Quality Inspection – CO was issued specifically related to the home's abuse and neglect policy.
-Inspection #2014_321501_0021, Resident Quality Inspection – CO was issued.
(604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 01, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shihana Rumzi

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