



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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
May 11, 2017;	2017_360111_0001 (A2)	035430-16	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON
N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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



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LYNDA BROWN (111) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

**Good afternoon Orchard Villa,
Here is the revised Inspection Report and Order for Compliance Order #003 for
LTCHA, 2007, s.19(1). The compliance date was extended to June 30, 2017.
Thank you,
Lynda Brown, Nursing Inspector
Ministry of Health and Long Term Care**

Issued on this 11 day of May 2017 (A2)

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

Original report signed by the inspector.



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LYNDA BROWN (111) - (A2)

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): January 16-20, 23-27, 30-31, February 1-3 & 8, 2017

The following inspections were completed concurrently with this inspection:

-Critical incident's related to allegations of resident abuse and/or neglect (02731-16, 023595-16, 026513-16, 034777-16, 033626-16, 034747-16, 000992-17, 002431-17, 002520-17)

-Critical incident's related to fall resulting in an injury and transfer to hospital (030254-16)

-Complaints related to staff shortages, of supplies, and food quality (022231-16, 025341-16, 033948-16)

-Complaints related to allegations of staff to resident abuse and/or neglect; poor pain management; and medication administration (034747-16 & 034927-16; 030157-16; 030904-16)

-Critical incident related to responsive behaviour (024245-16)

During the course of the inspection, the inspector(s) spoke with the Administrator, acting DOC, Registered Nurses (RN), Registered Practical Nurses (RPN), Environmental Services Manager (ESM), Nutritional Care Manager (NCM), Dietitian, maintenance, Physiotherapist (PT), Dietary Aides (DA), Housekeepers (HSK), Personal Support Workers (PSW), Social Worker (SW), Laundry Aides,



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Cooks and RAI Coordinator, Resident Council President, and Residents.

During the course of the inspection, the inspector(s) also toured the home, observed dining services, observed a medication administration pass, observed supplies, and measured lighting levels throughout the home, reviewed resident health records, reviewed Resident Council Meeting minutes, reviewed the home's complaints and investigations, and reviewed the following policies: Zero Tolerance of Abuse and Neglect, Weights, Responsive Behaviours, Complaints and Customer Service.

The following Inspection Protocols were used during this inspection:



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Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
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.

23 WN(s)

7 VPC(s)

3 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: 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:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii. equipped with a door access control system that is kept on at all times, and

iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

**A. is connected to the resident-staff communication and response system,
or**

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rules related to doors were complied with:

Doors that residents had access to and led to stairways and unsecured outdoor areas of the home were not equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and were not connected to the resident-staff communication and response system.



A) Eight doors leading to stairwells to which residents had access were checked. These doors were located in the main foyer (near the elevator), two in the Birch home area, one in the Linden home area, two in the Cedar home area and three in the Aspen home areas and did not have an audible alarm located at the door. When each door was tested, it was confirmed to be connected to the resident-staff communication and response system (at various enunciator panels) and an audible sound within the corridors was heard. However, each door did not have a separate audible alarm at the door that would sound until a staff member cancelled the alarm at the door.

B) The front main entrance door to the long term care home, which led to an unsecured outdoor area was not equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and was not connected to the resident-staff communication and response system. When the door was tested, the Linden area nursing station was identified by staff as the closest station to the door. The audio visual enunciator located at the nurse's station included a visual light labelled "front door", but it did not light up when the door was left open for more than one minute. The exit door leading from the Aspen home area to an unsecured outdoor area did not have an audible alarm at the door and it could not be confirmed if the door was connected to the Aspen home area audio visual enunciator.

C) Two stairwell doors accessible to residents in the basement (near the recreation room and chapel) were not equipped with an audible door alarm or connected to the audio visual enunciator at the Maple nurse's station. Management staff could not confirm if the doors were connected to any of the other enunciator panels within the home. Maintenance staff could not provide any drawings or a reference confirming which stairwell door and which door leading to the outside was connected to which enunciator panel and were not aware that the doors were not connected to the resident-staff communication and response system (via enunciator panels).

D) Two sets of glass doors leading to the retirement home area located in the basement (near the auditorium and a stairwell) and one set of doors located on the main floor leading to the retirement home area were not connected to any audio visual enunciator at any of the nurse's stations and were therefore not connected to the resident-staff communication and response system. The doors were not equipped with an audible alarm. Doors that separate a retirement home from a



long term care home area considered the equivalent of doors leading to an unsecured outdoor area. [s. 9. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a process to ensure that food service workers and other staff assisting residents were aware of the resident's diets, special needs and preferences. [s. 73. (1) 5.]



Observation of the lunch service in the main dining room (Linden servery) on a specified date by Inspector #111 indicated the dietary aide (DA #109) did not refer to the resident diet list while providing resident meals. PSW # 114 requested the meal choice and texture but did not identify the resident names when requesting food plates from the DA. PSW # 113 was requesting meal choice by resident names only and the DA did not refer to the resident diet list to ensure they received the correct diet and texture. The DA began asking the nursing staff to refer to the resident diet list after the inspector asked the DA why the resident diet list was not referred to.

Interview with the Nutritional Care Manager (NCM), by Inspector #111 indicated it is the DA responsibility to refer to the diet list prior to serving meal choices for each resident, not the nursing staff.

2. The licensee failed to ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement that was required to safely eat and drink as comfortably and independently as possible. [s. 73. (1) 9.]

An observation of the lunch meal service on a specified date, in the large main dining room was completed by Inspector #623. Resident #018, #060 and #062 were seated at the same table and the food was placed in front of these three residents. All three residents made no attempt to eat the meal. PSW#126 sat with resident #062 fifteen minutes later and began assisting with feeding. There was no verbal communication, no verbal cues or encouragement to eat their meals by PSW #126. Approximately half an hour later, all three residents had been removed from the table. Resident # 018 & #060's meal was untouched. Resident #062 had consumed 50% of meal (with staff assistance) and no dessert was offered to any of the three residents. Resident #002 was observed sitting at a different table and a plate of food was placed in front of the resident. The resident made no attempt to eat and the food was sitting for approximately 20 minutes in front of resident #002 when PSW #143 was observed removing the plate from the resident without asking the resident if the resident was finished eating or offering assistance. Resident #002 did not receive any lunch.

Interview with PSW #143 by Inspector #623 confirmed the plate was removed from resident #002, the meal was untouched and the PSW did not offer assistance to resident #002 . Interview with PSW #126 by Inspector #623, confirmed that residents #018, #060 and #062 require monitoring throughout the meal with verbal cuing and assistance if they do not eat. PSW#126 was unable to confirm the intake



for these residents at lunch.

3. An observation of the lunch meal service on the following day in the large main dining room was completed by Inspector #623 and residents #018, #060 and #062 had plates of food placed in front of these residents. The plates were removed approximately half hour later and the food was left untouched. No dessert was offered to any of these residents. Residents #018, #060 and #062 were not offered encouragement or assistance at any time throughout the meal. Resident's #060 and #061 did not receive any fluids. None of the three residents received their lunch meal. Resident #002 was observed to receive a plate of food at a specified time when PSW#126 sat down and fed resident#002 three bites of food and then left the table. The resident made no attempts to feed self. PSW#126 stated out loud "someone needs to feed, we have no one" and then continued to serve other tables. Approximately 20 minutes later, the plate of food was removed from resident #002. Resident #002 did not eat the remainder of the meal and dessert was also not offered to resident #002.

Interview with PSW#156 by Inspector #623, indicated that resident #002 requires assistance to eat "sometimes, but not today" and indicated resident #002 had consumed all of lunch meal as well as dessert today.

Review of the clinical records for residents #002, #018, #060, and #062 indicated that all four residents require staff to verbally cue and encourage to eat throughout the meal and staff are to provide assistance to eat if necessary. All four residents had experienced recent weight loss and were identified as high nutritional risk.

The licensee has failed to ensure that residents #002, #018, #060 and #062 were provided with the personal assistance and encouragement required to eat and drink as independently as possible.

4. An observation of the lunch meal service on a specified date in the large main dining room was completed by Inspector #111 and identified the following:

- resident #002 had a pureed meal placed in front of the resident. The resident made no attempt to eat the meal and no assistance or prompting was provided. Approximately 15 minutes later, PSW #115 then provided the resident two spoonfuls of food and then left the resident. No other assistance or encouragement was provided for the remainder of the meal and the resident did not receive the remainder of the meal.
- Resident #003 had completed the lunch meal and had asked PSW # 115 for



desert. The PSW indicated the resident would have to wait. The resident continued to ask three other staff for desert before it was provided. The resident expressed frustration with staff ignoring request for desert.

-Resident #055 had a pureed meal placed in front of the resident. The resident made no attempt to eat the meal and no assistance or encouragement was provided to the resident for a period of approximately 15 minutes when a staff member fed the resident the lunch meal and desert.

-Interview of PSW # 126 & #156 indicated resident #002, #003 and #055 required encouragement and/or total assistance with feeding of meals.

Review of the clinical records for residents #002, #003 and #055 indicated that resident #002 required staff to either verbally cue and encourage to eat throughout the meal and/or staff are to provide assistance to eat if necessary. Resident #003 and #055 required total assistance with feeding at meals. All four residents had experienced recent weight loss and were identified as high nutritional risk.

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: 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 failed to ensure that residents were protected from staff to resident verbal or physical abuse and/or neglect by staff and other residents, and failed to ensure vulnerable, cognitively impaired, residents were protected from alleged, suspected or witnessed sexual abuse by another resident, pursuant to s.19 of the LTCHA.

Under O.Reg. 79/10, s.2(1) For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "sexual abuse" means,(a) subject to subsection (3), (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Under O.Reg. 79/10, s.2(1), For the purposes of the definition of "abuse" in subsection 2(1) of the Act,
-"emotional abuse" means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour, or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a residents.
-"physical abuse" means, subject to subsection (2)(a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Under O.Reg. 79/10, s. 5, For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

1. Related to log #001738-17:

Critical Incident Report (CIR) was submitted to the Director on a specified date related to an alleged staff to resident verbal and physical abuse that was reported to Inspector #626 in stage one of the RQI. Inspector #626 reported the alleged incidents to the Administrator on the same day. Resident #010 reported the previous evening, two staff were rough when providing care and resulted in pain. The resident also indicated that PSW #139 and PSW #149 also made inappropriate comments towards the resident regarding personal care. The resident indicated the incidents were reported to RPN #120 the following morning (the same day the Inspector was notified). The RPN did not report the allegation to



the RN, DOC or Administrator until the following day during the investigation.

Interview with RPN #120 by Inspector #626 confirmed that the resident did report the alleged inappropriate comments made by the PSW #139 and #140 but was not informed of any incidents of physical abuse or rough handling. The RPN was uncertain of the date the RPN was informed. The RPN indicated was not informed of any incidents of physical abuse or rough handling. RPN #120 indicated that the resident had requested the RPN not to report the allegation but should have reported it immediately.

In an interview with the Administrator by Inspector #626 indicated that RPN #120 did not immediately report the allegations of staff to resident verbal abuse until the home's investigation the day after the allegation was received. The Administrator indicated that it is the expectation that staff report incidents of abuse immediately to their RN supervisor.

The licensee failed to ensure the written policy that promotes zero tolerance of abuse and neglect of residents was complied with as RPN #120 failed to immediately report an incident of staff to resident rough handling and emotional abuse as issued under WN #14 under s.20(1)(a)(626).

2. Related to log #020568-16:

A critical incident report (CIR) was submitted on a specified date for an alleged staff to resident neglect. The CIR indicated at a specified time, resident #015 was observed yelling and making threatening remarks towards resident #053. The incident was witnessed by PSW #151 and PSW #152, who did not intervene. RPN #132 then witnessed the incident and intervened. RPN #132 forwarded a complaint regarding the incident the same day indicating the staff failed to intervene. The CIR was not amended to provide the outcome of the licensee's investigation into the allegation.

An off-site enquiry was made to the Administrator on a specified date requesting the outcome of the licensee's investigation but the information was not provided. An inspection was then initiated a week later and the Administrator was asked for the investigation and outcome of the investigation. One staff interview was provided to the inspector at that time but no outcome of the investigation. Review of the health record of resident #053 indicated there was no documented evidence of the incident or to indicate the resident was assessed as per the home's Zero



Tolerance of Abuse policy. Further interview with Administrator confirmed she should be interviewing all staff who may have been involved in the incident, documenting the outcome of the investigation and the CIR should have been updated with the outcome.

Interview with Social Worker (SW) indicated she is responsible for maintaining the home's complaint log and enters all verbal and written complaints that are received once the investigations are completed. The SW was not aware of any verbal complaint received by the home on the specified date regarding allegations of staff to resident neglect towards resident #053. The SW indicated the acting DOC or Administrator are responsible for providing all verbal or written complaints to the SW.

- Review of the home's investigation and interview of staff indicated the home's Zero Tolerance of Abuse policy was not followed as: there was no documented evidence of the incident or to indicate resident #053 was assessed or offered support related to verbal abuse received by resident #015. The two PSW staff also failed to intervene as issued under WN #14 under LTCHA, 2007, s.20(1)(a).
- The licensee failed to ensure that a documented record was kept in the home that included: the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response, and; any response made by the complainant the verbal complaint made by the RPN regarding neglect was not documented in homes complaint log as issued under WN #22 under O.reg. 79/10, s.101(2)
- The CIR was not updated within 21 days of the incident, with the outcome of the investigation as the CIR was not updated as of the time of the inspection, six months later, as issued under WN #23 under O.Reg. 79/10, s.104(3).

3. Related to log # 002431-17:

Critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect that occurred over a two day period at specified times. The CIR indicated resident #061 (who is cognitively well) had reported staff to resident neglect towards resident #057 by PSW #129. Resident #061 reported additional staff were also aware of the incident. The CIR did not indicate which staff were involved in the allegation.



Interview with Administrator and acting DOC by Inspector #111, indicated PSW #129 was involved in the alleged neglect and resident #061 (who reported the allegation), were both interviewed two days later. The Administrator indicated the home determined the PSW #129 had provided care related to toileting to resident #057 on both dates. The Administrator indicated that PSW #129 could not provide a specified task due to lack of supplies available. Interview of the Administrator the following day indicated she forgot that she had also interviewed three other PSW's on the same day the allegation was made but did not document the interviews. The Administrator concluded the investigation and indicated the allegations were unfounded.

Review of the current written care plan for resident #057 indicated the resident is at risk for skin breakdown related to incontinence and interventions included: resident will not call for assistance with toileting, staff are to check and change the resident every 2-3 hours and as needed.

Review of the licensee's investigation, interview of staff, and review of the resident #057 health record indicated a complaint was received by resident #061 on a specified date regarding an allegation of staff to resident neglect that occurred towards resident #057 by PSW #129. The home's investigation indicated that PSW #123, #139, #145, #165 were involved or present in the allegation and their names were not provided in the CIR. The outcome of the investigation was unfounded despite the licensee's investigation indicating PSW #129 did not provide care to resident #057 as indicated in the plan related to toileting. PSW #123 reported assisting PSW #129 with toileting of resident #057 once per shift on the specified dates and indicated resident #057 required more frequently toileting. Interview with PSW #139 by Inspector #111 indicated resident #057 required toileting 3-4 times per shift. Resident #057 was not toileted as indicated in the plan.

- There was no documented evidence of the incident or to indicate resident #057 was assessed, as per the home's Zero Tolerance of Abuse and Neglect policy, as issued under WN #14 under LTCHA, 2007, s.20(1)(a).
- There was no documented evidence the investigation was completed immediately and no actions were taken related to the resident not being toileted as per the resident's plan of care or the lack of supplies available to complete a specified task as issued under WN #15 under LTCHA, 2007, s.23 (1)(a).
- The care set out in the plan of care was not provided to the resident as specified in the plan related to toileting as issued under WN #12 under LTCHA, 2007, s.6(7).



-The CIR was not amended to indicate which staff were involved with the allegation despite staff awareness two days after the allegation was made, as issued under WN #23 under O.reg.79/10, s.104(1)2.

4. Related to log # 027318-16:

The Ministry of Health after hours was called on a specified date to report an incident of injury of unknown cause to resident #045. A CIR was not submitted at that time. A CIR was submitted four months later as a result of an off-site enquiry. The CIR indicated at a specified time, RPN #117 noted an injury to a specified area to resident #045 and suspected rough handling by a staff or resident. The CIR indicated the outcome was pending the investigation. The CIR indicated the SDM was not notified of the incident.

Interview with the Administrator by Inspector #111 requesting the outcome of the investigation indicated the investigation was not yet completed (five months later). The Administrator confirmed the SDM was not notified of the incident.

Review of resident #045 progress notes indicated on a specified date and time, an RPN noted an injury to a specified area and suspected possible rough handling by a staff or resident due to location of injury. The RPN interviewed the PSW who was assigned to resident #045 and confirmed the injury was noted at start of shift but did not report to the RPN. The home did not complete the investigation to determine if the investigation was founded or unfounded. The home also failed to submit the CIR within 10 days of the incident. The licensee's Zero Tolerance of Abuse and Neglect policy was not complied with as an injury of unknown cause was not immediately reported by the PSW and there was no documented evidence to indicate that appropriate actions were taken.

-Review of the home's investigation and interview of staff indicated the home's Zero Tolerance of Abuse and Neglect policy was not followed related to failure to immediately report the injury suspected physical abuse as issued under WN #14 under LTCHA, 2007, s.20(1)(a).

-The licensee failed to ensure the resident's SDM and any other person specified by the resident, were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being as issued under WN #21 under O.Reg. 79/10, s.97(1)(a).



-The licensee failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director as issued under WN #23 under O.Reg. 79/10, s.104(2).

5. Related to log #002520-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse that occurred on the same day at a specified time. The CIR indicated program staff (PS #171) had reported resident #046 had reported being rough handled earlier in the day during care and had been occurring over the last two weeks to RN Manager #118 (the same day).

Review of the care plan for resident #046 indicated the resident had specified sleeping preferences.

Review of the licensee's investigation indicated on the specified date and time, resident #046 reported the PSW "is rough" and was upset and weepy while reporting the incident to PS #171. The SDM of resident #046 was present when the allegation was reported to PS #171 and confirmed incidents had been occurring over a two week period. RN Manager #118 did not report the allegation until the following day, when the police were notified. RN Manager #118 indicated the alleged PSW involved in the incident was PSW #172 and was interviewed two days later.

Interview with the Administrator by Inspector #111, confirmed that no other staff were interviewed regarding the allegation, the investigation was completed and determined to be inconclusive. The Administrator indicated as a result of the discussion with the Inspector, that other staff would be interviewed before the home determined the outcome.

-The investigation was not completed immediately as the investigation did not start until two days after the allegation was made of staff to resident rough handling and no other actions were taken to prevent a recurrence despite the resident not receiving care as per the resident's written plan of care, as issued under WN #15 under LTCHA, 2007, s.23(1)(a).

-The care set out in the plan of care was not provided to the resident as specified in the plan related to sleep preferences as issued under WN #12 under LTCHA, 2007, s.6(7).



6. Related to log # 033626-16 & # 034927-16:

A critical incident report (CIR) was received on a specified date for an allegation of staff to resident neglect. The CIR indicated the SDM of resident #049 brought forth complaints to RN Manager #118 regarding improper care and neglect to resident #049 by PSW #144. The CIR indicated the SDM also submitted a written complaint eight days later regarding the incidents that occurred and the resident "was upset" and requested not to have the same PSW providing care for the resident.

Review of the written complaint from the SDM of resident #049 indicated on a specified date and time, the resident reported PSW #144 had provided improper care and neglected the resident throughout the shift. The SDM indicated the allegations were reported to the acting DOC the same day they occurred as the resident was in discomfort. The SDM indicated PSW #173 and RPN #137 were also aware and or present when the improper care and neglect occurred.

Interview with acting DOC and RN Manager #118 by Inspector #111, confirmed the home was aware of a verbal complaint alleging staff to resident neglect on the day the incidents occurred (followed by a written complaint seven days later) and the investigation was not initiated until four days later. The acting DOC indicated the SDM was notified the outcome of the investigation was inconclusive.

Review of resident #046 progress notes had no documented evidence of the allegation or indication of an assessment of resident #046 related to the discomfort. The licensee's investigation indicated the resident (who was capable) was never interviewed regarding the incident and no indication any emotional support was provided.

Interview with Social Worker (SW) indicated she is responsible for maintaining the home's complaint log and enters all verbal written complaints that are received once the investigations are completed. The SW was not aware of any verbal or written complaint received by the home on specified dates regarding allegations of neglect towards resident #049. The SW indicated the acting DOC or Administrator are responsible for providing all verbal complaints (via client feedback forms) or written complaints to the SW.

Review of the home's complaint log for the two specified months did not have any indication of a verbal or written complaint received by the SDM of resident #049 related to neglect.



Review of the licensee's investigation and interview of staff indicated the home was aware of allegations of improper care and neglect towards resident #049 "who was upset" and in discomfort, on the day the incidents occurred, and the Director and police were not notified until the following day. The licensee's investigation and interview of staff by Inspector #111 indicated RPN #137, PSW # 173, PSW #174 and PSW #175 were present and or aware of the allegations and were not identified on the CIR. The home informed the family that the outcome of the investigation was "inconclusive" and PSW #144 was allowed to continue to provide care to resident #049.

- Review of the licensee's investigation and interview of staff indicated the licensee's policy was not followed related to the investigation process and there was no documented evidence the resident was assessed related to allegations of staff to resident neglect as issued under WN #14 under LTCHA, 2007, s.20(1)(a).
- There was no indication the investigation was completed immediately and there was no indication that appropriate actions were taken as a result of the licensee's investigation, when the allegations were confirmed, as issued under WN #15 under LTCHA, 2007, s.23(1)(a).
- The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: 1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm as issued under WN #16 under LTCHA, 2007, s.24 (1).
- The licensee failed to ensure that the report to the Director included the following description of all of the individuals involved in the incident: (ii) names of any staff members or other persons who were present at or discovered the incident as issued under WN #23 under O.Reg. 79/10, s.104 (1)2.
- The licensee failed to ensure that a documented record was kept in the home of a verbal and written complaints received in November and December 2016 that included: the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response, and; any response made by the complainant as issued under WN #22 under O.reg. 79/10, s.101(2)

7. Related to log # 023595-16:



A critical incident report (CIR) was submitted to the Director on a specified date for an allegation of resident to resident sexual abuse. The CIR indicated on a specified date and time, resident #043 and resident #044 were found demonstrating sexually inappropriate behaviour in resident #044 room and were not separated by staff for a specified period of time. Both residents were then supervised by staff for a specified period of time when resident #043 was redirected out of resident #044 room. The CIR indicated both residents are cognitively impaired and "neither resident is able to provide consent for sexual behaviour". The CIR indicated "Internal Investigation initiated". The CIR was not amended to indicate the outcome of the home's investigation. The CIR indicated 1:1 staffing was put in place and referral to BSO as a result.

Observation of resident #043 on a specified date by Inspector #111 indicated the resident was cognitively impaired and was independently mobile with use of a mobility aide. Resident #044 was no longer in the home.

Review of the progress notes for resident #043 and #044 related to sexually inappropriate responsive behaviours and/or sexual abuse indicated:the behaviours occurred over a three month period but in both residents' progress notes, the co-residents were not identified. There were seven documented incidents where resident #043 & #044 were observed demonstrating sexually inappropriate responsive behaviours. There were 2 incidents where suspected resident to resident sexual abuse and two incidents of suspected resident to resident sexual abuse that were not documented to indicate when they occurred and with whom.

The triggers and strategies for both resident #043 & #044 did not indicate which female/male resident(s) they were having inappropriate sexual behaviours towards; Resident #043 had demonstrated inappropriate sexual responsive behaviours towards more than one co-resident and this trigger was not identified; The plan of care did not clearly indicate what the "sexually inappropriate" behaviour included despite the progress notes for both residents clearly indicating what these behaviours and triggers included. The incident of resident #043 inappropriately touching another unidentified co-resident (as reported by an RN during an interview) was also not identified to indicate when it occurred and towards whom. The strategies to manage the sexually inappropriate responsive behaviours was also not clear as there was no indication how staff would monitor each of the two residents or what "increased observation" included. The observation period was unclear and sometimes resident #043 was placed on 1:1 and other times on every 15 minute observations. The sexually inappropriate responsive behaviours was



accepted by some staff as a 'relationship' and therefore did not intervene. The relocation of resident #044 to another unit was used as a strategy but was not considered until after the seventh incident and despite permission provided by the SDM after the fifth incident. There was no indication of a referral to psychogeriatric services despite the ongoing behaviours of sexually inappropriate behaviours and BSO discontinued resident #043 from the program despite continuing to display sexually inappropriate responsive behaviours.

Interview with Administrator by Inspector #111 regarding the incident indicated an investigation was completed but she was unable to locate the investigation. The Administrator indicated she was unaware the CIR was never amended to indicate the outcome of the home' investigation.

- There was no indication the investigation was completed immediately and appropriate actions were taken as the investigation had not yet been completed or concluded five months later, as issued under WN #15 under LTCHA, 2007, s.23(1) (a).

-The licensee failed to ensure that for resident #043 & #044 demonstrating sexually inappropriate responsive behaviours, the behavioural triggers for the resident were identified, where possible, strategies were developed and implemented to respond to these behaviours, where possible, and actions were taken to respond to the needs of the resident, including assessment, reassessments and interventions, and that the resident's responses to the interventions are documented as issued under WN #17 under O.Reg. 79/10, s.53(4)(a)(b).

8.In addition, the licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected and did not contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate, as issued under WN #20 under LTCHA, s.96(a)(b).

A Compliance Order was warranted as the scope and severity was demonstrated by the following:

1. A Compliance Order (CO #001), was issued during a Critical Incident Inspection (#2015_360111_0014), on June 3, 2015, under LTCHA, 2007, s.19(1), which included a written notification (WN) specific to LTCHA, 2007, s. 6(7), 20(1), 23(1) (a), 24 (1), 97(1) & 98 with a compliance date of August 15, 2015. A second CO (#



001), was issued during the Resident Quality Inspection(RQI) (#2015_365194_0028), on November 16, 2015, under LTCHA, 2007, s19 (1) which included a WN specific to LTCHA, 2007, s.20(1), 23(2) and s.24(1) with a compliance date of April 30, 2016. The order was complied with on August 5, 2016. In addition, LTCHA, 2007, S.23 (2) was issued during a Complaint Inspection (#2016_327570_0010), on April 25, 2016 which included a voluntary plan of correction (VPC) and O.Reg.79/10, s.104(2) with a WN at that time. A WN was issued during the RQI (#2016_327570_0014) for LTCHA, 2007, s.23(2). A WN was issued during RQI (#2016_327570_0014) for O.Reg.79/10, s.104(1)2. A WN was issued during a Complaint Inspection (#2016_327570_0022) specific to LTCHA, 2007, s. 6(7).

2. There was actual harm to residents related to physical, emotional, and sexual abuse towards multiple residents (both cognitively well and cognitively impaired resident). There was also a pattern of inaction related to allegations and complaints of staff to resident neglect as demonstrated by the above logs. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :



1. The licensee did not ensure that elevators within the long term care home were equipped to restrict resident access to areas that were not to be accessed by residents.

The home was equipped with two elevators which led to areas that had unsafe conditions or had unlocked exit doors to unsecured outdoor areas. Non-compliance was previously identified on inspection report # 2016-327570-0014 (dated September 8, 2016). A written notification was issued with a voluntary plan of compliance to address the issues. On January 16-20, 25 and 26, 2017, two separate elevators within the long term care home were operational and accessible to residents and restrictions were limited or not evident.

Elevator #1 located within the newer section of the building permitted limited access to inspector #120 to the basement, located below the Aspen and Cedar home areas. Access to the elevator on both first and second floors was granted by entering a code on a key pad to release the magnetic locks on doors that were located on either side of the elevator foyer. Although resident access to the elevator entrance via Aspen or Cedar home areas was restricted, the elevator was available for resident use to access the laundry room. According to one resident, they knew the code to leave their home area and often used the elevator to go to the laundry room to get their clothing labelled. If residents were aware of codes to exit their home areas, they therefore had access to the basement via the elevator. The basement included four exits, three to unsecured outdoor areas and one to the retirement building. On January 25, 2017, the exits were all unlocked with the exception of one in the garbage room. However this door was found unlocked on January 16-20, 2017 by inspector #623 and #111. The elevator, when used, also permitted inspector #120 to open the back door into the server's of both Aspen and Cedar by pressing one button on the elevator panel. Both servers were equipped with steam tables and hot water machines.

Elevator #2 located within the older section of the building permitted unrestricted access to various inspectors between the main floor (resident rooms), second floor (unoccupied offices, washroom and boardroom) and the lowest level of the building. The elevator was observed to be used by visitors, staff and residents without any limitations. The lowest level consisted of shared spaces, used by staff, retirement home residents and long-term care residents. However, with the exception of the laundry room, the areas were not continuously monitored by direct care staff. They included a chapel, hair salon, atrium, library, recreation room, staff



locker room, staff lunch room, auditorium, laundry room, outdoor courtyard and an entrance to the retirement building. The atrium included an open stairwell and a koi fish pond. The open stairwell consisted of 18 stairs leading up to a dining room with a locked gate at the top. It was not restricted at the bottom to prevent residents from trying to use the stairs and possibly falling while on the stairs. A koi fish pond was observed along one wall of the atrium and the edge was lined with medium sized rocks that could be picked-up. The koi pond was not designed to prevent safety hazards such as tripping into the pond, which was approximately three feet deep and a concern for visitors and residents.

Management of the home reported that elevator #1 was to be equipped with a key pad to restrict residents from accessing the lowest level and server's on January 25, 2017. However, the elevator contractor could not complete the work due to inaccurate electrical drawings. Completion of the work was scheduled for February 10, 2017. On January 26, 2017, no specific plans were provided by management regarding resident access to the lowest level via elevator #2 as it was used regularly by retirement home residents as a short cut into the retirement home via the lowest level. A memo dated January 20, 2017 was posted in various home areas with a message that the elevator would be available only between the hours of 6 a.m. and 9 p.m. and use after that time would require the assistance of a nurse. The memo was not posted until inspectors raised concerns to management staff about unrestricted access to the elevator on January 18 and 19, 2017. On February 2, 2017, management staff decided to install key locks on all doors leading to the atrium to prevent unsupervised access to the space by long term care residents. [s. 10. (1)]

Additional Required Actions:



VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that both elevators in the home are equipped with devices to restrict resident access to areas that are not to be accessed by residents, to be implemented voluntarily.

**WN #5: 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 the home, its furnishings and equipment were kept clean and sanitary.

Observation of the lunch meal service on a specified date by Inspector # 111, indicated the Linden servery in the main dining room had a glass partition that was heavily soiled with food prior to the meal being served. The wall to the right side of the servery glass also had a large food spill from above the glass partition, down to the floor. Three days later, both areas remained soiled until the Inspector reported the areas to the Administrator and Dietary Consultant.

Interview with the NCM by Inspector #111 indicated it was the responsibility of dietary staff after each meal to clean the glass partition at the Linden servery in the main dining room. The FSM stated "it would be common sense that after a spill of food, either the nursing staff or dietary staff would clean up the spill". The NCM indicated there was no specific job task related to each of these areas as it is just a part of the DA responsibilities. [s. 15. (2) (a)]

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 the home's furnishings and equipment and kept clean and sanitary, specifically in the main dining room, to be implemented voluntarily.

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17.
Communication and response system**



Specifically failed to comply with the following:

- s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
- (a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
 - (b) is on at all times; O. Reg. 79/10, s. 17 (1).**
 - (c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
 - (d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
 - (e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
 - (f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
 - (g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

Findings/Faits saillants :

1. The licensee did not ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

The activation station, which is a component of the resident-staff communication and response system, could not be seen or accessed by inspector #120 in the restorative care room. Restorative care staff identified the activation station behind a large cabinet where it could not be easily seen, accessed or used by residents, staff or visitors. [s. 17. (1) (a)]

2. The licensee did not ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

The Pine activity room (with sink and fridge) and the Pine sitting room (with television set), which were both fully accessible to residents, were not equipped with an activation station, which when used, would alert staff to the location of the alarm. [s. 17. (1) (e)]



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 the home is equipped with a resident to staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times in the restorative care room and Pine unit activity and sitting lounges, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.

TABLE

Homes to which the 2009 design manual applies

Location - Lux

Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout

All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout

In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux

All other homes

Location - Lux

Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout

All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout

In all other areas of the home - Minimum levels of 215.28 lux

Each drug cabinet - Minimum levels of 1,076.39 lux

At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux

O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4



Findings/Faits saillants :

1. The licensee failed to ensure that the lighting requirements set out in the lighting table were maintained.

An inspection was previously conducted on December 6 and 7, 2016 by Inspector #111 to determine compliance with this section. Non-compliance was identified and a written notification was issued with a voluntary plan of compliance to address the issue.

During this inspection, no changes to the lighting levels from December 7, 2016 were identified with the exception of one resident room on the Birch unit (B9) and one section of corridor (in the Linden unit) which were equipped with new LED lights and being used as test locations. The areas were measured by Inspector #120 on January 26, 2017 using a hand held digital light meter (Amprobe LM-120, accurate to +/- 5%) and determined the lighting levels exceeded the minimum lighting requirements.

The non-compliance identified on December 6 and 7, 2016 are as follows and were confirmed on January 26, 2017:

-The long term care home was built prior to 2009 and therefore the section of the lighting table that was applied is titled "all other homes". A hand held digital light meter was used (Amprobe LM-120, accurate to +/- 5%) and held a standard 30 inches above and parallel to the floor. Not all areas of the home were measured due to the inability to block out all sources of natural light. These included the main foyer, activity rooms and lounge spaces. The areas in the basement accessible to residents such as the chapel, library and recreation room were not measured but appeared to be poorly lit. Only a small sample of resident bedrooms and en suite washrooms were measured as all these types of rooms contained the same number, size and style of lighting fixtures and natural light could be controlled. Resident en suite washrooms met the minimum lighting requirements.

In bedrooms tested, all available lights were turned on and allowed to warm up. All doors and bedroom window coverings were closed in an effort to reduce the influence of natural light. When light levels were measured in semi-private or ward resident bedrooms, the privacy curtains between each bed was drawn, to further reduce the influence of natural light in the area of the entrance and around each



bed.

The following areas did not meet the minimum lighting requirements:

Corridors:

The lighting levels in the corridors on Linden, Birch, Maple and Pine were very low and did not meet the minimum requirement of 215.28 lux consistent and continuous lighting along the corridor. The lighting fixture styles varied and were different in Maple from the other three corridors. The fixtures in Maple were spaced 22 feet apart and ranged from 400 lux (directly under a light fixture) to 20 lux (between light fixtures). The fixtures in the other corridors were approximately eight feet apart and measured between 30 and 75 lux between fixtures.

The lighting level in the corridor in front of the main dining room (at entrance of the home) was 150-170 lux. This area was used by nursing staff to place medication carts in order to dispense medications for residents in the dining room.

Main Dining Room:

The main dining room was equipped with numerous light fixtures spaced out evenly over the ceiling area. The fixtures included a mix of round flush ceiling mounted dome lights with two bulbs and glass lens and suspended pendant lights with inverted large opaque glass lens. The levels achieved were approximately 150 lux under the lights and 100 lux between the lights, in areas between tables or path of travel. The levels did not meet the minimum requirement of 215.28 lux.

Resident bedrooms:

The home consisted of three different bedroom types, a private, semi private and ward bedroom. The majority of the bedrooms were equipped with the same number, type and style of fixture. Lux levels were taken in areas of activity (in front of closet, around each bed and path of travel from front door to bed). Upon entry to each bedroom type, a small ceiling mounted dome shaped light with a single bulb was noted with an opaque lens. The centre of each room was equipped with a suspended pendant fixture with two compact fluorescent bulbs and inverted glass lens. Each bed had an over bed light, which was determined to be adequate, as long as both fluorescent tubes in the fixture were working.



The lighting levels in resident rooms on both the Birch and Linden home areas (one private, one ward and three semi private rooms) were measured. The ranges included 50-100 lux at the entrance, 65-140 lux around each bed, 30-110 lux in front of closets/wardrobes. The minimum required level of 215.28 lux was not provided. [s. 18.]

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 the lighting requirements set out in the lighting table for homes built before 2009 were maintained, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all foods and fluids are prepared, stored and served using methods which preserve taste, nutritive value, appearance and food quality.

Related to log # 025341-16:



A complaint was received on a specified date indicating the food is overcooked and tasteless. The food portions are small for the residents who can't speak for themselves.

Interview with resident #052 by Inspector #623, indicated that the food quality is poor, especially the meat, and the chicken and sausage were always overcooked. Resident #052 indicated attends Food Committee meetings and brings these concerns forward to NCM #158. Resident #052 stated that she/he often chooses to not eat the food due to being overcooked.

Observations by inspector #623 in the large dining room on specified date and time had sausages being served as the alternative meal choice for residents. The sausages appeared overcooked. Staff were observed having difficulty attempting to cut the overcooked sausage for resident #056. Resident #056 was observed attempting to eat a piece of the overcooked sausage and was unable to chew it, so proceeded to spit out the food. Inspector #623 interviewed resident #056 and stated "the meat it too tough. It is always tough." Resident indicated was not able to eat the meat as a result. Observations in the large dining room also revealed seven resident plates that were cleared where the residents left the overcooked sausage on the plate uneaten.

During the same lunch service the Extendicare Dietary Consultant (RD #159) confirmed that the sausages served were tough and overcooked and would follow up with the Dietary Manager and NCM #158.

Interview with Cook#161 and Cook#160 by Inspector #623, indicated that the oven does not cook the food evenly and the right side of the food on the trays will burn before the left side is cooked. Cook #160 confirmed that today half of the tray of sausages were overcooked. The cook indicated that the overcooked sausages were supposed to be served last, that this happens a lot with the meat, there is never any extra meat to cook in order to replace the overcooked meat, so the meat is served to the residents anyway or they would not have enough. Cook #160 indicated the issue with the oven has been ongoing for at least seven months. Cook #160 confirmed never reporting the issue to the Nutritional Care Manager (NCM) #158.

Interview with NCM #158 indicated that he was not aware that there was a problem with the oven not cooking the food evenly. He has not been notified by the cooks that there was a problem. NCM was unable to confirm when the ovens were last



serviced. NCM agreed the sausages that was served the same day appeared overcooked and tough.

Interview with the Administrator by Inspector #623, she agreed the sausages appeared overcooked and tough. The Administrator agreed that the food did not look appetizing or palatable. She indicated that she was not aware there was a problem with the oven not cooking evenly. The Administrator indicated that there are food audits completed by the NCM monthly to evaluate the food quality. The Administrator indicated that there is record of one service to the ovens in 2016 as evidenced by the invoice provided. This service completed was to the top convection oven for replacement of the electronic temperature control. The work order confirms that the service was completed but the oven could not be calibrated at that time. There is no record of the oven being calibrated to ensure proper temperature. The Administrator indicated that following the lunch service on the specified day the sausages were overcooked, and interviews completed with the cooks (#106 and #161) confirmed the last tray of sausages was overcooked and they served it anyway. The Administrator indicated that the expectation is that cooks will monitor the food as it is cooked and not serve food that is over or under cooked. [s. 72. (3) (a)]

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 foods and fluids are prepared, stored and served using methods which preserve taste, nutritive value and food quality, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service



Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, there is a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the residents.

Related to logs #022045-16, #022231-16, #033257-16 and #033948-16:

Complaint log #022045-16:

An anonymous complaint was received on a specified date indicating the home does not have towels or linens, and staff are providing incontinence care with bed sheets as there are no towels available.

Complaint log #022231-16:

An anonymous complaint was received on the following day indicating there was a shortage of bed sheets, wash cloths and soap.

Complaint log #033257-16:

An anonymous complaint was received four months later indicating lack of available linens (face towels, bath towels, soaker pads and bed sheets) and complaints were made to the charge nurse and the supervisor and nothing has been done.

Complaint log #033948-16:

An anonymous complaint was received a month later indicating several weeks ago an unidentified resident could not be put to bed due to lack of available bed linens to make the bed with. A second occurred when an unidentified resident had to wait to return to bed due to lack of available bed linens. The complainant also indicated on several occasions, has had to use brown paper towel from the bathroom to dry self after morning care due to lack of available towels.



Over a two day period, a review of the available linens in the home was completed by inspector #623. Observations were made of the resident rooms, linen supply carts and storage cupboards in all six home areas as well as laundry room #1 and #2. None of the resident rooms had hand towels or face cloths for use to provide resident care throughout the day.

Review of the licensees policy HL-06-01-02 Linen Inventory Count and Appendix 2 document Linen Inventory Standards (December 2016) and the Bedding Linen & Towel inventory count sheet completed by the home on December 30, 2016 indicated that the home lacks supplies of linens and does not meet the linen inventory standards as indicated in the policy.

During an interview with the acting Director of Care (ADOC) confirmed that the home should have an adequate supply of hand towels and face cloths for all residents to use for morning care. ADOC indicated that there should be a hand towel and a face cloth on the towel bar in each resident bathroom for use throughout the day.

During an interview with Laundry Aide (LA) #142 by Inspector # 623 (working in laundry #1) indicated that there used to be a sheet that listed the quota of linens that are supposed to sent on the carts to the unit at specific times of day but this sheet is no longer available. Laundry Aide indicated that there is never enough linens to meet the quota, so just provides what is available. Laundry Aide #142 indicated that often PSW's will come to the laundry through out the day looking for additional supplies. Laundry Aide #142 indicated that every few months there is new linen, usually face cloths and hand towels put into circulation but despite that they are always running short. LA #142 indicated supposed to supply 74 hand towels and face cloths to Aspen and Cedar units for the evening and night shift to use. Today Cedar is getting 16 face cloths and 48 hand towels, Aspen is getting 32 face cloths and 48 hand towels. This is not enough to provide care for the 34 residents in each unit. LA #142 indicated that when short of supplies, the LA notifies ESM #106.

During an interview ESM #106 indicated that at this time there are no quota sheets for the amount of linens that are to be distribute to the units. The ESM indicated that he was aware of the Policy HL-06-01-02 Linen Inventory Count and Appendix 2 document Linen Inventory Standards (December 2016). The ESM indicated that when the year end linen inventory was completed in December 2016, it was



confirmed that the home lacked supplies of linens and did not meet the linen inventory standards indicated in the policy. The ESM indicated that since that inventory was completed there was a linen order done but it would not be enough to provide the residents with the suggested amounts. ESM #106 indicated that there is no inventory on hand of linens for an emergency, that are not already in circulation. The ESM indicated that if the budget allows, he will order linens to increase the amount in circulation but he cannot exceed his budget.

During an interview the Administrator indicated that the quantity of linens on hand were not sufficient to meet the needs of the residents. The inventory of supplies available does not meet the Extencicare policy HL-06-01-02- Linen Inventory Standards Guidelines for minimum quantities. She confirmed that there is no emergency supply available of linens in the home. The Administrator indicated that she was not aware that staff and residents were lacking supplies in order to complete morning care. The Administrator confirmed that every resident should have a towel and face cloth available to them in their room for care to be completed.

In addition, related to log # 002431-17 for resident #057: PSW #129 reported unable to make the resident's bed after a shower as there were no bed linens available. (#111). [s. 89. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the residents, to be implemented voluntarily.



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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 90.
Maintenance services**

Specifically failed to comply with the following:

s. 90. (3) The licensee shall ensure that the home's mechanical ventilation systems are functioning at all times except when the home is operating on power from an emergency generator. O. Reg. 79/10, s. 90 (3).

Findings/Faits saillants :



1. The licensee did not ensure that the home's mechanical ventilation systems were functioning at all times except when the home was operating on power from an emergency generator.

During a tour of the home beginning on a specified date, various inspectors identified lingering offensive odours throughout the day in the corridors identified as Maple, Birch, Linden and Pine. Inspector #120 identified on the morning of a specified date, stuffy conditions and uncomfortably warm air temperatures within the same corridors and few lingering odours. Ceiling fans were running in each corridor to disperse any odours and to move the air around. Numerous residents had portable air fans operating in their rooms. The outdoor air temperature was -2 degrees Celsius.

No fresh air was being supplied to the corridors from outdoors via the supply air grilles located on the ceiling in each corridor. When checked again in the afternoon and the following morning, no air was being supplied with the exception of a slight amount of passive cold air flow from the outside. One ceiling fresh air supply grille in the Birch corridor was covered with insulation on the interior of the duct. According to the maintenance staff in the home, the fresh air supply system was shut down as the electrical heaters used to warm the outdoor air before circulation to the home were unsafe. No information or records could be provided as to when the units were shut down.

Documentation provided related to maintenance repairs and inspections conducted by an external contractor on various heating, cooling and ventilation units in the building between May and September 2016 were unclear and did not identify if the various units inspected were in the retirement home or in the long term care home. No inventory of heating, cooling or ventilation equipment could be provided for review to determine if all units were inspected. On February 1, 2017, the contractor confirmed that there were six fresh air supply units and six exhaust units for the above noted corridors. The contractor inspected all of the fresh air supply units and the exhaust units on January 31, 2017 and confirmed that all six fresh air supply units were disconnected. The licensee therefore did not ensure that the home's mechanical ventilation system was functioning at all times (except when the home was operating from an emergency generator). [s. 90. (3)]



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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 the home's mechanical ventilation systems were functioning at all times except when the home was operating on power from an emergency generator, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :



1. The licensee has failed to ensure that the home is a safe and secure environment for residents related to buffet servers with "sterno gel" fuel pots left lit and unattended with residents having access.

During the initial tour of the home by Inspector #623, the Pine Activity room was noted to be used as a temporary the dining room for Pine residents as the home was experiencing a respiratory outbreak. The door to the activity room was noted to be propped open and contained two carts with four "buffet serving trays" with hot water in them and underneath the buffet trays had "sterno gel" fuel pots two of which were lit. The warming trays were hot to the touch and water in the trays was noted to be steaming, but no food present. There were no staff present in the room and two residents were observed walking by the room.

At that time, Inspector #623 interviewed Housekeeper #103 who was passing by the room. The housekeeper confirmed that the door should be locked when no one was in the room and that residents should not have access to the hot food servers. The Housekeeper then proceeded to lock the room.

The Administrator was notified by Inspector #623 of the observations in the Pine Activity room. Administrator confirmed that this room was being used as a temporary dining room for the Pine unit residents and that the room should be locked if there were no staff present. The Administrator indicated that the "sterno fuel pots" should not be left lit and unattended.

The licensee failed to ensure that the home is a safe and secure environment for the residents. [s. 5.]

WN #12: 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).

Findings/Faits saillants :

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

Related to log # 002431-17:

A Critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect that occurred over a two day period at specified times. The CIR indicated resident #061 (who is cognitively well) reported witnessing staff to resident neglect by PSW #129 towards resident #057 (who is cognitively impaired) on two separate days.

Review of the current written care plan for resident #057 indicated the resident was at risk for skin breakdown related to incontinence and is cognitively impaired. The interventions indicated the resident will not call for toileting and staff are to check and change the resident every 2-3 hours.

Review of the home's investigation indicated PSW #129 reported to the acting DOC that assistance was provided with toileting resident #057 on the two specified days twice during their shift, the resident would call for further assistance with toileting as needed. PSW #123 reported assisting PSW #129 only once on both specified days with toileting and indicated resident #057 required more frequent toileting due to level of incontinence. Resident #057 was not provided care according to the plan of care related to toileting as indicated in the plan of care. [s. 6. (7)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, related to sleep and rest patterns.

Related to log # 002520-17:

A critical incident report (CIR) was submitted to the Director on a specified date for



an alleged staff to resident physical abuse that occurred at a specified time. The CIR indicated program staff (PS #171) had reported resident #046 alleged being rough handled earlier that same day during care and had been occurring over the last two weeks to RN Manager #118 the same day. The CIR did not indicate which staff was involved with the allegation. The CIR indicated the outcome of the investigation was pending.

Review of the licensee's investigation indicated PSW #172 was involved in the allegation and the PSW was unaware of the residents sleep and rest preferences.

Review of the current written care plan for resident #046 indicated the under bed mobility: staff to monitor for signs and symptoms of pain when getting resident in and out of bed and under sleep and rest patterns: gets am care provided at a specified time. The plan of care was not provided to the resident according to the plan, related to sleep and rest patterns. [s. 6. (7)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).

(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure,



strategy or system instituted or otherwise put in place is complied with.

Related to Medication management system, Under O.Reg.79/10, s.114(3)The written policies and protocols must be, (a) developed, implemented, evaluated and updated in accordance with evidence-based practises and, if there are none, in accordance with prevailing practises

The Licensee failed to implement its "Medication Management Policy" (# RC-06-05 -07 and last updated in June 2016) related to administration of eye drops to resident #057. The policy indicated "scheduled medication will be administered according to standard medication administration times. Medication should be given within the recommended time frame, 60 minutes prior to and 60 minutes after the scheduled medication time."

Review of resident #057 current Medication Administration Record (MAR) revealed two physician prescribed eye drops related to diagnoses to be provided at two specified times and intervals.

A review of the medication administration audit report for the resident revealed that on four dates in a specified month, at a specified time, the morning dose was administered between 88 and 129 minutes after the scheduled administration time, by RPN # 130 & #138. The afternoon dose of both eye drops, was administered between 80 and 143 minutes after the scheduled administration time on eight specified dates during the same month period by a range of different nurses.

In interviews conducted by Inspector #624 with RPN #130, RPN #163 and RPN #162 (who had administered the 1600 hours eye drops on specified dates), all indicated that they had administered the medication at the times entered on the medication audit report. They all also indicated that the home's expectation is that medication should be administered 60 minutes prior to and 60 minutes after the scheduled medication time. They all indicated that in the event that a medication is administered late for any reason, an explanatory medication note is to be documented in the progress notes.

A review of resident #057's progress notes, did not reveal any entry on the dates identified above.

The Acting Director of Care, when interviewed by Inspector #624 on the home's expectation on medication administration, she indicated as well that medication



should be administered 60 minutes prior to and 60 minutes after the scheduled medication time. She added that if for any reason a scheduled medication is not administered 60 minutes before and 60 minutes after the scheduled medication time, an explanatory note is to be documented in the progress notes for the concerned resident.

The licensee failed to comply with the Medication Management Policy # RC-06-05-07, by administering a scheduled medication 80 to 143 minutes after the scheduled administration time. [s. 8. (1) (b)]

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance



Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,

(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).

(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).

(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).

(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).

(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).

(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).

(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).

(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Review of the licensee's policy "Zero Tolerance of Resident Abuse and Neglect" (RC-02-01-01) (April 2016) indicated:

immediately respond to any alleged or suspected incident of resident abuse or neglect.

-promptly and thoroughly investigate all alleged or reported incidents.

-identify and correct situations where abuse, neglect and /or mistreatment can occur.



-immediately respond to any alleged or suspected incident of resident abuse or neglect.

Related to log #001738-17:

Critical Incident Report (CIR) was submitted to the Director on a specified date for an alleged staff to resident verbal and physical abuse that was reported to Inspector #626 during the inspection. Inspector #626 reported the allegations to the Administrator on the same day. Resident #010 indicated the day before, at a specified time, two staff were rough when providing care resulting in pain. The resident also indicated that PSW #139 and PSW #149 made inappropriate comments towards the resident. The resident also indicated the incidents were reported to RPN #120 the following morning (the day it was reported to Inspector #626).

An interview with RPN #120 by Inspector #626 confirmed the resident reported allegations of verbal abuse by PSW #139 and #140 the day after they occurred but was unable to recall when the allegation was received. The RPN indicated no allegation of physical abuse were made at that time. RPN #120 indicated that the resident had requested the allegations not be reported and the RPN should have reported it.

An interview at two separate dates with the Administrator indicated that RPN #120 did not report the incident until the investigation was initiated two days later. The Administrator indicated that it is the expectation that staff report incidents of abuse immediately to their RN supervisor.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with as RPN #120 failed to immediately report the incident of verbal abuse until one day after it was reported by the resident. [s. 20. (1)]

2. Related to log #020568-16:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident verbal abuse. The CIR indicated at a specified time, resident #015 was observed being verbally abusive towards resident #053 by PSW #151 and PSW #152, who did not intervene. RPN #132 also witnessed the incident and intervened. RPN #132 reported a complaint of staff to resident neglect the



same day as staff failed to intervene regarding this incident.

A off-site enquiry was made to the Administrator requesting the outcome of the licensee's investigation into the allegation as the CIR was not updated to provide this information. The information was not provided by the home. An inspection was then initiated as a result six months later, and the Administrator was asked for the home's investigation at that time to determine the outcome of the investigation. One staff interview was provided to the inspector at that time but no outcome of the investigation.

Review of the home's investigation documentation, review of resident health records, and interview of staff indicated the licensee's policy was not followed related to the investigation process as there was no documented evidence to indicate the home promptly and thoroughly investigated the alleged or reported incidents. There was also no documented evidence to indicate the home corrected situations where abuse can occur as per the licensee's policy. [s. 20. (1)]

3. Related to log # 002431-17:

Critical incident report (CIR) was received by the Director on a specified date for an alleged staff to resident neglect that occurred over a two day period at specified times. The CIR indicated resident #061 (who is cognitively well) had reported witnessing resident #057 (who is cognitively impaired) being neglected over a two day period by PSW #129.

Interview with Administrator and acting DOC by Inspector #111, indicated PSW #129 (involved in the allegation of neglect) and resident #061 (who reported the allegation), were interviewed two days after the allegations were reported and determined the allegations were unfounded. The Administrator indicated the home determined that PSW #129 had provided proper care to resident # 057 and some of the care could not be provided due to lack of supplies available at the time. The following day, the Administrator indicated she forgot that she had also interviewed three other PSW's the day of the allegations but did not document the interviews. The Administrator concluded the investigation and indicated the allegations were unfounded.

Review of the licensee's investigation documentation, interview of staff, and review of resident #057 health record, indicated a complaint was received by resident #061 regarding an allegation of staff to resident neglect that occurred over a two



day period towards resident #057 by PSW #129. There was no documented evidence the investigation was promptly and thoroughly investigated and staff interviews were not documented as per the licensee's policy. There was no documented evidence indicating corrective actions were taken related to the resident not being provided proper care despite the resident's plan of care providing clear direction related to those care needs or any corrective actions related to the lack of supplies. [s. 20. (1)]

4. Related to log # 027318-16:

The Ministry of Health after hours was called on a specified date to report an incident of injury of unknown cause to resident #045. A CIR was not submitted at that time. A critical incident report (CIR) was received five months later as a result of the off-site enquiry. The CIR indicated that four months earlier (on a specified date and time) RPN #117 noted an injury to a specified area on resident #045 and suspected rough handling by a staff or other resident. The CIR indicated the investigation was still pending.

Interview with Administrator by Inspector #111 and request for the outcome of the investigation indicated the investigation was not yet completed (five months later).

The licensee's policy was not complied with when an allegation of resident physical abuse was made regarding unexplained injuries to a specified area was not promptly and thoroughly investigated. [s. 20. (1)]

5. Related to log #033626-16 & 034927-16:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect that occurred on the same day at a specified time. The CIR indicated the SDM of resident #049 brought forth complaints to the RN Manager #118 regarding improper care provided to resident #049 and would be submitting a written complaint regarding the incidents. The CIR indicated nine days later, the SDM provided the written complaint regarding the incidents that occurred nine days earlier and requested not to have the same PSW assigned to providing care for the resident.

Review of the written complaint from the SDM of resident #049 indicated: nine days earlier, on a specified shift, the resident reported PSW #144 had neglected and provided improper care. The SDM indicated the allegations were reported to



the acting DOC the same day. The SDM reported PSW #173 and RPN #137 were also aware of the allegations the same day they occurred.

Interview with acting DOC and RN Manager #118 by Inspector #111, confirmed the home was aware of allegations of neglect on the day they occurred and the day after they occurred. The investigation was not promptly and thoroughly investigated as per the licensee's policy as the investigation was not initiated until four days later and not all staff and resident who had knowledge of the incident were interviewed regarding the incident. There was no documented evidence to indicate the home corrected situations where abuse, neglect and /or mistreatment can occur as per the licensee's policy. [s. 20. (1)]

6. Related to log #002520-17:

A critical incident report (CIR) was submitted on a specified date for an allegation of staff to resident physical abuse that occurred on the same day at a specified time. The CIR indicated a program staff #171 had reported to RN Manager #118 that resident #046 had reported being rough handled and was upset regarding the incident.

Review of the home's investigation documentation indicated resident #046 was upset and weepy after reporting the incident. The program staff #171 indicated the SDM was also present and reported the incident had been occurring over the last weeks. The home's investigation determined PSW #172 was involved in the allegation and when interviewed, confirmed that resident #046 was not provided care as per the resident written plan of care related to sleep patterns and the resident had requested to remain sleeping. Review of the resident's current written plan of care related to sleep patterns and preferences indicated the care was not provided to resident #046 as indicated in the plan. There was no other staff interviewed regarding the incident and no further actions taken.

Interview with the Administrator by Inspector #111 indicated the outcome of the investigation was unfounded and no further actions were taken to prevent a recurrence.

The licensee's Zero Tolerance of Abuse and Neglect policy was not complied with as there was no documented evidence that despite the plan of care not provided to the resident as per the resident's preferences related to sleep and rest patterns and the resident being upset with how care was provided, there was no further



action taken by the home to correct the situation where improper care occurred as per the licensee's policy. There was also no documented evidence the home thoroughly investigated the allegation of staff to resident rough handling as only the person interviewed was the staff involved in the allegation. [s. 20. (1)]

7. The licensee has failed to ensure the policy to promote zero tolerance of abuse and neglect of residents shall:

(e) contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents

(f) set out the consequences for those who abuse or neglect residents.

Review of the home's policy "Zero Tolerance of Resident Abuse and Neglect" (RC-02-01-01) revised April 2016 indicated under procedures on page 2 of 7:

-promptly and thoroughly investigate all alleged or reported incidents.

-Identify and address root causes using quality improvement methods and tools and interdisciplinary care planning strategies.

-Identify and correct situations where abuse, neglect, and or mistreatment can occur.

-Promptly investigate resident to resident altercations, complaints and unexplained bruising or injuries to determine root cause and put in place measures to prevent recurrence.

The Licensee's "Zero Tolerance of Abuse and Neglect" policy:

- did not contain procedures for investigating and responding to alleged, suspected or witnessed incidents of abuse and/or neglect of a resident by "a staff member",

-did not set out the consequences for those who abuse and/or neglect residents.

-did not provide procedures for "preventing" staff to resident abuse and/or neglect.

-did not include how staff were to document when any alleged, suspected or witnessed incidents of abuse and/or neglect is identified by a staff member and what assessment and care was to be provided to the resident.

-the policy references the home's "Complaint and Customer Service" policy which contained procedures for investigating all complaints (including abuse and/or neglect) but this policy was also not complied with. [s. 20. (2)]



WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

- (i) abuse of a resident by anyone,**
 - (ii) neglect of a resident by the licensee or staff, or**
 - (iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
- (b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
- (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone or (ii) Neglect of a resident by the licensee or staff.

Related to log # 027318-16:

The Long Term Care Emergency after hours was contacted on a specified date to report resident #045 had an injury to a specified area and suspected rough handling from a staff or resident". A CIR was not submitted to the Director until four months later and indicated the investigation was still pending.

Interview with the Administrator by Inspector #111 regarding the outcome of the investigation, indicated the investigation was still ongoing. The Administrator indicated the investigation was started by the acting DOC four months later when the CIR was submitted. [s. 23. (1) (a)]

2. Related to log # 023595-16:



A critical incident report (CIR) was submitted on a specified date for an allegation of resident to resident sexual abuse. The CIR indicated the incident occurred over a two day period at specified times between resident #043 and #044. The CIR indicated both resident's were cognitively impaired and neither resident was able to provide consent for sexual behaviour.

Interview with Administrator by Inspector #111 regarding the incident indicated an investigation was completed into the incident but she was unable to locate the investigation documentation. [s. 23. (1) (a)]

3. Related to Log #026513-16:

Critical Incident Report (CIR) was submitted by the Director on a specified date for an allegation of neglect of care of resident #054. The CIR indicated on the same day, the Substitute Decision Maker (SDM) of resident #054 voiced concerns to the Social Worker regarding allegations of improper care.

Review of the CIR and the licensee's Client Feedback Log (completed by Social Worker approximately one month later) in relation to the allegations of improper care indicated the acting DOC "spoke with front line staff regarding customer services to residents and how to respond to resident/family concerns". The Administrator indicated to Inspector #570 that she confirmed with the Acting DOC that an investigation was not completed. There was no documented evidence that an investigation was initiated or completed into the allegation of improper care or neglect of resident #054.(570) [s. 23. (1) (a)]

4. Related to log # 002431-17:

A critical incident report (CIR) was submitted to the Director on a specified date related to an alleged staff to resident neglect that occurred on over a two day period at specified times. The CIR indicated resident # 061 (who is cognitively well) had reported that resident #057 had been neglected by PSW #129 over a two day period.

Interview with the Administrator by Inspector #111 and request for the home's investigation documentation into the allegation of staff to resident neglect towards resident #057 indicated two interviews (resident #061 and PSW #129) were completed two days after the allegations were reported. The Administrator



indicated at that time no other interviews were completed and the investigation was concluded as 'unfounded'. The following day, the Administrator then provided an interview of PSW #123 that was completed nine days after the allegation was reported and as a result of the inspection. The Administrator also indicated she had also interviewed three other PSW's (#140, #145 & #170) the day of the allegation but did not document the interviews. [s. 23. (1) (a)]

5. Related to log # 002520-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse that occurred on the same day at a specified time. The CIR indicated program staff #171 had reported in writing to RN Manager #118 that resident #046 had reported being rough handled earlier that morning during care. The program staff also indicated the SDM of resident #046 also reported it had been happening for two weeks.

Review of the home's investigation documentation indicated the allegation of staff to resident rough handling was reported immediately to RN Manager #118, the allegation identified PSW # 172 involved in the allegation and the resident was upset and weepy when reporting the allegation. RN Manager #118 did not report the allegation until the following day and then notified the police and interviewed the resident's SDM. PSW #172 was not interviewed until two days later regarding the allegation.

The investigation was not immediately initiated as the investigation did not start until the day after the allegation was made of staff to resident rough handling. [s. 23. (1) (a)]

6. Related to log # 033626-16 & # 034927-16:

A critical incident report (CIR) was received on a specified date for an allegation of staff to resident neglect that occurred on the same day and at a specified time. The CIR indicated the SDM of resident #049 brought forth complaints to the RN Manager #118 regarding improper care towards resident #049. The CIR indicated the resident has difficulty communicating due to diagnosis. The CIR indicated the SDM would be submitting a written complaint regarding the incidents. The CIR indicated seven days later, a written complaint was received by the SDM regarding the allegations. The CIR indicated the SDM requested not to have the same PSW providing care to the resident.



Review of the written complaint from the SDM of resident #049 indicated nine days earlier, on a specified shift, the resident reported PSW #144 had neglected and/or provided improper care throughout the specified shift. The SDM reported PSW #144 had provided improper care resulting in discomfort to resident #049 to the acting DOC the same day the incident occurred (nine days earlier). The SDM also reported the allegations to RN Manager #118 the following day. The SDM indicated that PSW # 173 and RPN #137 were aware of allegations of neglect the same day the incident occurred.

Interview with acting DOC and SDM by Inspector #111 confirmed the home was aware of allegations of improper care and/or neglect on the day the incidents occurred and the investigation was not initiated until four days later. [s. 23. (1) (a)]

WN #16: 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 failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: 1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.

Related to log # 033626-16 & # 034927-16:

A critical incident report (CIR) was submitted on a specified date for an allegation of staff to resident neglect that occurred the same day at a specified time. The CIR indicated the SDM of resident #049 brought forth complaints to the RN Manager #118 regarding improper care provided to resident #049 on the same day.

Review of the home's investigation and interview of staff indicated the SDM reported the allegations the day before the report to the Director, to the acting DOC. and the Director was not notified until the following day. [s. 24. (1)]



WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).

(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible, strategies are developed and implemented to respond to these behaviours, where possible, and actions are taken to respond to the needs of the resident, including assessment, reassessments and interventions, and that the resident's responses to the interventions are documented.

Related to log # 023595-16:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident sexual abuse. The CIR indicated the incident occurred the day before at a specified time when resident #043 and resident #044 were found demonstrating sexually inappropriate behaviour in resident #044 room. and staff did not intervene. Approximately three hours later, resident #043 and resident #044 were still in resident #044 room and observed demonstrating sexually inappropriate responsive behaviours. Resident #043 was then removed from the room. The CIR indicated both residents were cognitively impaired and



neither resident was able "to provide consent for sexual behaviour". The CIR indicated 1:1 staffing was put in place and referral to Behavioural Supports Ontario (BSO) as a result.

Observation of resident #043 on a specified date by Inspector #111 indicated the resident was cognitively impaired and independently mobile with use of a mobility aide. Resident #044 is no longer in the home.

Review of the progress notes for resident #043 and #044 related to sexually inappropriate responsive behaviours and/or sexual abuse over a three month period indicated:

- On a specified date, the initial incident occurred (as indicated in the CIR) and the SDM of resident #044 indicated "was not in agreement" with the relationship between both residents. Resident #043 was placed on dementia observation system (DOS every 15 minute checks) and not on 1:1 monitoring as per the CIR.
- Approximately ten days later, resident #043 continued on DOS every 15 minute monitoring. The resident was observed demonstrating sexually inappropriate behaviours towards resident #044. Resident #043 was also requesting inappropriate sexual arrangements with resident #044. Both residents continued to sit together near the nursing station or in the lounge. Resident #043 stated "want to get married".
- The following day, resident #043 was observed demonstrating sexually inappropriate behaviour towards resident #044 and was redirected to bed. Later in the shift, both residents were observed seeking each other and demonstrating sexually inappropriate behaviours. Resident #043 was redirected.
- Two days later, resident #043 was demonstrating sexually inappropriate behaviour in resident #044 room. The RN, DOC and physician were also notified and medication changes were received for resident #043. 1:1 staffing was authorized by DOC at this time. Resident #043 continued on DOS.
- The following day, resident #043 was sitting in front of resident #044 room seeking out the resident. The BSO team indicated resident #043: "remains in program, has increased responsive behaviours by way of increased agitation when staff attempt to re-direct from unspecified co-residents". BSO indicated resident #043 "is losing sleep at times" due to seeking unspecified co-residents, and other residents reporting resident #043 & #044 demonstrating sexually inappropriate behaviours in the dining room and threatening remarks made to other residents by resident #043. The BSO indicated resident #043 remained on DOS and current interventions not effective, recommended a room change. Later the same day, resident #043 was observed seeking resident #044. The staff administered medication to resident



#043 and "Remains on 1:1 intervention this shift".

-The following day, resident #043 was seeking out and attempting to enter the room of an unidentified co-resident and was redirected. Later in the evening, resident #043 was seeking out resident #044 and "encouraging" resident #044 not to take medications. 1: 1 monitoring continued. Both residents were observed sitting in the corridor demonstrating sexually inappropriate responsive behaviours for remainder of evening with no redirection.

-The following day, resident #043 remained on DOS and was observed demonstrating sexually inappropriate responsive behaviours with resident #044.

-Two days later, during lunch, resident #043 began calling resident #044 to join the resident's table. Resident #044 attempted to go to resident #043 table when staff intervened. BSO staff were notified and required 4 staff to redirect resident #044 back to own table. BSO indicated resident #043 & #044 were demonstrating sexually inappropriate behaviours and were posing a safety risk to other residents. Resident #044 had to be moved to another dining room to complete meal.

Resident #044 did not eat or drink well at the meal as a result. The SDM of resident #044 was contacted and discussed possible relocation to another unit due to "friendship with co-resident in the unit" and "increased behaviours". The SDM agreed with room transfer and resident #044 was transferred to a different unit.

Later the same day, resident #043 was noted sitting with resident #044 near nursing station. The Administrator assisted staff with redirection of resident #043 to allow [resident #044] to complete the dinner meal. Resident #044 became more aggressive and BSO staff were called to assist and relocated resident #044 to another dining room. The SDM of resident #043 was contacted and informed of the intervention that was initiated "just for this shift" by having to put resident #044 in a different dining room. Resident #043 was later observed sitting in hallway with resident #044 demonstrating sexually inappropriate behaviour.

-Five days later, resident #043 remained on DOS and continued "to seek out" unspecified co-residents. The resident was now seeking out another unidentified co-resident. The resident was also found in an unidentified co-resident's room attempting to get into the resident's bed.

-The following day, the BSO Team met with the physician, pharmacy and RN to review behaviours for resident #043 and noted the resident behaviours were increasing (more verbally and physically aggressive with staff, exhibiting paranoid behaviours, and verbally aggressive with roommate). Resident #043 was "started on a DOS to closely monitor resident's behaviours". During the evening, resident #043 was noted to wander throughout the shift seeking resident #044.

-The following day, resident #043 was awake during the night, confused, wandering different units and asking staff for resident #044. Later in afternoon,



resident #043 was sitting and talking outside of the doorway of [unidentified] co-resident, asking the resident to come out into the corridor. Resident #043 also continued asking staff for the room number of resident #044.

-Three weeks later, resident #043 continued to seek unspecified co-resident's, and was observed sitting in lounge with an [unidentified]co- resident through out the shift.

-Four days later, the BSO Team indicated: resident #043 had no reports of behaviours in the last month and discharged from BSO program.

Interview with RPN #132 & #133 (BSO) by Inspector #111, there was no referral to BSO regarding the initial incident of sexual abuse that occurred (as indicated on CIR), however, they read about the incidents and placed both residents in the BSO program as a result. The BSO staff indicated the family of resident #044 was upset about the initial incident between resident #043 & #044 and had requested "they be kept apart". The RPN's indicated resident #043 was then placed on 1:1 supervision as a result. Both RPN's indicated resident #043 and #044 would be seen demonstrating sexually inappropriate behaviours. The RPN's indicated the PSW's were to complete DOS every 15 minute monitoring record for resident #043 while on the program. The RPN's indicated resident #044 was then moved to another unit and the sexually inappropriate responsive behaviours between resident #043 & #044 discontinued so resident #043 was discharged from BSO. Both BSO staff were unaware the sexually responsive behaviours demonstrated by resident #043 continued towards other co- residents after resident #044 was relocated to another unit.

Interview with RN #035 by inspector #111, regarding any current responsive behaviours demonstrated by resident #043 and indicated "two weeks ago, a family reported witnessing" resident #043 demonstrate sexually inappropriate responsive behaviour and/or sexual abuse towards the resident. The RN was unable to recall who the recipient resident was. The RN was not aware of any prior sexually inappropriate responsive behaviours demonstrated by resident #043 but indicated resident #043 previously "believed" was married to resident #044, would seek the resident out, and they would just walk together, but no sexual activity". The RN indicated resident #044 was moved to another unit as the family of resident #044 was not agreeable to the relationship. The RN indicated the behaviour stopped once the male resident was relocated until the recent report. The RN was not aware of the resident having inappropriate sexual behaviours with any other male residents. Review of the progress notes of resident #043 had no documented evidence of the incident reported by the family member.



Review of the written care plan (at time of incidents) for resident #044 indicated cognitive impairment and the resident was recently relocated to a different room. Under socially inappropriate behaviour: the resident was witnessed demonstrating sexually inappropriate behaviour towards an (unidentified) co-resident [this incident was different from incident reported on CIR and had no documented evidence in progress notes] and sexually inappropriate with (unidentified) female co-residents. Interventions included: if becoming inappropriate with female co-resident, distract the resident and remove from the situation, monitor the resident to ensure does not have female co-residents in room, do not leave resident alone with a female co-resident, and currently on increased observation related to female co-resident in bed (incident on CIR). There was no indication what the sexually inappropriate behaviours were, which female residents they were directed towards, or how the staff were to monitor or frequency of monitoring.

Review of the written care plan for resident #043 (updated the day after incident on CIR) indicated resident #043 "believes she/he is in a long term romantic relationship with a male co-resident". Co-resident's family do not agree with the relationship. The care plan was updated nine days later and included monitor resident every shift and report to charge nurse for any inappropriate mood and behaviour. The interventions were updated three weeks later and included: monitor behaviour episodes and attempt to determine underlying causes, often becomes upset if redirected from male co-residents, validate the resident's feelings and redirect the conversation, monitor for increased behaviour, and initiate behaviour tracking, and in BSO program.

The written plan of care for both resident #043 & #044 did not indicate the triggers and strategies to manage the sexually inappropriate responsive behaviours, and did not indicate which female/male resident(s) they were demonstrating sexually inappropriate behaviours towards. Resident #043 had demonstrated inappropriate sexual responsive behaviours towards more than one male resident and this trigger was not identified (nor were the male residents identified); The plan of care did not clearly indicate what the "sexually inappropriate" behaviour included for either resident despite the progress notes for both residents indicating, seeking out males (resident #043), and describing the behaviours of both residents. There was no documentation in resident #044 health record related to the sexually inappropriate incident referred to in the written plan of care of resident #044, to indicate who the recipient resident was, or when this occurred. The incident with resident #043 as reported by a family member of an unidentified resident to RN #035 (during

interview) was also not identified in the health record of resident #043 to indicate when it occurred and towards whom. The strategies to manage the sexually inappropriate responsive behaviours was also not clear as there was no indication how staff would ensure the residents would be monitored, what "increased observation" included, and have they would ensure specified co-resident was not in the residents' room. The observation period was unclear and sometimes resident #043 was placed on 1:1 and other times on DOS (every 15 minute observations). The sexually inappropriate responsive behaviours were accepted by some staff as "a relationship" and allowed to occur despite directions to intervene when they occurred. Other strategies were not considered for both resident #043 & #044 when current strategies were not effective and one strategy (relocating resident #044 to another unit) was not considered until after several more incidents occurred, despite the responsive behaviour negatively affecting both residents, and as requested by the SDM of resident #044. There was no indication of a referral to psychogeriatric services and the resident was discharged from the BSO program despite the sexually inappropriate responsive behaviours continuing for resident #043. [s. 53. (4)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

- 1. A change of 5 per cent of body weight, or more, over one month.**
- 2. A change of 7.5 per cent of body weight, or more, over three months.**
- 3. A change of 10 per cent of body weight, or more, over 6 months.**
- 4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.**

Findings/Faits saillants :



1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months

Review of the licensee's Weight Change Program policy (#RESI-05-02-07) on page 1 of the policy, under Procedures indicated registered nursing staff:

1. Compare to previous month's weight; and any weight with a 2.5 kg difference from the previous month requires a re-weigh. Registered staff is to direct care staff to re-weigh the resident.

Related to Log #026513-16:

A Critical Incident Report (CIR) was submitted by the Director in relation to an allegation of neglect of care of resident #054 that occurred on a specified date. The CIR indicated that on the same day, and at a specified time, the Substitute Decision Maker (SDM) of resident #054 voiced concerns to the Social Worker regarding improper care and included concerns related to weight loss.

Review of clinical records for resident #054 indicated when the resident was admitted to the home, the resident was assessed at a moderate nutritional risk.

Resident #054's weights were reviewed over a six month period and noted a significant weight change of 4.7 kg between two of the specified months and a -9.75% weight change in last month period.

Inspector #570 interviewed the home's Registered Dietitian (RD #157) regarding resident's weight variances from the previous month. The RD stated the expectation was that if the resident's weight differs by 2.2 kg or more from the previous month's weight, then a re-weigh should be completed. The RD indicated that resident #054 should have been reweighed when the resident's weight dropped by 4.7 kg.(570) [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. Related to Resident #007:

During an interview with Inspector #626 and resident #007's SDM, the SDM



expressed concerns that the resident had lost weight because the resident was not eating, and that if the resident does not go to the dining room for meals, the SDM was concerned that staff would not assist the resident to the dining room.

Review of resident #007 weight over a six month period indicated on a specified month, the resident had a weight variance of approximately 4 kg between two months. Progress note by the Dietitian during the same time period indicated a 10% weight loss over six months.

Inspector #626 interviewed the home's Registered Dietitian (RD #167) regarding the expectations when a resident's weight varies from the previous month. The RD stated the expectation was that if the resident's weight differs by 2.5 kg or more from the previous month's weight, then a re-weigh should be completed. The RD indicated that resident #007 should have been reweighed when the resident's weight decreased

In an interview with RPN #101, the RPN indicated that the resident should have been reweighed when the weight was decreased.

Interview with the Administrator by Inspector #626 confirmed that when a resident is weighed and determined to have significant weight loss, the resident must be re-weighted right away.

The resident was not re-weighed when there was a significant decrease in the resident's weight and actions were not taken and the outcomes evaluated.(626) [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

**WN #19: The Licensee has failed to comply with LTCHA, 2007, s. 85.
Satisfaction survey**



Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,

(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).

(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).

(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).

(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to ensure the resident satisfaction survey results were made available to the Residents Council in order to seek the advice of the Council about the survey, and the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents Council.

During an interview with Resident Council President (RCP) by Inspector #623, the RCP indicated that the resident satisfaction survey was completed annually in the home, however, the results of the resident satisfaction survey were not communicated to the Resident's Council in 2016.

Interview with the Administrator indicated the 2015 resident satisfaction survey results were not communicated in 2016 to the Residents Council.

The licensee failed to document and make available to the Residents' Council the results of the satisfaction survey in 2015. (623)[s. 85. (4) (a)]



WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :



1. The licensee failed to ensure that the licensee's written policy to promote zero tolerance of abuse and neglect of residents:

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate.

Review of the home's policy "Zero Tolerance of Resident Abuse and Neglect"

(RC-02-01-01) revised April 2016 indicated under procedures on page 2 of 7:

-identify and address root causes using quality improvement methods and tools and interdisciplinary care planning strategies.

-identify and correct situations where abuse, neglect, and or mistreatment can occur.

-promptly investigate resident to resident altercations, complaints and unexplained bruising or injuries to determine root cause and put in place measures to prevent recurrence.

This policy does not provide specific procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected and does not provide specific procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents



Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the resident's Substitute Decision Maker (SDM) and any other person specified by the resident, were immediately notified upon becoming aware of any alleged, suspected or witnessed incidents of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Related to log # 027318-16:

The Long Term Care Emergency after hours was contacted on a specified date to report resident #045 had an injury to a specified area and suspected rough handling from a staff or resident. A CIR was not submitted at that time until four months later as a result of an off-site enquiry completed by Inspector #111. The CIR indicated the SDM was not notified of the incident.

Interview with the Administrator by Inspector #111 indicated the SDM was not notified of the incident. [s. 97. (1) (a)]



WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,

(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).

(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).

(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).

(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).

(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the verbal complaints made to licensee or a staff member concerning the care of a resident or operation of the home: has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately.



Related to log # 034747-16:

On a specified date, a complaint was received from resident #012's Substitute Decision Maker (SDM) related to improper care of resident #012.

During a telephone interview with the complainant on a specified date, it was indicated to Inspector #166, resident #012's SDM came to the home to visit the resident and met with the Acting DOC, the physician, RN #118 and RPN #101. The SDM indicated, at that meeting, the complaint was brought forward related to improper care of resident #012.

The SDM indicated no response was received by the home related to the concerns brought forward.

Review of the licensee's documentation does not provide any evidence that a response to the improper care concerns expressed by the SDM was provided to the SDM.

Review of email correspondence (approximately one month later) from the Social Worker addressed to RN #118, indicated the SDM for resident #012 approached the Social Worker to discuss care concerns. The content of the email indicated that the SDM was planning to discharge the resident due to the improper care concerns.

Interview with RN #118, concerning the email from the Social Worker, by Inspector #166 indicated could not recall receiving the email and therefore did not respond to the SDM related to the improper care concerns of resident #012 . [s. 101. (1) 1.] (166)

2. The licensee has failed to ensure that a documented record is kept in the home that includes:

- (a) the nature of each verbal or written complaint
- (b) the date the complaint was received
- (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
- (d) the final resolution, if any
- (e) every date on which any response was provided to the complainant and a description of the response, and
- (f) any response made by the complainant



Related to log# 034747-16:

A complaint was received from resident #012's SDM on a specified date related to improper care for resident #012.

Telephone interview with the complainant indicated the improper care concerns for resident #012 were reported to the ADOC, the physician, RCAM#118 and RPN#101 approximately two months prior.

Review of email correspondence approximately one month after initial verbal complaint, the Social Worker addressed to RN #118, indicated the SDM for resident #012 approached the Social Worker to discuss improper care concerns and the family was planning to discharge the resident as a result.

Review of the licensee's policy "Complaints and Customer Service" revised April 2016 indicated on page 3 of 6, under Investigation:

-each contact with the complainant should be recorded on the contact log by the person making the contact (appendix 4)

Review of the licensee's complaint log during the same two month period did not have any documented evidence that resident #012's SDM verbal complaints related to improper care of resident #012, were received on either of the two separate dates they were received. (166) [s. 101. (2)]

3. Related to log # 033626-16 & #034927-16:

A verbal complaint was provided to the acting DOC on a specified date related to improper care provided to resident #049 the same day the incident occurred.

A written complaint letter was also received by the home nine days later, from the SDM of resident #049 indicating allegations of staff to resident neglect and improper care by PSW #144. The letter indicated the incidents occurred nine days prior on a specified shift.

Interview with Social Worker(SW) indicated she was responsible for maintaining the home's complaint log and enters all verbal and written complaints that are received once the investigations are completed. The SW was not aware of a verbal complaint received by the home on a specified date or a written complaint received nine days later regarding allegations of staff to resident improper care and neglect towards resident #049. The SW indicated the acting DOC or Administrator usually



provides her with the verbal or the written complaints.

Review of the home's complaint log for the specified time period did not have any documented evidence of a verbal or written complaint received by the SDM of resident #049 related to staff to resident improper care and neglect. [s. 101. (2)]

4. Related to log # 002520-17:

A verbal complaint was made on a specified date regarding staff to resident rough handling towards resident #046 and there was no documented evidence on the home's complaint log regarding this complaint.

Interview of the SW indicated she was not aware of this verbal complaint and did not log the complaint in the complaint log. [s. 101. (2)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act



Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

2. A description of the individuals involved in the incident, including,

- i. names of all residents involved in the incident,**
- ii. names of any staff members or other persons who were present at or discovered the incident, and**
- iii. names of staff members who responded or are responding to the incident.**

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

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident: (ii) names of any staff members or other persons who were present at or discovered the incident.

Related to log # 002431-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect that occurred the day before and the same day the CIR was submitted, at a specified time. The CIR indicated resident #061 (who is cognitively well) had reported that resident #057 had been neglected by PSW #129. The CIR did not indicate any other staff were present at the time of the incident.

Review of the licensee's investigation, documentation and interview with



Administrator and acting DOC indicated that PSW # 123, 140, #145 & #170 had also been interviewed related to the allegation as they were present or working at the time of the incident. [s. 104. (1) 2.]

2. Related to log # 002520-17:

A critical incident report (CIR) was submitted on a specified date for an allegation of staff to resident physical abuse that occurred on the same day at a specified time. The CIR indicated a program staff #171 had reported to RN Manager #118 that resident #046 had reported being rough handled during care. The CIR did not indicate which staff was involved with the allegation.

Review of the home's investigation and interview of staff indicated that PSW #172 was involved in the allegation. The name of PSW #172 who was involved in the allegation was not identified in the CIR. [s. 104. (1) 2.]

3. Related to log # 033626-16 & # 034927-16:

A critical incident report (CIR) was submitted on a specified date for an allegation of staff to resident neglect that occurred on the same day at a specified time. The CIR indicated the SDM of resident #049 brought forth complaints to RN Manager #118 regarding improper care provided to resident #049.

Review of the licensee's investigation, documentation and interview of staff by inspector #111 indicated RPN #137, PSW # 173, PSW #174 and PSW #175 had been present but were not identified in the CIR. [s. 104. (1) 2.]

4. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

Related to log # 027318-16:

The Ministry of Health and Long Term Care (MOHLTC) after hours was called on September 4, 2016 to report resident #045 had an injury to a specified area and suspected rough handling by a staff or from a resident. A CIR was not submitted at that time. A critical incident report (CIR) was submitted four months following the incident. [s. 104. (2)]



5. The licensee has failed to ensure that if unable to provide a report within 10 days, that a preliminary report is made to the Director within 10 days, followed by a final report within the time specified by the Director (in 21 days unless otherwise specified by the Director).

Related to log #023595-16:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident sexual abuse. The CIR indicated the incident occurred the day before at a specified time when resident #043 and resident #044 were found in resident #044 room demonstrating sexually inappropriate behaviour. Approximately three hours later, resident #043 was still in resident #044 room and both residents were observed demonstrating sexually inappropriate responsive behaviours. Resident #043 was then removed from the room. The final report to the Director was not submitted indicating the outcome of the licensee's investigation.

Interview with the Administrator indicated four months later, she was unaware the finale report to the Director was not submitted to indicate the outcome of investigation. [s. 104. (3)]

6. Related to log #020568-16:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect that occurred the same day. The CIR indicated at a specified time, resident #015 was observed being verbally abusive towards resident #054 . The incident was witnessed by PSW # 151 and #152 who did not intervene. RPN #132 then witnessed the incident and intervened. The CIR indicated the investigation was initiated but the final report was not submitted to the Director with the outcome of the licensee's investigation to date. [s. 104. (3)]

7. Related to log # 034777-16:

Review of critical incident report (CIR) documentation indicated that on a specified date, the Substitute Decision Maker (SDM) for resident #012, voiced concerns to the licensee related to the improper wound care management for resident #012.

Interview with the Acting Director of Care and the Administrator on a specified date indicated that a final report had not been submitted to the Director within the 21



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days as specified by legislation. The final amendment report was submitted to the Director approximately one month later. (166) [s. 104. (3)]



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**Rapport d'inspection prévue
le Loi de 2007 les foyers de
soins de longue durée**

Issued on this 11 day of May 2017 (A2)

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

Original report signed by the inspector.



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**Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

Ottawa Service Area Office
347 Preston St, Suite 420
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Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : LYNDA BROWN (111) - (A2)

Inspection No. /

No de l'inspection : 2017_360111_0001 (A2)

Appeal/Dir# /

Appel/Dir#:

Log No. /

Registre no. : 035430-16 (A2)

Type of Inspection /

Genre d'inspection: Resident Quality Inspection

Report Date(s) /

Date(s) du Rapport : May 11, 2017;(A2)

Licensee /

Titulaire de permis : CVH (No.6) GP Inc. as general partner of CVH
(No.6) LP
c/o Southbridge Care Homes Inc., 766 Hespeler
Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

LTC Home /

Foyer de SLD : Orchard Villa
1955 VALLEY FARM ROAD, PICKERING, ON,
L1V-3R6



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Name of Administrator / Andrea Loft
Nom de l'administratrice
ou de l'administrateur :

To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # /	Order Type /
Ordre no : 001	Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :



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O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and

iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system,
or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

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.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

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The licensee shall complete the following:

1. Equip all doors located in each home area that lead to stairwells to which residents have access with an audible door alarm that is separate from the resident-staff communication and response system. The alarm shall be capable of being cancelled only at the point of activation.
2. Equip the front main foyer doors located in the older section of the building which lead to an unsecured outdoor area and to which residents have access, with an audible door alarm that is separate from the resident-staff communication and response system. The alarm shall be capable of being cancelled only at the point of activation.
3. Connect two stairwell doors to which residents have access located in the basement to the resident-staff communication and response system.
4. Equip all interior doors that lead to the retirement home and to which residents have access, with an audible door alarm that is separate from the resident-staff communication and response system. The alarm shall be capable of being cancelled only at the point of activation.
5. Connect all interior doors that lead to the retirement home and to which residents have access, to the resident-staff communication and response system.
6. Connect the main foyer doors located in the older section of the building to the resident-staff communication and response system.

Grounds / Motifs :

1. The licensee did not ensure that the following rules were complied with:

Doors that residents had access to and led to stairways and unsecured outdoor areas of the home were not equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and were not connected to the resident-staff communication and response system.

A) Eight doors leading to stairwells to which residents had access were checked. These doors were located in the main foyer (near the elevator), two in the Birch home area, one in the Linden home area, two in the Cedar home area and three in the Aspen home areas and did not have an audible alarm located at the door. When each door was tested, it was confirmed to be connected to the resident-staff communication and response system (at various enunciator panels) and an audible sound within the corridors was heard. However, each door did not have a separate



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audible alarm at the door that would sound until a staff member cancelled the alarm at the door.

B) The front main entrance door to the long term care home, which led to an unsecured outdoor area was not equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and was not connected to the resident-staff communication and response system. When the door was tested, the Linden area nursing station was identified by staff as the closest station to the door. The audio visual enunciator located at the nurse's station included a visual light labelled "front door", but it did not light up when the door was left open for more than one minute. The exit door leading from the Aspen home area to an unsecured outdoor area did not have an audible alarm at the door and it could not be confirmed if the door was connected to the Aspen home area audio visual enunciator.

C) Two stairwell doors accessible to residents in the basement (near the recreation room and chapel) were not equipped with an audible door alarm or connected to the audio visual enunciator at the Maple nurse's station. Management staff could not confirm if the doors were connected to any of the other enunciator panels within the home. Maintenance staff could not provide any drawings or a reference confirming which stairwell door and which door leading to the outside was connected to which enunciator panel and were not aware that the doors were not connected to the resident-staff communication and response system (via enunciator panels).

D) Two sets of glass doors leading to the retirement home area located in the basement (near the auditorium and a stairwell) and one set of doors located on the main floor leading to the retirement home area were not connected to any audio visual enunciator at any of the nurse's stations and were therefore not connected to the resident-staff communication and response system. The doors were not equipped with an audible alarm. Doors that separate a retirement home from a long term care home area considered the equivalent of doors leading to an unsecured outdoor area.

(120)

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

Jul 17, 2017



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Order # / Ordre no : 002	Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)
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Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).



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Order / Ordre :

The licensee shall:

- put a monitoring process in place during each meal, including who will be responsible to ensure that all residents requiring assistance and/or encouragement with meals are provided the encouragement and assistance they need in order to they receive the nutritional intake as required.
- ensure that all food service workers and any staff assisting residents, know the residents diet and texture and any special needs and preferences.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a process to ensure that food service workers and other staff assisting residents were aware of the resident's diets, special needs and preferences.

Observation of the lunch service in the main dining room (Linden servery) on a specified date by Inspector #111 indicated the dietary aide (DA #109) did not refer to the resident diet list while providing resident meals. PSW # 114 requested the meal choice and texture but did not identify the resident names when requesting food plates from the DA. PSW # 113 was requesting meal choice by resident names only and the DA did not refer to the resident diet list to ensure they received the correct diet and texture. The DA began asking the nursing staff to refer to the resident diet list after the inspector asked the DA why the resident diet list was not referred to.

Interview with the Nutritional Care Manager (NCM), by Inspector #111 indicated it is the DA responsibility to refer to the diet list prior to serving meal choices for each resident, not the nursing staff. [s. 73. (1) 5.] (111)



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(A1)

2. The licensee has failed to ensure that there was a process to ensure that food service workers and other staff assisting residents were aware of the resident's diets, special needs and preferences.

Observation of the lunch service in the main dining room (Linden servery) on a specified date by Inspector #111 indicated the dietary aide (DA #109) did not refer to the resident diet list while providing resident meals. PSW # 114 requested the meal choice and texture but did not identify the resident names when requesting food plates from the DA. PSW # 113 was requesting meal choice by resident names only and the DA did not refer to the resident diet list to ensure they received the correct diet and texture. The DA began asking the nursing staff to refer to the resident diet list after the inspector asked the DA why the resident diet list was not referred to.

Interview with the Nutritional Care Manager (NCM), by Inspector #111 indicated it is the DA responsibility to refer to the diet list prior to serving meal choices for each resident, not the nursing staff. [s. 73. (1) 5.] (623)

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

Mar 31, 2017(A1)

Order # / **Order Type /**
Ordre no : 003 **Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :



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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 ensure that the licensee's Abuse and Neglect policy is complied with and a monitoring process is developed and implemented to protect residents in incidents of alleged, suspected or witnessed abuse and/or neglect.

The monitoring process shall include, but is not limited to:

- a) a process whereby residents exhibiting sexually inappropriate responsive behaviours are identified, triggers to the behaviours are identified, and for each behaviour identified, strategies are implemented to assist staff in managing the responsive behaviours;
- b) a process whereby the Director of Care and/or delegate is reviewing all communication from the front line staff at least daily to determine the presence of suspected, alleged or witnessed incidents of resident abuse and/or neglect;
- c) a process whereby an effective information-sharing protocol amongst all members of the multidisciplinary health care team, the residents, their families is established to ensure supervisory and management staff always have current, reliable and comprehensive information about suspected, alleged or witnessed incidents of resident abuse and/or neglect;
- d) a process whereby, when there are reasonable grounds to suspect that abuse and/or neglect has occurred, the licensee and/or delegate immediately conducts a thorough investigation, ensuring that all legislative requirements have been fulfilled (both internal and external reporting requirements), especially as it relates to the assessment of the residents involved and the implementation of interventions to meet their needs for support and protection;
- e) revision of the licensee's policy relating to 'Zero Tolerance of Abuse and Neglect', specifically, actions to be taken when allegations, suspicions or witnessed incidents of staff to resident neglect occur, including assessments of residents, and including actions to be taken by the home that include support to be provided to the residents, investigating and reporting

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requirements, and documentation related same.

f) a process to assess the knowledge and skills of all staff in relation to the implementation of the licensee's Abuse and Neglect policy, in order to effectively address deficiencies through targeted, focused and individualized interventions; and

f) a formal linkage to the home's quality improvement program, to ensure that all aspects of the development and implementation of the required monitoring process are documented, reviewed and analyzed on an ongoing basis to determine the need for further corrective actions.

Grounds / Motifs :

1. 1. The licensee failed to ensure that residents were protected from staff to resident verbal or physical abuse and/or neglect by staff and other residents, and failed to ensure vulnerable, cognitively impaired, residents were protected from alleged, suspected or witnessed sexual abuse by another resident, pursuant to s.19 of the LTCHA.

Under O.Reg. 79/10, s.2(1) For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "sexual abuse" means,(a) subject to subsection (3), (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Under O.Reg. 79/10, s.2(1), For the purposes of the definition of "abuse" in subsection 2(1) of the Act,
-"emotional abuse" means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour, or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a residents.
-"physical abuse" means, subject to subsection (2)(a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Under O.Reg. 79/10, s. 5, For the purposes of the definition of "abuse" in subsection 2(1) of the Act, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.



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1. Related to log #001738-17:

Critical Incident Report (CIR) was submitted to the Director on a specified date related to an alleged staff to resident verbal and physical abuse that was reported to Inspector #626 in stage one of the RQI. Inspector #626 reported the alleged incidents to the Administrator on the same day. Resident #010 reported the previous evening, two staff were rough when providing care and resulted in pain. The resident also indicated that PSW #139 and PSW #149 also made inappropriate comments towards the resident regarding personal care. The resident indicated the incidents were reported to RPN #120 the following morning (the same day the Inspector was notified). The RPN did not report the allegation to the RN, DOC or Administrator until the following day during the investigation.

Interview with RPN #120 by Inspector #626 confirmed that the resident did report the alleged inappropriate comments made by the PSW #139 and #140 but was not informed of any incidents of physical abuse or rough handling. The RPN was uncertain of the date the RPN was informed. The RPN indicated was not informed of any incidents of physical abuse or rough handling. RPN #120 indicated that the resident had requested the RPN not to report the allegation but should have reported it immediately.

In an interview with the Administrator by Inspector #626 indicated that RPN #120 did not immediately report the allegations of staff to resident verbal abuse until the home's investigation the day after the allegation was received. The Administrator indicated that it is the expectation that staff report incidents of abuse immediately to their RN supervisor.

The licensee failed to ensure the written policy that promotes zero tolerance of abuse and neglect of residents was complied with as RPN #120 failed to immediately report an incident of staff to resident rough handling and emotional abuse as issued under WN #14 under s.20(1)(a)(626).

2. Related to log #020568-16:

A critical incident report (CIR) was submitted on a specified date for an alleged staff to resident neglect. The CIR indicated at a specified time, resident #015 was observed yelling and making threatening remarks towards resident #053. The



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incident was witnessed by PSW #151 and PSW #152, who did not intervene. RPN #132 then witnessed the incident and intervened. RPN #132 forwarded a complaint regarding the incident the same day indicating the staff failed to intervene. The CIR was not amended to provide the outcome of the licensee's investigation into the allegation.

An off-site enquiry was made to the Administrator on a specified date requesting the outcome of the licensee's investigation but the information was not provided. An inspection was then initiated a week later and the Administrator was asked for the investigation and outcome of the investigation. One staff interview was provided to the inspector at that time but no outcome of the investigation. Review of the health record of resident #053 indicated there was no documented evidence of the incident or to indicate the resident was assessed as per the home's Zero Tolerance of Abuse policy. Further interview with Administrator confirmed she should be interviewing all staff who may have been involved in the incident, documenting the outcome of the investigation and the CIR should have been updated with the outcome.

Interview with Social Worker (SW) indicated she is responsible for maintaining the home's complaint log and enters all verbal and written complaints that are received once the investigations are completed. The SW was not aware of any verbal complaint received by the home on the specified date regarding allegations of staff to resident neglect towards resident #053. The SW indicated the acting DOC or Administrator are responsible for providing all verbal or written complaints to the SW.

-Review of the home's investigation and interview of staff indicated the home's Zero Tolerance of Abuse policy was not followed as: there was no documented evidence of the incident or to indicate resident #053 was assessed or offered support related to verbal abuse received by resident #015. The two PSW staff also failed to intervene as issued under WN #14 under LTCHA, 2007, s.20(1)(a).

- The licensee failed to ensure that a documented record was kept in the home that included: the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response, and; any response made by the complainant the verbal complaint made by the RPN regarding neglect was not documented in homes complaint log as issued under WN #22 under O.reg. 79/10, s.101(2)

-The CIR was not updated within 21 days of the incident, with the outcome of the



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investigation as the CIR was not updated as of the time of the inspection, six months later, as issued under WN #23 under O.Reg. 79/10, s.104(3).

3. Related to log # 002431-17:

Critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect that occurred over a two day period at specified times. The CIR indicated resident #061 (who is cognitively well) had reported staff to resident neglect towards resident #057 by PSW #129. Resident #061 reported additional staff were also aware of the incident. The CIR did not indicate which staff were involved in the allegation.

Interview with Administrator and acting DOC by Inspector #111, indicated PSW #129 was involved in the alleged neglect and resident #061 (who reported the allegation), were both interviewed two days later. The Administrator indicated the home determined the PSW #129 had provided care related to toileting to resident #057 on both dates. The Administrator indicated that PSW #129 could not provide a specified task due to lack of supplies available. Interview of the Administrator the following day indicated she forgot that she had also interviewed three other PSW's on the same day the allegation was made but did not document the interviews. The Administrator concluded the investigation and indicated the allegations were unfounded.

Review of the current written care plan for resident #057 indicated the resident is at risk for skin breakdown related to incontinence and interventions included: resident will not call for assistance with toileting, staff are to check and change the resident every 2-3 hours and as needed.

Review of the licensee's investigation, interview of staff, and review of the resident #057 health record indicated a complaint was received by resident #061 on a specified date regarding an allegation of staff to resident neglect that occurred towards resident #057 by PSW #129. The home's investigation indicated that PSW #123, #139, #145, #165 were involved or present in the allegation and their names were not provided in the CIR. The outcome of the investigation was unfounded despite the licensee's investigation indicating PSW #129 did not provide care to resident #057 as indicated in the plan related to toileting. PSW #123 reported assisting PSW #129 with toileting of resident #057 once per shift on the specified dates and indicated resident #057 required more frequently toileting. Interview with PSW #139 by Inspector #111 indicated resident #057 required toileting 3-4 times per



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shift. Resident #057 was not toileted as indicated in the plan.

-There was no documented evidence of the incident or to indicate resident #057 was assessed, as per the home's Zero Tolerance of Abuse and Neglect policy, as issued under WN #14 under LTCHA, 2007, s.20(1)(a).

-There was no documented evidence the investigation was completed immediately and no actions were taken related to the resident not being toileted as per the resident's plan of care or the lack of supplies available to complete a specified task as issued under WN #15 under LTCHA, 2007, s.23 (1)(a).

-The care set out in the plan of care was not provided to the resident as specified in the plan related to toileting as issued under WN #12 under LTCHA, 2007, s.6(7).

-The CIR was not amended to indicate which staff were involved with the allegation despite staff awareness two days after the allegation was made, as issued under WN #23 under O.reg.79/10, s.104(1)2.

4. Related to log # 027318-16:

The Ministry of Health after hours was called on a specified date to report an incident of injury of unknown cause to resident #045. A CIR was not submitted at that time. A CIR was submitted four months later as a result of an off-site enquiry. The CIR indicated at a specified time, RPN #117 noted an injury to a specified area to resident #045 and suspected rough handling by a staff or resident. The CIR indicated the outcome was pending the investigation. The CIR indicated the SDM was not notified of the incident.

Interview with the Administrator by Inspector #111 requesting the outcome of the investigation indicated the investigation was not yet completed (five months later). The Administrator confirmed the SDM was not notified of the incident.

Review of resident #045 progress notes indicated on a specified date and time, an RPN noted an injury to a specified area and suspected possible rough handling by a staff or resident due to location of injury. The RPN interviewed the PSW who was assigned to resident #045 and confirmed the injury was noted at start of shift but did not report to the RPN. The home did not complete the investigation to determine if the investigation was founded or unfounded. The home also failed to submit the CIR within 10 days of the incident. The licensee's Zero Tolerance of Abuse and Neglect policy was not complied with as an injury of unknown cause was not immediately reported by the PSW and there was no documented evidence to indicate that



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appropriate actions were taken.

-Review of the home's investigation and interview of staff indicated the home's Zero Tolerance of Abuse and Neglect policy was not followed related to failure to immediately report the injury suspected physical abuse as issued under WN #14 under LTCHA, 2007, s.20(1)(a).

-The licensee failed to ensure the resident's SDM and any other person specified by the resident, were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being as issued under WN #21 under O.Reg. 79/10, s.97(1)(a).

-The licensee failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director as issued under WN #23 under O.Reg. 79/10, s.104(2).

5. Related to log #002520-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident physical abuse that occurred on the same day at a specified time. The CIR indicated program staff (PS #171) had reported resident #046 had reported being rough handled earlier in the day during care and had been occurring over the last two weeks to RN Manager #118 (the same day).

Review of the care plan for resident #046 indicated the resident had specified sleeping preferences.

Review of the licensee's investigation indicated on the specified date and time, resident #046 reported the PSW "is rough" and was upset and weepy while reporting the incident to PS #171. The SDM of resident #046 was present when the allegation was reported to PS #171 and confirmed incidents had been occurring over a two week period. RN Manager #118 did not report the allegation until the following day, when the police were notified. RN Manager #118 indicated the alleged PSW involved in the incident was PSW #172 and was interviewed two days later.

Interview with the Administrator by Inspector #111, confirmed that no other staff were interviewed regarding the allegation, the investigation was completed and determined to be inconclusive. The Administrator indicated as a result of the



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discussion with the Inspector, that other staff would be interviewed before the home determined the outcome.

-The investigation was not completed immediately as the investigation did not start until two days after the allegation was made of staff to resident rough handling and no other actions were taken to prevent a recurrence despite the resident not receiving care as per the resident's written plan of care, as issued under WN #15 under LTCHA, 2007, s.23(1)(a).

-The care set out in the plan of care was not provided to the resident as specified in the plan related to sleep preferences as issued under WN #12 under LTCHA, 2007, s.6(7).

6. Related to log # 033626-16 & # 034927-16:

A critical incident report (CIR) was received on a specified date for an allegation of staff to resident neglect. The CIR indicated the SDM of resident #049 brought forth complaints to RN Manager #118 regarding improper care and neglect to resident #049 by PSW #144. The CIR indicated the SDM also submitted a written complaint eight days later regarding the incidents that occurred and the resident "was upset" and requested not to have the same PSW providing care for the resident.

Review of the written complaint from the SDM of resident #049 indicated on a specified date and time, the resident reported PSW #144 had provided improper care and neglected the resident throughout the shift. The SDM indicated the allegations were reported to the acting DOC the same day they occurred as the resident was in discomfort. The SDM indicated PSW #173 and RPN #137 were also aware and or present when the improper care and neglect occurred.

Interview with acting DOC and RN Manager #118 by Inspector #111, confirmed the home was aware of a verbal complaint alleging staff to resident neglect on the day the incidents occurred (followed by a written complaint seven days later) and the investigation was not initiated until four days later. The acting DOC indicated the SDM was notified the outcome of the investigation was inconclusive.

Review of resident #046 progress notes had no documented evidence of the allegation or indication of an assessment of resident #046 related to the discomfort. The licensee's investigation indicated the resident (who was capable) was never interviewed regarding the incident and no indication any emotional support was



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provided.

Interview with Social Worker (SW) indicated she is responsible for maintaining the home's complaint log and enters all verbal written complaints that are received once the investigations are completed. The SW was not aware of any verbal or written complaint received by the home on specified dates regarding allegations of neglect towards resident #049. The SW indicated the acting DOC or Administrator are responsible for providing all verbal complaints (via client feedback forms) or written complaints to the SW.

Review of the home's complaint log for the two specified months did not have any indication of a verbal or written complaint received by the SDM of resident #049 related to neglect.

Review of the licensee's investigation and interview of staff indicated the home was aware of allegations of improper care and neglect towards resident #049 "who was upset" and in discomfort, on the day the incidents occurred, and the Director and police were not notified until the following day. The licensee's investigation and interview of staff by Inspector #111 indicated RPN #137, PSW # 173, PSW #174 and PSW #175 were present and or aware of the allegations and were not identified on the CIR. The home informed the family that the outcome of the investigation was "inconclusive" and PSW #144 was allowed to continue to provide care to resident #049.

- Review of the licensee's investigation and interview of staff indicated the licensee's policy was not followed related to the investigation process and there was no documented evidence the resident was assessed related to allegations of staff to resident neglect as issued under WN #14 under LTCHA, 2007, s.20(1)(a).
- There was no indication the investigation was completed immediately and there was no indication that appropriate actions were taken as a result of the licensee's investigation, when the allegations were confirmed, as issued under WN #15 under LTCHA, 2007, s.23(1)(a).
- The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: 1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm as issued under WN #16 under LTCHA, 2007, s.24 (1).
- The licensee failed to ensure that the report to the Director included the following



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description of all of the individuals involved in the incident: (ii) names of any staff members or other persons who were present at or discovered the incident as issued under WN #23 under O.Reg. 79/10, s.104 (1)2.

-The licensee failed to ensure that a documented record was kept in the home of a verbal and written complaints received in November and December 2016 that included: the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response, and; any response made by the complainant as issued under WN #22 under O.reg. 79/10, s.101(2)

7. Related to log # 023595-16:

A critical incident report (CIR) was submitted to the Director on a specified date for an allegation of resident to resident sexual abuse. The CIR indicated on a specified date and time, resident #043 and resident #044 were found demonstrating sexually inappropriate behaviour in resident #044 room and were not separated by staff for a specified period of time. Both residents were then supervised by staff for a specified period of time when resident #043 was redirected out of resident #044 room. The CIR indicated both residents are cognitively impaired and "neither resident is able to provide consent for sexual behaviour". The CIR indicated "Internal Investigation initiated". The CIR was not amended to indicate the outcome of the home's investigation. The CIR indicated 1:1 staffing was put in place and referral to BSO as a result.

Observation of resident #043 on a specified date by Inspector #111 indicated the resident was cognitively impaired and was independently mobile with use of a mobility aide. Resident #044 was no longer in the home.

Review of the progress notes for resident #043 and #044 related to sexually inappropriate responsive behaviours and/or sexual abuse indicated:the behaviours occurred over a three month period but in both residents' progress notes, the co-residents were not identified. There were seven documented incidents where resident #043 & #044 were observed demonstrating sexually inappropriate responsive behaviours. There were 2 incidents where suspected resident to resident sexual abuse and two incidents of suspected resident to resident sexual abuse that were not documented to indicate when they occurred and with whom.

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The triggers and strategies for both resident #043 & #044 did not indicate which female/male resident(s) they were having inappropriate sexual behaviours towards; Resident #043 had demonstrated inappropriate sexual responsive behaviours towards more than one co-resident and this trigger was not identified; The plan of care did not clearly indicate what the "sexually inappropriate" behaviour included despite the progress notes for both residents clearly indicating what these behaviours and triggers included. The incident of resident #043 inappropriately touching another unidentified co-resident (as reported by an RN during an interview) was also not identified to indicate when it occurred and towards whom. The strategies to manage the sexually inappropriate responsive behaviours was also not clear as there was no indication how staff would monitor each of the two residents or what "increased observation" included. The observation period was unclear and sometimes resident #043 was placed on 1:1 and other times on every 15 minute observations. The sexually inappropriate responsive behaviours was accepted by some staff as a 'relationship' and therefore did not intervene. The relocation of resident #044 to another unit was used as a strategy but was not considered until after the seventh incident and despite permission provided by the SDM after the fifth incident. There was no indication of a referral to psychogeriatric services despite the ongoing behaviours of sexually inappropriate behaviours and BSO discontinued resident #043 from the program despite continuing to display sexually inappropriate responsive behaviours.

Interview with Administrator by Inspector #111 regarding the incident indicated an investigation was completed but she was unable to locate the investigation. The Administrator indicated she was unaware the CIR was never amended to indicate the outcome of the home' investigation.

- There was no indication the investigation was completed immediately and appropriate actions were taken as the investigation had not yet been completed or concluded five months later, as issued under WN #15 under LTCHA, 2007, s.23(1) (a).
- The licensee failed to ensure that for resident #043 & #044 demonstrating sexually inappropriate responsive behaviours, the behavioural triggers for the resident were identified, where possible, strategies were developed and implemented to respond to these behaviours, where possible, and actions were taken to respond to the needs of the resident, including assessment, reassessments and interventions, and that the resident's responses to the interventions are documented as issued under WN #17



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under O.Reg. 79/10, s.53(4)(a)(b).

8. In addition, the licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected and did not contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate, as issued under WN #20 under LTCHA, s.96(a)(b).

A Compliance Order was warranted as the scope and severity was demonstrated by the following:

1. A Compliance Order (CO #001), was issued during a Critical Incident Inspection (#2015_360111_0014), on June 3, 2015, under LTCHA, 2007, s.19(1), which included a written notification (WN) specific to LTCHA, 2007, s. 6(7), 20(1), 23(1)(a), 24 (1), 97(1) & 98 with a compliance date of August 15, 2015. A second CO (# 001), was issued during the Resident Quality Inspection(RQI) (#2015_365194_0028), on November 16, 2015, under LTCHA, 2007, s19 (1) which included a WN specific to LTCHA, 2007, s.20(1), 23(2) and s.24(1) with a compliance date of April 30, 2016. The order was complied with on August 5, 2016. In addition, LTCHA, 2007, S.23 (2) was issued during a Complaint Inspection (#2016_327570_0010), on April 25, 2016 which included a voluntary plan of correction (VPC) and O.Reg.79/10, s.104(2) with a WN at that time. A WN was issued during the RQI (#2016_327570_0014) for LTCHA, 2007, s.23(2). A WN was issued during RQI (#2016_327570_0014) for O.Reg.79/10, s.104(1)2. A WN was issued during a Complaint Inspection (#2016_327570_0022) specific to LTCHA, 2007, s. 6(7).

2. There was actual harm to residents related to physical, emotional, and sexual abuse towards multiple residents (both cognitively well and cognitively impaired resident). There was also a pattern of inaction related to allegations and complaints of staff to resident neglect as demonstrated by the above logs. [s. 19. (1)] (111)

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

Jun 30, 2017(A2)



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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



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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

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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



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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 11 day of May 2017 (A2)

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :**

LYNDA BROWN - (A2)

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

Ottawa