Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 21, 2017	2017_619550_0016	009690-17, 011260-17, 012148-17	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE MEDEX
1865 BASELINE ROAD OTTAWA ON K2C 3K6

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

JOANNE HENRIE (550)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 18, 19, June 26, 27, 28, 29 and 30, 2017.

This Critical Incident Inspection is related to two critical incidents the home submitted related to the allegations of abuse to residents.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Support Service Manager, several Registered Nurses (RN), and several Personal Support Workers (PSW).

In addition, the inspector reviewed resident health care records and the policy related to Code White - Violent Situations.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to protect resident #002 from being physically abused by resident #001.

As per O. Reg. 79/10, s. 2. (1), physical abuse is defined as (a) the use of physical force by anyone other than a resident that causes physical injury or pain, (b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre physique").

This inspection is related to Log # 012148-17.

On a specific date, an incident of resident to resident physical abuse was reported to the Director through the Action Line after hour pager, followed by a critical incident report submitted to the Director four days later. It was reported through the Action Line that on a specific date and time, resident #002 was pushed by resident #001 in a specific area of the home. Resident #002 fell to the floor and sustained an injury to a specific body part for which resident #002 required to be transferred to the hospital where he/she received a specific medical procedure. On a specific date, the critical incident report indicated that on a specific date, the video footage of the incident was viewed by the management team and the incident was observed as follows:

Resident #002 was observed wandering with a mobility device into a specific home area where resident #001 was sitting quietly in a chair. Resident #002 stood beside resident #001 for a few minutes and then decided to keep on going but as he/she was leaving, he/she hit resident #001's specific body part twice with a mobility device trying to move forward not realizing an obstacle was in the way. Resident #001 got up and punched resident #002 in a specific body area. The force of the punch threw resident #002 back approximately 3 feet before he/she fell to the floor.

Resident #002 was admitted to the home on a specific date, with multiple health conditions including dementia. As per this resident's plan of care, the resident is independent with a mobility device for mobility and walks on the unit unassisted. During an interview on June 29, 2017, the ADOC and the charge day nurse, RN #103, indicated to inspector #550 that resident #002 is a cognitively impaired resident and he/she does not have any responsive behaviours of physical aggression towards residents or staff. A review of the resident's progress notes for a specific period of time by the inspector revealed that there was no documentation related to any incidents of physical abuse or altercation with other residents.

Resident #001 was admitted to the home on a specific date with multiple diagnosis. The

resident also had a specific physical behaviour as a result of a specific diagnosis. The resident was mobilizing independently on the unit and in the dining room throughout the day. He/she was known to have responsive behaviours of physical aggression towards staff and residents and unpredictable outbursts.

Inspector #550 reviewed the progress notes for resident #001 for a specific period of time and noted documented six other incidents of physical aggression towards residents on specific dates.

As it is identified in WN #4, interviews with different staff members, the home's ADOC and a review of the resident's plan of care revealed that there was no identification of the resident's physical aggression towards other residents due to specific actions from other residents, in his plan of care. There were no interventions identified and implemented to minimize the risk of altercations and potentially harmful interactions between residents other than keeping an eye on the resident. The resident was able to move on the unit without supervision and he/she was not monitored to ensure the safety of the other residents.

As a result, resident #002 was not protected against the physical aggression of resident #001.

The scope and severity of the incident were reviewed and the inspector identified that a compliance order was warranted. Although the scope was isolated, there was a serious incident of physical aggression by resident #001 to resident #002, where this resident suffered bodily harm. [s. 19. (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. 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 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 (b) is complied with.

O.Reg. 79/10, s. 230 (4) iii, requires that the emergency plans required under subsection 87 (1) of the Act, provide for:
1. Dealing with,
iii. violent outbursts.

This inspection is related to an incident of physical abuse.

On a specific date a Critical Incident report (CIS) was submitted to the Director reporting an incident of abuse/neglect to resident #001 by RN #100. It was reported that on a specific date and time, resident #001 became physically aggressive towards RN #100 and the RN in turn, performed a specific intervention with the assistance of PSW #101. As a result of the incident, the resident sustained multiple injuries to different body parts. Although the Administrator indicated to inspector #550 that their internal investigation determined that RN #100 used excessive force during the specific intervention to resident #001, the inspector was not able to establish through interviews, a review of health care records and a viewing of the video footage from the security camera, that the injuries sustained by the resident were caused by RN #100 when she performed a specific intervention to the resident. Therefore, the inspector was not able to determine that physical abuse had occurred.

On May 18, 2017, the ADOC indicated to the inspector that RN #100 submitted a

workplace health and safety report where she reported that resident #001 physically assaulted her on a specific date and time. While viewing the video footage of the incident, the ADOC and the Support Service Manager observed an escalation of agitation from resident #001 which led to physical aggression from resident #001 to RN #100.

Resident #001 was admitted to the home on a specific date. This resident was known to have unpredictable responsive behaviours and physical aggression towards staffs and residents. Resident #001 had multiple diagnoses, unstable gait and communication problems which could therefore result in responsive behaviours.

On a specific date and time, resident #001 was in a specific home area; he/she was agitated, exhibiting a specific behaviour. After approximately ten minutes, RN #100 and PSW #102 were able to bring the resident back to his/her room in a wheelchair. The agitation escalated in the resident's room and in the hallway and the resident became physically aggressive towards RN #100. This incident lasted for thirty eight minutes as per the video from the security camera and at no time during the incident did the RN call a Code White.

Inspector #550 reviewed the home's Code White – Violent Situation policy, updated November 2016. On page 1 of 3, under "Procedures" it is indicated:

Staff involved:
During a violent or potentially uncontrollable situation
1. If you identify a crisis situation, feel threatened or there is a possibility of an escalation of violence, remove yourself from the confrontation and immediately call 9-1-1. Provide as much information as possible about the situation to the police.
2. Advise other staff of a Code White identifying the location of the incident and if a weapon is involved.
3. Delegate a staff member to declare a Code White and announce "Code White (location), 3 times.

During an interview with RN #100 on May 23, 2017, she indicated to the inspector #550 that she thought of calling a Code White when she was performing a specific intervention to the resident but she was not able to.

The ADOC indicated to the inspector during an interview on June 28, 2017, that as per their policy, RN #100 should have called a Code White after she brought the resident to

his/her room and saw that his/her behaviours were escalating and she felt threatened. She further indicated that she could have also delegated someone else to call the Code White.

As evidenced above, RN #100 did not comply with the home's Code White policy and initiate a "Code White" when the situation escalated and resident #001 did not calm

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 Code White policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following are developed to meet the needs of residents with responsive behaviours:

2. Written strategies including techniques and interventions, to prevent, minimize or

respond to the responsive behaviours.

This inspection is related to a suspected abuse of a resident by a staff member.

On a specific date, a Critical Incident report (CIS) was submitted to the Director reporting an incident of abuse/neglect to resident #001 by RN #100. It was reported that on a specific date and time, resident #001 became physically aggressive towards RN #100 and the RN in turn, performed a specific intervention with the assistance of PSW #101. As a result of the incident, the resident sustained multiple injuries to different body parts. Although the Administrator indicated to inspector #550 that their internal investigation revealed that RN #100 used excessive force during the specific intervention to resident #001, the inspector was not able to establish through interviews, a review of health care records and a viewing of the video footage from the security camera, that the injuries sustained by the resident were caused by RN #100 when she performed a specific intervention to the resident. Therefore, the inspector was not able to determine that physical abuse had occurred.

On June 30, 2017 during an interview, RN# 103 who is the full-time day RN on the unit, indicated to inspector #550 that when resident #001 was physically aggressive, staff were to let the resident go calm down and never go after him/her as this would increase the physical aggression.

PSW #104 who was the primary PSW for resident #001 indicated that when the resident became aggressive, staff would re-direct him/her to his/her room and never make the resident do something he/she did not want to do or invade his/her personal space as this would increase the responsive behaviour.

PSW #101 indicated during an interview on May 19, 2017 that when the resident exhibited a specific behaviour, he/she usually calmed down when he/she was left alone. She indicated that she usually watched the resident from a distance and that he/she usually returned to his/her room to sleep on his/her own.

Inspector #550 reviewed the resident's plan of care in place at the time of the incident for responsive behaviours . The inspector noted that although some interventions were documented to deal with resident #001's aggressive behaviour, three specific interventions identified by the three staff members who were interviewed by the inspector were not in his/her plan of care.

During an interview on June 28, 2017, the ADOC indicated to the inspector that the above interventions to attempt to mitigate resident #001's physical aggression were not documented in his/her plan of care and that she needs to review the residents' plan of care to make sure that all the interventions are documented in their plan of care and that they are more personalized. [s. 53. (1) 2.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

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

This inspection is related to Log #012148-17.

On a specific date, an incident of resident to resident physical abuse was reported to the Director through the Action Line after hour pager, followed by a critical incident report submitted to the Director four days later. It was reported through the Action Line that on a specific date and time, resident #002 was pushed by resident #001 in a specified home area. Resident #002 fell to the floor and sustained an injury to a specific body part for which the resident required to be transferred to the hospital where he/she received a specific medical intervention. The critical incident report submitted on a specific date, indicated that on another specific date the video footage of the incident was viewed by the management team and the incident was observed as follows:

Resident #002 was observed wandering with a mobility device into a specific home area where resident #001 was sitting quietly in a chair. Resident #002 stood beside resident #001 for a few minutes and then decided to keep on going but as he/she was leaving, resident #002 hit resident #001 twice on a specific body part with the mobility device trying to move forward not realizing an obstacle was in the way. Resident #001 got up and punched resident #002 in a specific body part. The force of the punch threw resident #002 back approximately 3 feet before he/she fell to the floor.

Resident #001 is known to be physically aggressive towards residents and staff as he/she is very protective of his/her personal environment.

Inspector #550 reviewed the progress notes for resident #001 for a specific period of time and noted documented six incidents of physical aggression towards residents on different days.

On June 30, 2017, during an interview, the full-time day RN in charge, RN #103, indicated to inspector #550 that resident #001 had a specific physical condition as a result of a specific diagnosis and that he/she mobilized independently on the unit. This resident was known to have altercations and being physically aggressive towards other residents related to specific actions from other residents. He/she also had unpredictable outbursts. RN #103 indicated that other than a specific intervention when the resident was walking on the unit and keeping an eye on him/her, there were no other interventions in place to prevent altercations and physical aggression towards other residents.

PSW #104, who was resident #001's primary PSW, indicated to the inspector four specific triggers that would trigger an altercation and physical aggression. She indicated there was nothing in place to deter other residents from entering resident #001's bedroom. He/she was eating meals in a specific dining room with other residents and had another resident sitting with him/her at his/her dining room table. The resident was mobilizing independently and he/she was able to access the dining room whenever he/she liked throughout the day although there was not always someone supervising the dining room. Other than keeping an eye on the resident, there was no formal security check of this resident's whereabouts on a regular basis.

Inspector #550 reviewed the resident's plan of care at the time of the incident. The plan of care did not indicate the resident's potential physical aggression to residents related to specific actions from other residents or any steps taken to minimize the risk of

altercations.

During an interview and a review of resident #001's plan of care with the ADOC, she indicated to the inspector that there was no indication in this resident's plan of care of his/her physical aggression towards other residents related to specific actions by other residents. No interventions were identified and implemented to minimize the risk of altercations and potentially harmful interactions between residents other than keeping an eye on this resident. She indicated that she needed to review the plan of care of all residents to ensure they are more personalized. [s. 54. (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense.

This inspection is related to suspected abuse of a resident by two staff members.

On a specific date, a Critical Incident report (CIS) was submitted to the Director reporting an incident of abuse/neglect to resident #001 by a staff member. It was reported that on a specific date and time, resident #001 became physically aggressive towards RN #100 and the RN in turn, performed a specific intervention to the resident with the assistance of PSW #101. As a result of the incident, the resident sustained multiple injuries to different body parts. Although the Administrator indicated to inspector #550 that their internal investigation revealed that RN #100 used excessive force while performing a specific intervention to resident #001, the inspector was not able to establish through interviews, a review of health care records and a viewing of the video footage from the security camera, that the injuries sustained by the resident were caused by RN #100 when she performed a specific intervention to the resident. Therefore, the inspector was not able to determine that physical abuse had occurred.

During an interview on May 18, 2017, the ADOC indicated to inspector #550 that on a specific date she viewed the video footage of the incident with the Support Services Manager. After viewing the whole incident, they both suspected this incident to be a possible incident of physical abuse to resident #001 by the RN and PSW because of the force and the length of time they used to perform a specific intervention to the resident. The ADOC indicated she forgot to report this incident to the police, as she was not sure she had to call them and that no one instructed her to do so. She indicated that she did suspect this incident could constitute a criminal offense and that she was going to call them immediately after our interview. On May 19, 2017, the Support Services Manager confirmed to the inspector that the police were notified of this incident of suspected abuse and that they came to the home on May 18, 2017.

As evidenced above, the police force was not immediately informed of the incident of suspected physical abuse to resident #001; they were made aware on May 18, 2017, two days after the licensee became aware of the incident. [s. 98.]

Issued on this 21st day of July, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE HENRIE (550)
Inspection No. / No de l'inspection :	2017_619550_0016
Log No. / Registre no:	009690-17, 011260-17, 012148-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 21, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE MEDEX 1865 BASELINE ROAD, OTTAWA, ON, K2C-3K6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tina Nault

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is hereby ordered to ensure that residents currently residing in the home who are at risk of harm due to altercations or potentially harmful interactions receive heightened monitoring and the plan of care for each of those residents should be reviewed, revised and interventions should be implemented to effectively manage the behaviours linked to these altercations/potentially harmful interactions.

Grounds / Motifs :

1. The licensee has failed to protect resident #002 from being physically abused by resident #001.

As per O. Reg. 79/10, s. 2. (1), physical abuse is defined as (a) the use of physical force by anyone other than a resident that causes physical injury or pain, (b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre physique").

This inspection is related to Log # 012148-17.

On a specific date, an incident of resident to resident physical abuse was reported to the Director through the Action Line after hour pager, followed by a critical incident report submitted to the Director four days later. It was reported through the Action Line that on a specific date and time, resident #002 was pushed by resident #001 in a specific area of the home. Resident #002 fell to the floor and sustained an injury to a specific body part for which resident #002 required to be transferred to the hospital where he/she received a specific medical procedure. On a specific date, the critical incident report indicated that

on a specific date, the video footage of the incident was viewed by the management team and the incident was observed as follows:

Resident #002 was observed wandering with a mobility device into a specific home area where resident #001 was sitting quietly in a chair. Resident #002 stood beside resident #001 for a few minutes and then decided to keep on going but as he/she was leaving, he/she hit resident #001's specific body part twice with a mobility device trying to move forward not realizing an obstacle was in the way. Resident #001 got up and punched resident #002 in a specific body area. The force of the punch threw resident #002 back approximately 3 feet before he/she fell to the floor.

Resident #002 was admitted to the home on a specific date, with multiple health conditions including dementia. As per this resident's plan of care, the resident is independent with a mobility device for mobility and walks on the unit unassisted. During an interview on June 29, 2017, the ADOC and the charge day nurse, RN #103, indicated to inspector #550 that resident #002 is a cognitively impaired resident and he/she does not have any responsive behaviours of physical aggression towards residents or staff. A review of the resident's progress notes for a specific period of time by the inspector revealed that there was no documentation related to any incidents of physical abuse or altercation with other residents.

Resident #001 was admitted to the home on a specific date with multiple diagnosis. The resident also had a specific physical behaviour as a result of a specific diagnosis. The resident was mobilizing independently on the unit and in the dining room throughout the day. He/she was known to have responsive behaviours of physical aggression towards staff and residents and unpredictable outbursts.

Inspector #550 reviewed the progress notes for resident #001 for a specific period of time and noted documented six other incidents of physical aggression towards residents on specific dates.

As it is identified in WN #4, interviews with different staff members, the home's ADOC and a review of the resident's plan of care revealed that there was no identification of the resident's physical aggression towards other residents due to specific actions from other residents, in his plan of care. There were no interventions identified and implemented to minimize the risk of altercations and

potentially harmful interactions between residents other than keeping an eye on the resident. The resident was able to move on the unit without supervision and he/she was not monitored to ensure the safety of the other residents.

As a result, resident #002 was not protected against the physical aggression of resident #001.

The scope and severity of the incident were reviewed and the inspector identified that a compliance order was warranted. Although the scope was isolated, there was a serious incident of physical aggression by resident #001 to resident #002, where this resident suffered bodily harm. (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 05, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 21st day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joanne Henrie

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