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 le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 13, 2017;	2016_356618_0016 (A1)	016219-16	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

CASTLEVIEW WYCHWOOD TOWERS
351 CHRISTIE STREET TORONTO ON M6G 3C3

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

CECILIA FULTON (618) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date for this order has been extended to March 31, 2017 per agreement between the Licensee and the LTCH Inspector.

Issued on this 13 day of February 2017 (A1)

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

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

CECILIA FULTON (618) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 30 and 31, June 1, 2, 3, 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 20, 22, 23, 24 and August 8, 9, 10, 11 and 12, 2016.

The following Critical Incident (CI) intakes were inspected concurrently with this RQI:

Related to Duty to Protect: 009982-16, 004395-14, 028889-15, 008936-14, 027554-15, 009186-16, 034559-15, 013366-16, 003341-14, 002975-14, 000979-14, 002375-16, 034561-15, 021031-15, 019967-15, 008963-15, 001694-15, 010076-14, 008055-14, 007177-14, 008182-16, 015056-16, 033550-15, 032490-15, 031651-15, 031159-15, 026192-15, 014213-15, 026271-15, 002889-15, 021168-15, 012844-16, 033601-15, 029256-15, 005326-14, 006196-14, 014286-15, 008454-14, 032810-15, 003619-16, 009246-16.

Related to Plan of Care: 016237-16, 015337-16.

Related to Personal Support Services: 004667-14.

Related to Falls Prevention and Management: 002724-16.

Related to Communication and response system: 024590-15.

The following Complaint intakes were inspected concurrently with this RQI:

Related to Duty to Protect: 007343-16, 008561-14, 015559-16, 005029-16, 017682-15, 028550-15, 000480-15.

Related to Interference with Resident's Council: 004917-16.

Related to Emergency Plans: 013804-15.

Related to Authorization for Admission to a Home: 010080-15, 004230-16.

Related to Safe and Secure Home: 002250-15.

Related to Resident's Bill of Rights: 004397-15.

Related to Care Conference: 030375-15.

Related to Continence Care and Bowel Management: 001747-16, 009206-14.

Related to Personal Care: 001602-15.

Related to Plan of Care: 000480-15, 030961-15, 024416-15.

Follow up to the following intakes wwere conducted concurrently with the RQI: 014324-15, 014323-15, 012452-16.

During the course of the inspection, the inspector(s) spoke with Residents, Resident's family members, Resident's Council President, Family Council Representative, Personal Care Assistants (PCA), Registered Practical Nurses (RPN), Registered Nurses (RN), Building Services Manager (BSM), Nurse Managers (NM), Rehabilitation Assistant (RA), Administrator, Director of Care (DOC), Food Service Workers (FSW), Community Care Access Center (CCAC) staff, Nutrition Manager (NM), Administrative Assistant (AA), Social Worker (SW), Physiotherapist (PT) and Music Therapist and Hair Dresser.

During the course of this inspection, the inspectors toured the home, observed resident care, observed staff to resident interactions, observed meal service, reviewed resident health

records, meeting minutes, schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Admission and Discharge

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

13 WN(s)
6 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 15. (2)	CO #001	2015_357101_0017	120
LTCHA, 2007 s. 15. (2)	CO #002	2015_357101_0017	120
O.Reg 79/10 s. 18.	CO #003	2015_357101_0017	120
LTCHA, 2007 s. 6. (7)	CO #001	2016_413500_0003	646

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. 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 :

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

Review of an identified Critical Incident System (CIS) report, revealed that on an identified date in August 2015, resident #031 pushed resident #032, causing resident #032 to fall to the ground. As a result of this, resident #032 sustained an injury.

Review of resident #031's plan of care revealed that the resident suffers from an identified medical condition with resulting responsive behaviors.

Interviews with staff #130 and registered staff #136 confirmed resident #031's responsive behaviors.

Interview with staff #130 confirmed that at the start of their shift, on an identified date in August 2015, staff #130 heard screaming. Staff #130 went to investigate and found resident #032 on the floor, in front of their room, with resident #031 beside them in their wheelchair. Resident #032 communicated that resident #031 had pushed the resident, causing resident #032 to fall.

Interview with registered staff #136 confirmed that on the night of the incident they had spoken to resident #032. According to the registered staff, resident #032 stated that resident #031 had been trying to enter resident #032's room, and when resident #032 attempted to stop resident #031 from entering, resident #031 pushed resident #032 and caused them to fall to the ground.

Interviews with registered staff #136 and Nurse Manager (NM) #153 confirmed that resident #032 continued experience pain after they fell, and it was eventually discovered that resident #032 had sustained an injury. [s. 19. (1)] (178)

2. The licensee has failed to ensure resident #021 was protected from abuse by anyone.

A review of an identified CIS report, submitted on an identified date in October 2014, revealed staff #174 had observed resident #020 abuse resident #021. A head to toe assessment of resident #021, completed by staff, revealed redness on a specific area of the resident's body. Police were contacted.

A review of the progress notes for resident #021 on an identified date in October 2014, revealed redness was noted on an identified area of resident #021's body.

The inspector was unable to interview resident #021.

Resident #020 no longer resides at the home.

An interview with staff #174 confirmed they had witnessed resident #020 physically abuse resident #021 and that after the incident they could see a reddened area on an identified part of resident #021's body.

An interview with the Director of Nursing (DON) confirmed resident #020 was abusive towards resident #021. [s. 19. (1)] (605)

3. The licensee has failed to protect residents from abuse by anyone.

A review of an identified CIS report revealed that resident #056 reported to the home that resident #051 had inappropriately touched resident #055 without consent on an identified date in December 2015. Resident #051 confirmed that they had touched resident #055 without receiving consent. Resident #055 reported that it had made them feel uncomfortable.

A review of progress notes from an identified date in December 2015 revealed that NM #110 had interviewed resident #051 and that resident #051 had admitted touching resident #055 without consent. The notes also revealed that resident #051 had stated that they had not realized that it was wrong. The progress notes further revealed that resident #055 reported feeling uncomfortable because resident #051 had touched then without obtaining consent.

Interview with resident #055 revealed that they recalled the incident and that they never expected it from resident #051. Resident #055 also stated that resident #051 had touched them without consent and made an inappropriate comment. Resident #055 indicated that they felt very uncomfortable after the incident.

A review of resident #051's care plan revealed that the resident demonstrated inappropriate behaviors towards other residents. Interventions specific to these identified behaviours were included in the care plan.

A review of resident #056 revealed that they had witnessed resident #051 touching resident #055 on an identified area of the resident's body and then make an inappropriate comment. Resident #056 stated that resident #055 was visibly shaking and looked uncomfortable, and that resident #051's behavior was very inappropriate.

Interview with resident #051 confirmed that they had touched resident #055 without consent. Resident #051 did not remember if they had made any comment to resident #055 as this incident was a long time ago.

A review of the home's policy #RC-0305-00, entitled, "Zero Tolerance of Abuse and Neglect", revised October 1, 2014, revealed that the purpose of the policy is to ensure residents' rights are protected and to prevent incidents of resident abuse.

Interview with NM #110 revealed that resident #051 admitted touching resident #055 without obtaining consent and resident #055 admitted feeling uncomfortable because of the incident. [s. 19. (1)] (500)

4. The licensee has failed to ensure that residents were protected from abuse by anyone and that residents are not neglected by the licensee or staff.

A review of an identified CIS report revealed that on an identified date in May 2016, while resident #040 was receiving personal care, PCA #150 left the resident to attend to another resident in the same room. While PCA #150 was assisting the other resident, a bang was heard from the area where resident #040 had been left. When PCA #150 responded, they saw resident #040 had sustained injuries. Registered staff assessment also revealed injuries.

An interview with PCA #150, conducted by the inspector, revealed that resident #040 required assistance of one staff for this personal care and that resident #040 was not to be left alone due to the resident's high risk for falls. PCA #150 revealed that they turned their attention away from resident #040 to attend to another resident that was in a situation placing them at a high risk for falls, and when turned slightly and bent down to assist this other resident, PCA #150 heard the bang of resident #040 hitting against a wall.

An interview with registered staff #151confirmed that resident #040 required assistance of one staff for this personal care, and that the resident should not have been left unattended during the delivery of this care. Registered staff #151 stated that they felt this incident could have been prevented had PCA #150 not left resident #040 unattended, and that in doing so, the resident's care needs were neglected.

An interview with acting NM #110 confirmed that PCA #150 failed to keep resident

#040 safe while assisting the resident with this personal care, and that the resident's care needs were neglected. [s. 19. (1)] (566)

5. The licensee has failed to ensure all residents are free from neglect by the licensee or staff.

a. A review of an identified CIS report revealed resident #054 stated they had been abused by resident #020, on an identified date in August 2015. The incident was not witnessed. Police were contacted.

Resident #054 was cognitively intact. A review of progress notes and an interview with resident #054 revealed resident #054 was not injured in this altercation.

b. A review of an identified CIS report revealed that on an identified date in September 2015, resident #020 abused resident #023 while resident #023 was sitting in their chair. Resident #023 fell to the ground; no injury was noted and the police were contacted. Resident #023 was cognitively intact. Resident #023 declined to be interviewed about this incident.

c. A review of an identified CIS report revealed that on an identified date in November 2015, resident #020 was acting inappropriately on an identified resident home area. The resident was consuming alchohol and was asked by the acting NM to surrender it. The resident then left the unit. The resident was found outside the home and refused to return to the unit. Approximately 10-15 minutes later, a co-resident and family member reported to staff that resident #020 was observed abusing resident #054.

Review of progress notes and interview with resident #054 revealed that resident #054 was not injured.

An identified intervention was then implemented for resident #20.

d. A review of an identified CIS report revealed that on an identified date in November 2015, resident #054 reported that they had been abused by resident #020. Police were contacted.

At the time of the incident, PCA #206 was monitoring resident #020. An interview with PCA #206 revealed they had witnessed resident #020 approach resident #054 from behind and hug them. Staff #206 stated resident #020 was not being

aggressive but resident #054 overreacted and was upset.

An interview with resident #054 revealed resident #020 had abused them on multiple occasions. Resident #054 stated they were never injured, but that the incidents of abuse had been frightening. Resident #054 also stated the home did not do anything to protect them from resident #020.

Record review revealed resident #020 had an identified medical condition and disorders, and as per the written plan of care, resident #020 exhibited abusive behaviours. Resident #020 was discharged from the home on an identified date in 2015.

Interviews with identified staff members revealed resident #020 would have no recollection of the incidents of abuse. Resident #020 was followed by the Geriatric Mental Health Outreach Team (GHMOT) and an identified program nurse. Staff at the home tried to refer the resident to various community programs, but resident #020 did not meet the entrance criteria.

An interview with the Administrator revealed that monitoring was initiated for resident #020 on an identified date in November 2015. In addition, the home obtained the services of a security company to monitor the outdoor space (where most altercations took place). The Administrator stated the altercations involving resident #020 were random.

Residents #023 and #054's safety had been at risk due to resident #020's abusive behaviors. [s. 19. (1)] (605)

6. The licensee has failed to ensure that resident #001 was protected from abuse.

Review of an identified CIS report, revealed that PCA #200 had a conversation with resident #001 which was considered inappropriate.

Review of resident #001's progress notes, the home's investigation notes, and an interview with staff and the resident revealed that the resident reported to a family member that, on an unidentified date in either late 2014 or early 2015, PCA #200 had had an inappropriate conversation with the resident while providing care to this resident. The resident reported that this conversation made them feel nervous.

Interview with staff #199 revealed that resident #001's family member report to

them that the resident had told them that PCA #200 had an inappropriate conversation with resident #001. The conversation was reported to have occurred while the resident was receiving personal care by PCA #200, and was not witnessed by anyone.

Interview with resident #001 revealed that the conversation was brief, silly and that it did make the resident feel unsafe and a little nervous.

Review of the home's investigation revealed that resident #001 consistently recounted the events of this incident when questioned. PCA #200 received disciplinary action, was required to participate in further education and was re-assigned to a different resident care area.

These findings were confirmed by the homes Administrator. [s. 19. (1)] (618)

7. The licensee has failed to ensure that resident #062 was protected from verbal abuse.

Review of an identified CIS report revealed that on an identified date in October 2014, PCA #166 entered the room of resident #062 to provide care and treated the resident in a manner that the resident considered abusive. Resident #062 documented their concerns in a written letter to the unit NM.

A review of the written letter submitted by resident #062 provided details of an abusive exchange between the resident and PCA #166.

Resident #062 told the inspector during an interview that PCA #166 was abusive during care on a specified date.

The home conducted an investigation into the incident and PCA #166 received disciplinary action, was required to participate in further education, and was re-assigned to a different resident assignment.

The findings of this inspection were confirmed by the home's Administrator. [s. 19. (1)] (618)

8. The licensee has failed to ensure that resident #116 was protected from physical abuse by staff in the home.

Review of an identified CIS report revealed that PCA #200 physically abused resident #116 during the delivery of care.

Review of the resident's progress notes, home's investigation notes and interview with staff revealed that resident #116 told staff #201 that while they were receiving care a few days earlier, PCA #200 had physically abused them.

Interview with staff member #201 revealed that while speaking with resident #116 about the disclosure of abuse, the resident was consistent in their re-telling of the incident, and staff #201 was confident that the information the resident was providing was accurate. The incident had not been reported by the resident to any one else.

The home conducted an investigation into the incident and PCA #200 received disciplinary action, was required to participate in further education, and was re-assigned to a different resident home area.

These findings were confirmed by the home's Administrator. [s. 19. (1)] (618)

9. The licensee has failed to ensure that residents were protected from abuse by anyone and are not neglected by the licensee or staff.

A review of an identified CIS report revealed that an altercation occurred between residents #021 and #083, resulting in an injury to resident #083.

A review of the progress notes for the date of the incident revealed that resident #083 sustained multiple areas of injury to identified parts of their body.

An interview with RPN #133 revealed that on an identified date in October 2015, raised voices were heard and residents #021 and #083 were found to be engaged in a physical altercation. RPN #133 confirmed resident #083 had sustained injuries.

An interview with the Administrator confirmed that resident #083 suffered injuries from this altercation, therefore, the resident was not protected from physical abuse. [s. 19. (1)] (513)

10. The licensee has failed to ensure that residents were protected from abuse by anyone and were not neglected by the licensee or staff.

A review of an identified CIS report revealed that an altercation had occurred between residents #085 and #086. According to the report, resident #086 approached resident #085's dining table. In response, resident #085 spread their arms to prevent resident #086 from coming to the table, then picked up an identified object from the table and pointed it toward resident #086.

When staff approached, resident #085 continued to exhibit responsive behaviors.

A review of the resident's medical records revealed resident #085 had multiple episodes of abusive behavior toward staff and residents over a seven month period in 2016. An identified intervention was negotiated with the resident if the resident continued the abusive behavior. This intervention was implemented in response to an incident of abuse on an identified date.

A review of medical records for resident #086 revealed cognitive impairment. Observations of resident #086 indicated that they were unable to appreciate a threat .

Interview with PCA #147, who witnessed the altercation between residents #085 and #086, confirmed resident #085 picked up the identified object from the table, was verbally abusive, and then followed instructions to put the object down.

Interview with registered staff #175, confirmed resident #085's responsive behavior.

Interviews with the registered staff #205, NM #110 and ADOC #182 confirmed that residents were not protected from verbal abuse by resident #085. [s. 19. (1)] (513)

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

Record review of an identified CIS report revealed that on an identified date in June 2016, resident #010 went outside to get a newspaper and asked resident #131 for help. According to resident #010, resident #131 approached them from behind to provide assistance with locomotion and touched the resident in an inappropriate manner. Resident #010 responded by telling resident #131 to stop. According to resident #131, they were helping resident #010 and had not deliberately touched resident #010 inappropriately. There were no witnesses, and the police were

immediately notified.

A review of the notes from the home's investigation revealed that the police, as well as the Administrator and NM #101 had reviewed the video surveillance footage of this incident. In the home's interview with resident #010 following the incident, resident #010 indicated that they would like to press charges against resident #131.

Record review of the health records for residents #010 and #131 revealed that resident #010 had an identified level of cognitive impairment and resident #131 had no previous history of specified inappropriate behaviours.

Interview with resident #010 and resident #131 revealed that resident #131 was assisting resident #010 enter the building. Resident #010 revealed that while providing this assistance, that resident #131 touched them in what they felt was a deliberate, inappropriate manner. Resident #131 revealed that they were not aware they had touched resident #010 and if they had, it was accidental.

Interview with NM #101, revealed that they had viewed the security footage with the Administrator and that resident #131 did touch an identified area of resident #010's body very quickly while helping resident #010. Resident #010 had responded by pushing resident #131's hand away. NM #101 confirmed that they considered this incident to be abuse.

Observation of the video surveillance footage by two inspectors, revealed that resident #131 was seen assisting resident #010 to enter the home. While providing this assistance, resident #131 appeared to touch resident #010. Resident #010 responded by brushing resident #131's hand away. Resident #131 immediately removed their hand and resumed assisting resident #010 through the second set of doors into the main lobby. There was no further interaction observed between the two residents.

Record review of resident #131's progress notes revealed that they had been seen by GMHOT following the incident and no recommendations were made as the resident had no history of abuse, and maintained that any inappropriate touching was unintentional. On an identified date in June 2016, resident #131 was charged with the assault of resident #010 by an identified police detective. The conditions of resident #131's bail included that resident #131 must abstain from communicating with resident #010 or attending anywhere where resident #010 resides and that

resident #131 could continue to reside in their identified room in the home until alternate accommodations at a different address were arranged.

Record review and staff interviews confirmed there have been no further incidents between resident #131 and resident #010, nor any other co-residents since.

An interview with the Administrator confirmed that the home's investigation revealed that resident #131 had touched resident #010 inappropriately, and that charges had been laid by the police.

An interview with the identified detective confirmed that as of October 5, 2016, the case was still open.

The severity of the non-compliance and the severity of the harm were actual. The scope of the noncompliance was pattern. A review of the Compliance History revealed that there was a Written Notification (WN) and a Compliance Order (CO) issued in inspection #2014_159178_002, dated October 23, 2014; a WN and CO issued in inspection #2014_159178_0012, dated May 5, 2014; a WN and CO issued in inspection #2013_109153_0027, dated November 19, 2013, and a WN and VPC issued in inspection #2013_159178_022, dated September 26, 2013. As a result of the severity, scope, and the licensee's previous compliance history, a compliance order is warranted. [s. 19. (1)] (566)

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 every resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Record review of an identified CIS report revealed that on an identified date in November 2015, resident #003 approached resident #010 in the library and repeatedly asked resident #010 to touch an identified area of resident #003's body. Following that incident, resident #010 stated that they felt unsafe.

Record review of resident #010's progress notes revealed that the resident reported they had been approached by resident #003 who asked if they would like to touch an identified area of resident #003's body, to which resident #010 responded "no, thank you". Resident #003 then left resident #010 alone.

Record review revealed that resident #003 often asks people if they want to "hook up", and if they say "no", resident #003 will not persist. Resident #003 revealed that they would never force themself on another person and understood that they were not to approach resident #010 again.

Interview with resident #010, revealed that the resident recalled this incident, that resident #003's comment upset them, and that there have been no further incidents between the two residents. An interview with resident #003 revealed that they could no longer recall the incident and did not know who resident #010 was.

Interview with NM #101 revealed that there were no long-term negative outcomes to resident #010 following the incident.

Review of the home's investigation notes revealed that police responded to the incident and no charges were laid.

An interview with the Administrator confirmed that the comment made by resident #003 was inappropriate and violated the resident #010's right to be treated with courtesy and respect. [s. 3. (1) 1.] (566)

2. Review of an identified CIS report from an identified date in July 2015, reported that PCA #202 provided care to resident #006 in a manner that the resident stated came across as the PCA being angry at the resident while assisting this resident with their care.

Review of the resident's progress notes, home's investigation notes, and interviews with staff and the resident revealed, that on an identified date in July 2015, the resident reported to staff #141 that earlier that day PCA #202 made statements to the resident that were inappropriate and made the resident feel hurt and embarrassed.

Resident #006 had no identified deficits with communication or cognition.

Interview with staff member #203 revealed that resident #006 had informed them that PCA #202 had spoken rudely to them.

Interview with staff #141 revealed that they had been informed by the resident that a staff member, identified as PCA #202, made a comment to the resident regarding the resident refusing care from other PCAs, so as a result PCA #202 had to provide this resident care. Staff #141 revealed that the resident reported having felt this comment was demeaning to them.

PCA #202 was not available for interview during this inspection.

The home conducted an investigation and actions were taken in regards to the incident. These findings were confirmed by the home's Administrator. [s. 3. (1) 1.] (618)

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 every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, and to be protected from abuse is fully respected and promoted, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 the care set out in the plan of care is provided to the resident as specified in the plan.

A review of an identified CIS report revealed that on an identified date in May 2016, while resident #040 was receiving assistance with personal care, PCA #150 left the resident to attend to another resident in the same room. While PCA #150 was helping the other resident, a bang was heard from the area where resident #040 had been left. When PCA #150 responded, they saw resident #040 had sustained injuries.

An interview with PCA #150, conducted by the inspector revealed that resident #040 required one person assistance for this personal care and was not to be left alone. PCA #150 revealed that they were aware that this requirement had been in the resident's plan of care since admission to ensure resident #040's safety. PCA #150 revealed that when this incident occurred, PCA #150 had turned away from the resident to attend to another resident who they felt was at a high risk for injury. While PCA #150 was assisting the other resident, they heard a loud noise and saw that resident #040 had hit an identified area of their body on the wall.

Interview with registered staff #151, confirmed that resident #040 required assistance by one staff for the delivery of this care, and that the resident should not have been left unattended. Staff #151 revealed that this care need was identified in resident #040's plan of care.

A review of the resident's written care plan for activities of daily living updated on an identified date in April 2016, revealed that the resident required a specific level of assistance for the provision of this care. The written care plan was updated following the incident.

An interview with the acting NM #110 confirmed that resident #040 should not have been left alone by the PCA and that care was not provided as per the plan of care. [s. 6. (7)] (566)

2. The licensee has failed to ensure that the provision of the care set out in the plan of care is documented.

A review of resident #051's written care plan revealed that the resident exhibited responsive behaviours towards another resident and that staff were to monitor and document the behaviors.

A review of an identified CIS report revealed that resident #056 reported to the

home that resident #051 had been touching resident #055 without consent on an identified date in December2015. Resident #051confirmed that they had touched resident #055 without consent.

Resident #055 reported that this had made them feel uncomfortable. NM #110 advised resident #051 that their actions towards resident #055 were inappropriate and unwanted. Staff were directed to initiate behaviour monitoring for resident #051 for a specified number of days.

Review of the progress note from an identified date in June 2016, revealed that resident #055 voiced a concern about resident #051 coming to their room and offering money to help resident #051 get out of the trouble they were in as a result of the incident of inappropriate touching. Resident #055 reported that they felt uncomfortable as a result of this encounter and resident #051 was told to stay away from resident #055 and monitoring was initiated.

Interview with RN #197 revealed that the home's expectation was to complete behavioural monitoring documentation for an identified number of days after the incident occurred.

A review of the Modified Dementia Observation System (DOS) records revealed many missing entries between December 2015 and in June 2016.

Interviews with RN #197, Social Worker (SW) #141 and NM #110 confirmed that staff are required to document behavior monitoring and that the above mentioned missing entries should have been documented. [s. 6. (9) 1.] (500)

3. The licensee has failed to ensure that the provision of the care set out in the plan of care is documented.

A review of resident #053's written care plan revealed that when the resident exhibits responsive behaviours, staff are to initiate behaviour monitoring and document it on a flow sheet.

A review of the resident #053's progress note from an identified date in January 2016, revealed that behaviour monitoring and documentation was initiated as a result of an incident of resident #053's aggressive behaviour to a fellow resident and visitor.

A review of flow sheet records for resident #053 revealed many missing entries between January and February 2016.

Interviews with RN #197, SW #141 and NM #110 confirmed that staff are required to document behavior monitoring and that the above mentioned missing entries should have been documented. [s. 6. (9) 1.] (500)

4. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A review of resident #054's written care plan revealed that the resident exhibited responsive behaviour and staff are to observe and document these behaviours.

A review of home's incident reports from identified dates in November and December 2015, revealed that resident #053 and resident #054 had exhibited both physical and verbal aggression. Police were called and the police warned both residents to stay away from each other.

A review of the flow sheet records revealed many missing entries between November and December 2015.

Interviews with RN #197, SW #141 and NM #110 confirmed that staff are required to document behavior monitoring and that the above mentioned missing entries should have been documented. [s. 6. (9) 1.] (500)

5. The licensee has failed to ensure that different approaches were considered in the revision of the plan of care when a resident is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective.

A review of an identified CIS report revealed that resident #056 reported to the home that resident #051 had touched resident #055 without consent on an identified date in December 2015 Resident #051 confirmed that they had touched resident #055 without obtaining consent. Resident #055 reported feeling uncomfortable.

NM #110 advised that resident #051's action toward resident #055 were inappropriate and unwanted.

A review of resident #051's care plan revealed that the resident had exhibited inappropriate physical behaviours towards another resident, and that an intervention was identified for this behavior.

A review of the progress note from an identified date in June 2016, revealed resident #051 approached resident #055 and offered money to get resident #051 out of the trouble that was occurring due to the above mentioned incident investigation from the police. Resident #055 reported feeling uncomfortable due to resident #051 coming near them.

Interview with resident #055 confirmed that they felt uncomfortable due to this encounter with resident #051. Resident #055 admitted that resident #051 was always around and this made resident #055 feel uncomfortable as it reminded the resident of the incident.

Interview with resident #056 revealed that resident #055 mentioned feeling uncomfortable because resident #051 had been able to approach them and offered them money.

Interview with RN #196 revealed that resident #051 was supposed to stay away from resident #055 but had approached resident #055 and offered money. RN #196 confirmed that the current interventions for resident #051's behavior were not effective.

Interview with NM #197 revealed that staff are continuing interventions for resident #051, however resident #055's statements reveal that interventions have not been effective.
Staff were monitoring resident #051 and had staff had observed resident #051 attempting to approach resident #055 then the incident might have been prevented.

Interview with SW #144 confirmed that if resident #051 had succeeded in approaching resident #055 then the current intervention had not been effective.

Interview with NM #110 confirmed that interventions intended to keep resident #051 away from resident #055, had not been effective. [s. 6. (10) (c)] (500)

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 ensure that the care set out in the plan of care is provided to the resident as specified in the plan; the provision of the care set out in the plan of care is documented; that different approaches are considered in the revision of the plan of care when a resident is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective; and that different approaches were considered in the revision of the plan of care when a resident was reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Observations made on an identified date in May 2016, confirmed that the door to the servery behind the main floor cafeteria was left unlocked and open while no staff were present.

The room contained a number of chemical dispensers including Apex presoak, Micro-quat detergent germicidal deodorizer, and Klenefusion detergent dispenser. A couple of minutes later, maintenance staff #190 entered the servery and stated the door had been opened for a few minutes only, in order for an electrician to check the breaker.

Observations made on an identified date in June 2016, at revealed this same door was again unlocked and open, with no staff present. The inspector observed the above chemical dispensers in the room, and also a pail of broken glass and china dishes was observed on the floor. The inspector was in the room for seven minutes and no staff appeared.

The inspector accompanied NM staff #112 to the room who confirmed that the servery is a non-residential area and that it should be kept locked when staff are not present. [s. 9. (1) 2.] (178)

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 all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails were used, the residents were assessed in accordance with evidence-based practices to minimize risk to the resident.

An identified resident's bed was observed to have a portable bed rail attached to the mattress on an identified date in June 2016. The bed rail was designed in the shape of an "L" so that a portion slid under the mattress and the handle remained above the level of the mattress which, according to the identified resident, was used for support getting into and out of the bed. According to Health Canada, the Food and Drug Administration and the Consumer Product Safety Commission in the United States, bed rails are hazardous and pose an unacceptable risk for strangulation, entrapment and suffocation. According to the licensee's bed manufacturer, any accessory not manufactured by the bed manufacturer intended to be used on their beds would require consultation with the accessory

manufacturer to determine compatibility and limitations prior to use to prevent possible injury or death. The portable bed rail was purchased by the resident for their own use on their own domestic bed prior to being admitted to the home several months prior.

The resident's written plan of care did not include any reference to the use of the bed rail. According to the resident's PSW, the portable bed rail was installed upon admission.

According to the licensee's bed system entrapment audit results for the bed on May 27, 2016, the assessor identified that a "different bed rail" was on the bed but did not report the concern. According to the Occupational Therapist (OT) who spoke to the resident and family upon admission, the bed rail was installed by the family of the resident and that the family and the resident were discouraged from keeping it and were offered a quarter-sized bed rail that could be affixed to the bed frame if needed.

The family member and the resident insisted on keeping the portable bed rail in place as the resident had "gotten used to it". The risk to the resident related to entrapment, suspension, suffocation or entanglement was not evaluated. According to the Director of Care (DOC), this type of bed rail should not have been permitted however no written directives were developed for staff to guide their decision-making.

During the inspection, it was noted that many residents were provided with one or more bed rails and the DOC was requested to provide a copy of their formal assessment related to risk. However, the DOC stated that none of the residents who used bed rails in the home were formally assessed for any potential risks associated with bed rail use. The licensee's policy titled "Bedrail Use for Resident Self Mobility" (RC-0518-32 dated 2015) was limited to evaluating whether a resident could use a bed rail and whether they would benefit from having one applied.

The DOC was not aware of the evidence-based practice titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada) and therefore did not incorporate the guidelines into their practices.

According to the guidance document, all residents who use one or more bed rails are to be evaluated by an interdisciplinary team, over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be completed to determine whether the bed rail(s) are a safe device for residents while fully awake and while they are asleep. The guideline also emphasizes the need to document clearly whether alternative interventions were trialled before bed rails were implemented and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, falls history, toileting habits, sleeping patterns (if next to a rail and along edge of bed) and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM (Substitute Decision Maker) about the necessity and safety of a bed rail (medical device). The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any approved accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident. [s. 15. (1) (a)] (120)

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 where bed rails are used, the residents are assessed in accordance with evidence-based practices to minimize risk to the resident, to be implemented voluntarily.

WN #6: 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 :

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.

Review of the home's incident reports on identified dates in November and December 2015, revealed that resident #053 and resident #054 had exhibited physical and verbal aggression towards each other. Police were called and warned both residents to stay away from each other.

A review of progress notes from an identified date in December 2015, revealed that police officers had visited the home and met with the management and suggested that the home develop a strong plan to keep these residents separated from one another. A note from an identified date in December 2015, by the administration, indicated that the police had advised both residents to stay away from each other while in the building or out of the building.

A review of incident reports from two identified dates in December 2015 revealed that these residents had two other incidents of physical and verbal aggression towards each other after the police had provided their suggestions to the home to put a strong plan in place to keep these residents apart and safe from each other.

Review of resident #053's plan of care revealed resident #053 exhibited responsive behaviours and strategies to manage these behaviours were included in the plan of care.

Review of progress notes revealed that on an identified date in January 2016, resident #053 became aggressive towards a co-resident.

Review of the home’s documentation regarding this incident revealed that resident #053 verbally threatened resident #098 with physical abuse after having an argument with them.

Review of the home’s incident report from an identified date in February 2016, revealed that resident #053 had threatened a visitor when the visitor had asked them not to smoke in the home.

Interview with PCA #198 confirmed that resident #053 had continued to exhibit verbal and physical aggression towards residents, staff and visitors and that the current interventions and strategies in place had not been effective to manage this resident's behaviours.

Interview with RN #196, and NM #110 revealed that current interventions had not been effective as resident #053 consistently exhibited aggressive behaviour.

Interviews with SW #141 and NM #197 revealed that resident #053 is very challenging in terms of their behaviour management due to their responsive behaviors. . [s. 54. (b)] (618)

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee did not ensure that hazardous substances were kept inaccessible to residents at all times.

Two bottles of hydrogen peroxide and one bottle of iodine were observed in a resident's room on an identified date in June 2016.

The iodine was seen in the resident's wardrobe, of which the door was wide open. The hydrogen peroxide was sitting out on the resident's dresser. All were confirmed to contain some liquid in each bottle. According to the registered staff #195 on an identified date in June 2016, the resident had been applying the products without staff assistance, but confirmed that staff should have been aware of the products and the need to ensure safe storage and use.

The products were then re-located to the medical room where they could be kept locked and their use monitored.

Iodine is a hazardous (poisonous) substance and can be fatal even if small quantities are consumed, and hydrogen peroxide is corrosive and can cause internal bleeding and damage to mucous membranes (eyes, nose, throat). [s. 91.] (120)

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 hazardous substances are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that furnishings and equipment are kept clean and sanitary.

Observations made on an identified date in May and June 2016, revealed that wheelchairs belonging to residents #008, #009, and #010 were unclean. Food particles were noted on the wheelchair padding for resident #008, and food and dirt was noted on the seat and wheelchair frames for residents #009 and #010.

Interviews with staff #100, #102 and #105 revealed that residents' wheelchairs are cleaned on a prescheduled basis by housekeeping staff, and if the wheelchairs are soiled in between, then nursing staff will attempt to wipe off the soiling, and inform housekeeping staff if further cleaning is necessary.

The home's Building Services Manager (BSM) confirmed that the housekeeping staff cleans the wheelchairs during the night shift on a rotating schedule, which works out to approximately every four to six weeks. In between these cleanings, the nursing staff is expected to clean the chair if it is a simple spill, and if they are unable to clean it they will inform the housekeeping department and the wheelchair will be cleaned by the Cleaner Heavy Duty working that day. If further cleaning is necessary the wheelchair will also be added to the next scheduled cleaning night.

The BSM observed the three wheelchairs with the inspector and confirmed that each required cleaning. [s. 15. (2) (a)] (178)

WN #9: The Licensee has failed to comply with LTCHA, 2007, 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 the person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately report the suspicion and the information upon which it was based to the Director.

A review of an identified CIS report revealed that resident #057 reported witnessing resident #060 and #091 involved in a physical altercation on an identified date in March 2016.

Resident #057 reported that resident #091 entered into their room and grabbed an identified object. Resident #057 tried to stop resident #091 verbally when resident #060 came in the room and the residents engaged in a physical fight towards each other. The CI was not submitted to the Director until an identified date in March 2016.

Interview with NM #101 confirmed that the incident was not reported immediately to the Director. It was a long weekend and the nurse on the duty had forgotten to call the after hour's phone number. The NM arrived on an identified date in March 2016, and submitted the critical incident to the Director. There was no after hours call made for this incident to inform the Director. [s. 24. (1)] (500)

2. Review of an identified CIS report revealed that an incident of alleged verbal abuse was reported by resident #040's Substitute Decision Maker (SDM) to the acting NM #110 on an Identified date in March 2016. The incident was not reported to the Director until the next day.

An interview with the acting NM #110 confirmed that although an investigation was immediately initiated in the home, the incident of alleged abuse was not immediately reported to the Director, as per the requirement. [s. 24. (1)] (566)

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that they have approved an applicant's admission to the home.

On an identified date in May 2015, the Ministry of Health and Long Term Care (MOHLTC) received a complaint related to the refusal of resident #081's admission to a long-term care (LTC) home. The resident was residing in one LTC home and was requesting a transfer to this LTC facility.

A review of the LTC application from an identified date in April 2015, and

Community Care Access Centre (CCAC) records from an identified date in November 2014, revealed that the resident #081 had an identified level of cognitive impairment and exhibited responsive behaviors.

A review of the letters from an identified date in May 2015, from the LTCH to resident #081 and the CCAC, identified the home withheld approval of admission for resident #081 on the grounds that the home lacked the nursing expertise to manage resident #081's behavioural care needs.

Record review and interview with the Administrator indicated that based on identified behavioural needs, the home would not be able to manage the resident's responsive behaviours.

An interview with the Administrator revealed the home had a responsive behaviour program that was effective and that staff received annual responsive behaviour education. The Administrator reported that resident #081 was cognitively intact and the home's behaviour program was appropriate for cognitively impaired persons.

Interview with the acting Administrator revealed that it was not so much the nursing expertise, as it was the environmental aspects that would trigger resident #081's responsive behavior.

The Administrator and acting Administrator did not provide sufficient evidence that the staff of the home lacked the nursing expertise necessary to meet the resident's behavioral care needs. [s. 44. (7) (b)] (513)

2. The licensee has failed to ensure that when it withheld approval for admission, the licensee provided the persons described in subsection (10) a written notice setting out contact information of the Director.

On an identified date in May 2015 the MOHLTC received a complaint related to the refusal of admission of resident #081 to a LTC home.

A review of the written notices from an identified date in May 2015, from the LTC home to resident #081, the CCAC, and the MOHLTC, identified the home withheld approval of admission for resident #081 on the grounds that the LTC home lacked the nursing expertise to manage resident #081's behavioural care needs.

Written notices to the applicant and placement coordinator did not include the

contact information for the Director.

An interview with the Administrator confirmed that the notices did not include all required information. [s. 44. (9) (d)] (513)

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually relating to the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and the whistle-blowing protections.

Interviews with the home's Assistant Administrator (AA), #177 revealed that the home did not ensure that all staff received training in the home's policy to promote zero tolerance of abuse and neglect of residents, which includes duty to make mandatory reports and whistle blowing protections.

The AA revealed that in 2015, 85 per cent of the home's staff received training in the home's policy to promote zero tolerance of abuse and neglect of residents, and 80 per cent of the staff received training in Residents' Rights.

Review of home records confirmed the above training percentages for 2015. [s. 76. (4)] (178)

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures were developed and subsequently implemented to address incidents of lingering offensive odours.

During the inspection on June 22 and 23, 2016, through direct observations, dirty linen and soiled briefs were stored in bags (either cloth or plastic bags) which hung from wire framed carts with loose fitting lids that were parked in the corridors throughout the day. Some were parked directly outside certain resident rooms. During the inspection on June 22, 2016, two residents reported that they had to keep their bedroom door closed all the time because the odour from the cart was "bad" and permeated into their room. The cart was also within a few feet of their sitting area and impacted on their decision to use the space. On June 23, 2016, a staff member was observed carrying a fully exposed soiled brief from a resident's room to the cart where it was disposed of into a garbage bag. The odour that emanated from the brief was of urine. All of the hampers located on an identified home area on June 23, 2016 at approximately 1430 hrs were very full of soiled briefs. Odours were quite noticeable as some of the briefs had been sitting in the bags for over an hour and were in an inappropriate type of waste receptacle for the type of odours they emitted. None of the briefs were placed into an air tight bag prior to disposal into the larger garbage bag. This step alone would have kept the odours from permeating and lingering in the corridors. The soiled briefs were noted to have been removed once in the morning just before lunch and once in the afternoon just before 1500 hrs.

The licensee did not develop a written procedure to address how soiled briefs or odourous soiled clothing would be managed once removed from a resident's room to contain odours. The licensee's policy "Waste Removal" identified that "regular waste is disposed of in the appropriate waste receptacles" but did not reference what type of waste that would include and what kind of receptacles would be necessary. The policy included food waste and biomedical waste but did not identify how they would be stored and managed to "maintain cleanliness and control odour" as identified under the "purpose" section of their policy. [s. 87. (2) (d)] (120)

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff have received annual training in Behaviour Management as required under subsection 76 (7) of the Act.

Review of the home's education attendance records for the year 2015 revealed that 60 per cent of full time staff and 72 per cent of part time staff had completed the required education in Behavior Management for the year 2015.

These findings were confirmed by the home. [s. 221. (2) 1.]

Issued on this 13 day of February 2017 (A1)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : CECILIA FULTON (618) - (A1)

Inspection No. / No de l'inspection : 2016_356618_0016 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 016219-16 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Feb 13, 2017;(A1)

Licensee / Titulaire de permis :
City of Toronto
55 JOHN STREET, METRO HALL, 11th FLOOR,
TORONTO, ON, M5V-3C6

LTC Home / Foyer de SLD :
CASTLEVIEW WYCHWOOD TOWERS
351 CHRISTIE STREET, TORONTO, ON, M6G-3C3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Nancy Lew

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 City of Toronto, 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, 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 for achieving compliance with s. 19. (1). to ensure that residents are protected from abuse by anyone and are not neglected by the licensee or staff.

The plan will include but not be limited to the following elements:

1. Develop and implement steps to ensure that all staff receive training and/or retraining on the home's policy to promote zero tolerance of abuse and neglect of residents, including strategies that foster a culture of respect for residents, and the prevention of abuse and neglect.

2. Staff are educated to recognize forms of abuse and neglect and comply with the home's policy on the prevention of abuse and neglect.

3. Within one week of receipt of this order, conduct a meeting between management and direct care staff to review and discuss the following:

i) Review the findings of this compliance order as examples of abuse and neglect in the home and in relation to the definitions of abuse and neglect;

ii) Discussion about each individual staff person's role in how each of these incidents of abuse and neglect could have been prevented;

iii) Discussion of each staff person's responsibility in resident centered approaches to care that demonstrate respect of residents and that are free from abuse and neglect; and;

iv) Discussion of each staff person's responsibility toward the safety of the residents who have been abused or neglected and reporting incidents of abuse and neglect to the home and MOHLTC.

4. Develop and implement a schedule to test and monitor staff compliance with the home's abuse policies.

Grounds / Motifs :

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

Record review of an identified CIS report revealed that on an identified date in June 2016, resident #010 went outside to get a newspaper and asked resident #131 for help.

According to resident #010, resident #131 approached them from behind to provide assistance with locomotion and touched the resident in an inappropriate manner. Resident #010 responded by telling resident #131 to stop. According to resident #131, they were helping resident #010 and had not deliberately touched resident #010 inappropriately. There were no witnesses, and the police were immediately notified.

A review of the notes from the home's investigation revealed that the police, as well as the Administrator and NM #101 had reviewed the video surveillance footage of this incident. In the home's interview with resident #010 following the incident, resident #010 indicated that they would like to press charges against resident #131.

Record review of the health records for residents #010 and #131 revealed that resident #010 had an identified level of cognitive impairment and resident #131 had no previous history of specified inappropriate behaviours.

Interview with resident #010 and resident #131 revealed that resident #131 was assisting resident #010 enter the building. Resident #010 revealed that while providing this assistance, that resident #131 touched them in what they felt was a deliberate, inappropriate manner. Resident #131 revealed that they were not aware they had touched resident #010 and if they had, it was accidental.

Interview with NM #101, revealed that they had viewed the security footage with the Administrator and that resident #131 did touch an identified area of resident #010's body very quickly while helping resident #010. Resident #010 had responded by pushing resident #131's hand away. NM #101 confirmed that they considered this incident to be abuse.

Observation of the video surveillance footage by two inspectors, revealed that resident #131 was seen assisting resident #010 to enter the home. While providing this assistance, resident #131 appeared to touch resident #010. Resident #010 responded by brushing resident #131's hand away. Resident #131 immediately removed their hand and resumed assisting resident #010 through the second set of

doors into the main lobby. There was no further interaction observed between the two residents.

Record review of resident #131's progress notes revealed that they had been seen by GMHOT following the incident and no recommendations were made as the resident had no history of abuse, and maintained that any inappropriate touching was unintentional.

On an identified date in June 2016, resident #131 was charged with the assault of resident #010 by an identified police detective. The conditions of resident #131's bail included that resident #131 must abstain from communicating with resident #010 or attending anywhere where resident #010 resides and that resident #131 could continue to reside in their identified room in the home until alternate accommodations at a different address were arranged.

Record review and staff interviews confirmed there have been no further incidents between resident #131 and resident #010, nor any other co-residents since.

An interview with the Administrator confirmed that the home's investigation revealed that resident #131 had touched resident #010 inappropriately, and that charges had been laid by the police.

An interview with the identified detective confirmed that as of October 5, 2016, the case was still open. (566)

2. The licensee has failed to ensure that residents were protected from abuse by anyone and were not neglected by the licensee or staff.

A review of an identified CIS report revealed that an altercation had occurred between residents #085 and #086. According to the report, resident #086 approached resident #085's dining table. In response, resident #085 spread their arms to prevent resident #086 from coming to the table, then picked up an identified object from the table and pointed it toward resident #086.

When staff approached, resident #085 continued to exhibit responsive behaviors.

A review of the resident's medical records revealed resident #085 had multiple episodes of abusive behavior toward staff and residents over a seven month period in 2016. An identified intervention was negotiated with the resident if the resident continued the abusive behavior. This intervention was implemented in response to an incident of abuse on an identified date.

A review of medical records for resident #086 revealed cognitive impairment.

Observations of resident #086 indicated that they were unable to appreciate a threat .

Interview with PCA #147, who witnessed the altercation between residents #085 and #086, confirmed resident #085 picked up the identified object from the table, was verbally abusive, and then followed instructions to put the object down.

Interview with registered staff #175, confirmed resident #085's responsive behavior.

Interviews with the registered staff #205, NM #110 and ADOC #182 confirmed that residents were not protected from verbal abuse by resident #085. [s. 19. (1)] (513)

3. The licensee has failed to ensure that residents were protected from abuse by anyone and are not neglected by the licensee or staff.

A review of an identified CIS report revealed that an altercation occurred between residents #021 and #083, resulting in an injury to resident #083.

A review of the progress notes for the date of the incident revealed that resident #083 sustained multiple areas of injury to identified parts of their body.

An interview with RPN #133 revealed that on an identified date in October 2015, raised voices were heard and residents #021 and #083 were found to be engaged in a physical altercation. RPN #133 confirmed resident #083 had sustained injuries.

An interview with the Administrator confirmed that resident #083 suffered injuries from this altercation, therefore, the resident was not protected from physical abuse. [s. 19. (1)] (513)

4. A review of the CIS M510-000039-16 dated May 2016 revealed that an altercation had occurred between residents #085 and #086, where resident #086, who has wandering behaviour, approached resident #085's dining table. In response, resident #085 spread his/her arms to prevent resident #086 from coming to the table, and physically threatened resident #086. When staff approached, resident began to threaten staff.

Interview with PSW #147, who witnessed the altercation, confirmed resident #085 verbally and physically threatened resident #086.

Interview with RPN #175 confirmed resident #085's response was a verbal threat.

Interviews with the registered staff #205, NM #110 and ADOC #182 confirmed that residents were not protected from verbal abuse by resident #085. (513)

5. The licensee has failed to ensure that resident #116 was protected from physical abuse by staff in the home.

Review of an identified CIS report revealed that PCA #200 physically abused resident #116 during the delivery of care.

Review of the resident's progress notes, home's investigation notes and interview withstaff revealed that resident #116 told staff #201 that while they were receiving care a few days earlier, PCA #200 had physically abused them.

Interview with staff member #201 revealed that while speaking with resident #116 about the disclosure of abuse, the resident was consistent in their re-telling of the incident, and staff #201 was confident that the information the resident was providing was accurate.

The incident had not been reported by the resident to any one else.

The home conducted an investigation into the incident and PCA #200 received disciplinary action, was required to participate in further education, and was re-assigned to a different resident home area.

These findings were confirmed by the home's Administrator. [s. 19. (1)] (618)

6. The licensee has failed to ensure that resident #062 was protected from verbal abuse.

Review of an identified CIS report revealed that on an identified date in October 2014, PCA #166 entered the room of resident #062 to provide care and treated the resident in a manner that the resident considered abusive. Resident #062 documented their concerns in a written letter to the unit NM.

A review of the written letter submitted by resident #062 provided details of an abusive exchange between the resident and PCA #166.

Resident #062 told the inspector during an interview that PCA #166 was abusive during care on a specified date.

The home conducted an investigation into the incident and PCA #166 received disciplinary action, was required to participate in further education, and was re-assigned to a different resident assignment.

The findings of this inspection were confirmed by the home's Administrator. [s. 19. (1)] (618)

7. The licensee has failed to ensure that resident #001 was protected from abuse.

Review of an identified CIS report, revealed that PCA #200 had a conversation with resident #001 which was considered inappropriate.

Review of resident #001's progress notes, the home's investigation notes, and an interview with staff and the resident revealed that the resident reported to a family member that, on an unidentified date in either late 2014 or early 2015, PCA #200 had had an inappropriate conversation with the resident while providing care to this resident. The resident reported that this conversation made them feel nervous.

Interview with staff #199 revealed that resident #001's family member report to them that the resident had told them that PCA #200 had an inappropriate conversation with resident #001. The conversation was reported to have occurred while the resident was receiving personal care by PCA #200, and was not witnessed by anyone.

Interview with resident #001 revealed that the conversation was brief, silly and that it did make the resident feel unsafe and a little nervous.

Review of the home's investigation revealed that resident #001 consistently recounted the events of this incident when questioned. PCA #200 received disciplinary action, was required to participate in further education and was re-assigned to a different resident care area.

These findings were confirmed by the homes Administrator. [s. 19. (1)] (618)

8. The licensee has failed to ensure all residents are free from neglect by the licensee or staff.

a. A review of an identified CIS report revealed resident #054 stated they had been abused by resident #020, on an identified date in August 2015. The incident was not witnessed. Police were contacted.

Resident #054 was cognitively intact. A review of progress notes and an interview

with resident #054 revealed resident #054 was not injured in this altercation.

b. A review of an identified CIS report revealed that on an identified date in September 2015, resident #020 abused resident #023 while resident #023 was sitting in their chair.

Resident #023 fell to the ground; no injury was noted and the police were contacted.

Resident #023 was cognitively intact. Resident #023 declined to be interviewed about this incident.

c. A review of an identified CIS report revealed that on an identified date in November 2015, resident #020 was acting inappropriately on an identified resident home area. The resident was consuming alchohol and was asked by the acting NM to surrender it. The resident then left the unit. The resident was found outside the home and refused to return to the unit. Approximately 10-15 minutes later, a co-resident and family member reported to staff that resident #020 was observed abusing resident #054.

Review of progress notes and interview with resident #054 revealed that resident #054 was not injured.

An identified intervention was then implemented for resident #20.

d. A review of an identified CIS report revealed that on an identified date in November 2015, resident #054 reported that they had been abused by resident #020. Police were contacted.

At the time of the incident, PCA #206 was monitoring resident #020. An interview with PCA #206 revealed they had witnessed resident #020 approach resident #054 from behind and hug them. Staff #206 stated resident #020 was not being aggressive but resident #054 overreacted and was upset.

An interview with resident #054 revealed resident #020 had abused them on multiple occasions. Resident #054 stated they were never injured, but that the incidents of abuse had been frightening. Resident #054 also stated the home did not do anything to protect them from resident #020.

Record review revealed resident #020 had an identified medical condition and disorders, and as per the written plan of care, resident #020 exhibited abusive behaviours.

Resident #020 was discharged from the home on an identified date in 2015.

Interviews with identified staff members revealed resident #020 would have no recollection of the incidents of abuse. Resident #020 was followed by the Geriatric Mental Health Outreach Team (GHMOT) and an identified program nurse. Staff at the home tried to refer the resident to various community programs, but resident #020 did not meet the entrance criteria.

An interview with the Administrator revealed that monitoring was initiated for resident #020 on an identified date in November 2015. In addition, the home obtained the services of a security company to monitor the outdoor space (where most altercations took place). The Administrator stated the altercations involving resident #020 were random.

Residents #023 and #054's safety had been at risk due to resident #020’s abusive behaviors. [s. 19. 1)] (605)

9. The licensee has failed to ensure that residents were protected from abuse by anyone and that residents are not neglected by the licensee or staff.

A review of an identified CIS report revealed that on an identified date in May 2016, while resident #040 was receiving personal care, PCA #150 left the resident to attend to another resident in the same room. While PCA #150 was assisting the other resident, a bang was heard from the area where resident #040 had been left. When PCA #150 responded, they saw resident #040 had sustained injuries. Registered staff assessment also revealed injuries.

An interview with PCA #150, conducted by the inspector, revealed that resident #040 required assistance of one staff for this personal care and that resident #040 was not to be left alone due to the resident's high risk for falls. PCA #150 revealed that they turned their attention away from resident #040 to attend to another resident that was in a situation placing them at a high risk for falls, and when turned slightly and bent down to assist this other resident, PCA #150 heard the bang of resident #040 hitting against a wall.

An interview with registered staff #151confirmed that resident #040 required assistance of one staff for this personal care, and that the resident should not have been left unattended during the delivery of this care. Registered staff #151 stated that they felt this incident could have been prevented had PCA #150 not left resident #040 unattended, and that in doing so, the resident's care needs were neglected.

An interview with acting NM #110 confirmed that PCA #150 failed to keep resident #040 safe while assisting the resident with this personal care, and that the resident's care needs were neglected. [s. 19. (1)] (566)

10. The licensee has failed to protect residents from abuse by anyone.

A review of an identified CIS report revealed that resident #056 reported to the home that resident #051 had inappropriately touched resident #055 without consent on an identified date in December 2015. Resident #051 confirmed that they had touched resident #055 without receiving consent. Resident #055 reported that it had made them feel uncomfortable.

A review of progress notes from an identified date in December 2015 revealed that NM #110 had interviewed resident #051 and that resident #051 had admitted touching resident #055 without consent. The notes also revealed that resident #051 had stated that they had not realized that it was wrong. The progress notes further revealed that resident #055 reported feeling uncomfortable because resident #051 had touched them without obtaining consent.

Interview with resident #055 revealed that they recalled the incident and that they never expected it from resident #051. Resident #055 also stated that resident #051 had touched them without consent and made an inappropriate comment. Resident #055 indicated that they felt very uncomfortable after the incident.

A review of resident #051's care plan revealed that the resident demonstrated inappropriate behaviors towards other residents. Interventions specific to these identified behaviours were included in the care plan.

A review of resident #056 revealed that they had witnessed resident #051 touching resident #055 on an identified area of the resident's body and then make an inappropriate comment. Resident #056 stated that resident #055 was visibly shaking and looked uncomfortable, and that resident #051's behavior was very inappropriate.

Interview with resident #051 confirmed that they had touched resident #055 without consent. Resident #051 did not remember if they had made any comment to resident #055 as this incident was a long time ago.

A review of the home's policy #RC-0305-00, entitled, "Zero Tolerance of Abuse and Neglect", revised October 1, 2014, revealed that the purpose of the policy is to ensure residents' rights are protected and to prevent incidents of resident abuse.

Interview with NM #110 revealed that resident #051 admitted touching resident #055 without obtaining consent and resident #055 admitted feeling uncomfortable because of the incident. [s. 19. (1)] (500)

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

Review of an identified Critical Incident System (CIS) report, revealed that on an identified date in August 2015, resident #031 pushed resident #032, causing resident #032 to fall to the ground. As a result of this, resident #032 sustained an injury.

Review of resident #031's plan of care revealed that the resident suffers from an identified medical condition with resulting responsive behaviors.

Interviews with staff #130 and registered staff #136 confirmed resident #031's responsive behaviors.

Interview with staff #130 confirmed that at the start of their shift, on an identified date in August 2015, staff #130 heard screaming. Staff #130 went to investigate and found resident #032 on the floor, in front of their room, with resident #031 beside them in their wheelchair. Resident #032 communicated that resident #031 had pushed the resident, causing resident #032 to fall.

Interview with registered staff #136 confirmed that on the night of the incident they had spoken to resident #032. According to the registered staff, resident #032 stated that resident #031 had been trying to enter resident #032's room, and when resident #032 attempted to stop resident #031 from entering, resident #031 pushed resident #032 and caused them to fall to the ground.

Interviews with registered staff #136 and Nurse Manager (NM) #153 confirmed that resident #032 continued experience pain after they fell, and it was eventually discovered that resident #032 had sustained an injury. [s. 19. (1)]

The severity of the non-compliance and the severity of the harm were actual. The scope of the noncompliance was pattern. A review of the Compliance History revealed that there was a Written Notification (WN) and a Compliance Order (CO) issued in inspection #2014_159178_002, dated October 23, 2014; a WN and CO issued in inspection #2014_159178_0012, dated May 5, 2014; a WN and CO issued in inspection #2013_109153_0027, dated November 19, 2013, and a WN and VPC issued in inspection #2013_159178_022, dated September 26, 2013. As a result of the severity, scope, and the licensee's previous compliance history, a compliance order is warranted. [s. 19. (1)] (178)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Mar 31, 2017(A1)

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

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 13 day of February 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CECILIA FULTON - (A1)

Service Area Office /
Bureau régional de services : Toronto