Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Jan 28, 2016;	2015_320612_0026 (A1)	031722-15	Resident Quality Inspection

Licensee/Titulaire de permis

F. J. DAVEY HOME
733 Third Line East Box 9600 Sault Ste Marie ON P6A 7C1

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

F. J. DAVEY HOME
733 Third Line East Sault Ste Marie ON P6A 7C1

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

SARAH CHARETTE (612) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Corrected the resident number in compliance order #001.

Issued on this 28 day of January 2016 (A1)

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

Original report signed by the inspector.

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SARAH CHARETTE (612) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

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

This inspection was conducted on the following date(s): December 1 to 4 and 7 to 10, 2015

The Inspectors also conducted a Follow-up Inspection related to abuse, log #029621-15. Three Complaint logs were also inspected, two related to bed refusals and one related to abuse of a resident, log #027106-15, 021698-15 and 033736-15. The inspectors also inspected 20 Critical Incident logs related to abuse, neglect, falls and medications, log #007586-14, 016548-15, 008176-14, 001655-15, 002541-15, 001896-15, 006038-15, 006884-15, 011703-15, 018084-15, 019779-15, 018237-15, 022473-15, 026194-15, 024206-15, 001785-15, 023241-15, 031036-15, 032265-15 and 030329-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Executive Director of Care, two Directors of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Infection Prevention and Control Lead, Director of Resident and Volunteer Services, Admission, Discharge and Transfer Clerk, Behaviour Support Services Registered Practical Nurse, Residents and resident's family members.

The inspector(s) conducted a daily walk through of the units and resident care areas, observed staff to resident interactions, observed the provision of care, reviewed clinical records, internal investigation documents, critical incident reports, the home's policies and procedures and employee personnel files.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

- **9 WN(s)**
- **4 VPC(s)**
- **2 CO(s)**
- **1 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. 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 of the long-term care home failed to protect resident #023 from abuse by resident #022.

Inspector #613 reviewed a Critical Incident (CI) report related to physical abuse by

resident #022 that resulted in an injury to resident #023. Both residents were walking in the lounge area when the altercation occurred. Resident #022 grabbed resident #023 then proceeded to forcefully push resident #023, causing them to fall to the floor.

Under O.Reg. 79/10, physical abuse is defined as "the use of physical force by a resident that causes physical injury to another resident".

The Inspector completed a health care record review for resident #023 which identified that resident #023 sustained an injury and a significant change to their health status.

The Inspector reviewed resident #022's health care record. It identified that the resident had a cognitive impairment and an Aggressive Behaviour Score (ABS) which indicated a very high risk of aggressive behaviour occurring. The Inspector reviewed the resident's behaviour progress notes for the past year, which identified that the resident had a history of verbally and physically responsive behaviours with other residents and staff. There was documentation from March, 2015 which indicated that the staff had observed the resident be physically aggressive towards a co-resident, another incident in March, 2015 which indicated that the resident was striking out at staff, and in July, 2015 where the resident was physically aggressive towards a co-resident.

The Inspector reviewed resident #022's care plan which identified that the resident had responsive behaviours. There was no documentation to support that resident #022 was reassessed and new interventions documented after resident was first observed to be physically aggressive to a co-resident in March 2015.

The Inspector met with manager #115 who reported that they did not know why the incident between resident #022 and #023 had occurred. Manager #115 identified that the internal Behavioural Supports Ontario (BSO) staff did not become involved with resident #022 until after the incident between residents #022 and #023 had occurred. The manager did not know why there was no BSO referral for resident #022 and stated, "that is a good question." Manager #115 reported that after the incident in October, 2015 where resident #022 caused injury to resident #023, the BSO team become involved with resident #022 but that they only monitored the resident's behaviours and that no new interventions were attempted.

The Inspector met with RPN #132 who confirmed that there was no BSO referral for resident #22 prior to the incident in October, 2015. RPN #132 reported that they

received a referral in November, 2015 and reviewed resident #022's documentation but felt that no update to the care plan were required at that time.

Inspector reviewed the home's policy titled, 'Responsive Behaviours (#009-05-01) which indicated that a resident whose behaviour changes, or their response to interventions change, should be re-assessed regarding their behaviour and possible contributing factors. Following the re-assessment, the interdisciplinary team is to meet to review the outcome of the assessments and the care plan is to be reviewed, revised and updated accordingly.

The home failed to protect resident #022 from resident #023's responsive behaviours and as a result they sustained an injury and significant change to their health status. [s. 19. (1)]

2. The licensee has failed to protect resident #001 from abuse by resident #037.

A Critical Incident (CI) report was submitted to the Director in October, 2015 related to a reported incident of resident to resident abuse occurring in October, 2015. It was reported by PSW #106 that resident #037 abused resident #001.

During an interview with Inspector #593, PSW #106 reported that resident #001 was sitting in their wheelchair in the common area of the home. As PSW #106 was walking down the corridor, they saw resident #037 abuse resident #001. PSW #106 separated the two residents and reported that resident #001 was visibly upset by this incident. PSW #106 further reported that at the time of the incident, there were interventions in place as there had been previous incidents of resident #037 abusing resident #001.

During an interview with Inspector #593, RPN #114 reported that they were aware of resident #037's specific responsive behaviours. They further reported that the incidents usually happened when resident #037 believed that no one was watching and that prior to the incident, resident #037 had abused resident #001. Interventions were put into place including regular documented checks of resident #037's location as well as staff were to sit resident #001 in the lounge where staff were able to see resident #001.

During an interview with Inspector #593, PSW #117 reported that resident #037 seemed to be aware of their behaviours and would wait until they believed that no one was looking before they exhibited specific responsive behaviours. Previously, PSW #117 reported that they saw resident #037 exhibit specific responsive behaviours

towards resident #001. As an intervention, they have to keep resident #001 seated at the nurses' station where they can be monitored and staff are also to keep watch for resident #037.

During an interview with Inspector #593, PSW #116 reported that they were aware of resident #037's specific responsive behaviours. They further reported that they were with PSW #106 and witnessed resident #037 abusing resident #001.

During an interview with Inspector #593, manager #115 reported that interventions were put into place to keep resident #037 away from resident #001 after two occasions where they exhibited specific responsive behaviours. They further reported that the interventions were added to resident #001's care plan as a precaution to ensure that no abuse occurred toward resident #001.

A review of resident #037's health care record revealed three entries related specific responsive behaviours toward female residents in the home.

Inspector #593 reviewed resident #037's current care plan and found the resident had a history of specific responsive behaviour. The goal related to these behaviours indicated that resident #037 will have no episodes of exhibiting specific responsive behaviours towards other residents.

Inspector #593 reviewed resident #001's current care plan and found that resident #001 was to be seated on the outer aspect of the lounge away from co-resident #037 for closer monitoring.

Non-compliance was previously identified under inspections 2015_281542_0014, 2015_281542_0002 and 2015_281542_0024. A compliance order was issued during each inspection pursuant to 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.

As evidenced by documented progress notes, staff interviews and documented plans of care, resident #037 was known to exhibit specific responsive behaviours towards female residents in the home. Furthermore, after two witnessed incidents occurring with resident #001, resident #037's care plan was updated to include interventions to prevent any further responsive behaviours toward resident #001. The licensee has failed to protect resident #001 within the home from resident #037 with known and documented specific responsive behaviours. [s. 19. (1)]

Additional Required Actions:

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

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to

suspect that abuse or neglect occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector reviewed a Critical Incident (CI) report which alleged PSW #134 and PSW #135 neglected to toilet resident #039 when they requested assistance.

Resident #039 reported the incident to manager #115 immediately, however the CI report was not submitted to the Director until the next day.

Inspector reviewed the CI report with the Executive Director of Nursing (EDON) who stated that expectation is that the incident is immediately reported to the Director of the Ministry of Health and Long-Term Care. The EDON confirmed that it this incident was not immediately reported. [s. 24. (1)]

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

Inspector reviewed a Critical Incident (CI) report that was submitted to the Director on April, 2015 regarding staff to resident abuse. The CI indicated that PSW #139 was verbally abusive towards resident #019.

A review of the home's investigation file revealed that the same staff member was also verbally abusive towards resident #019 the day prior. According to the documentation, PSW #105 reported the incident to RPN #140. There was no further documentation to indicate that this incident was reported to the Director immediately.

An interview with manager #118 confirmed that the incident that occurred on the previous day was not reported to the Director at any time and the incident referred to in the CI report was not reported immediately to the Director. [s. 24. (1)]

3. The licensee has failed to ensure that abuse of a resident by anyone that resulted in harm or risk of harm to the resident and the suspicion and the information upon which it is based was immediately reported to the Director.

A Critical Incident (CI) report was submitted to the Director May, 2015 related to a reported incident of staff to resident abuse. During an interview with Inspector #593, manager #115 reported that the staff member who witnessed the alleged abuse did

not report it to the home until four days after the abuse was alleged to have occurred.

The CI was submitted to the Director four days after the incident occurred.

A CI was submitted to the Director July, 2015 related to a reported incident of staff to resident abuse. During an interview with Inspector #593, manager #115 reported that the staff member received the report of alleged abuse from the resident, and did not report it to the home until the day after the abuse was alleged to have occurred.

The CI was submitted to the Director one day after the incident occurred.

A CI was submitted to the Director July, 2015 related to a reported incident of staff to resident abuse. During an interview with Inspector #593, manager #115 reported that the staff member who witnessed the alleged abuse did not report it to the home until three days after the abuse was alleged to have occurred. Manager #115 further reported that the home did not report the alleged abuse to the Director until one day after the abuse was reported to the home.

The CI was submitted to the Director four days after the alleged incident occurred.

A CI was submitted to the Director October, 2015 related to a reported incident of resident to resident abuse. During an interview with Inspector #593, manager #115 reported that the staff member who witnessed the alleged abuse reported it to their RPN team lead who reported it to another RPN team lead at shift changeover. Neither team leads reported the witnessed abuse further to the home.

The CI was submitted to the Director two days after the incident occurred.

Non-compliance was previously identified under inspection 2015_281542_0016 with a VPC issued and inspection 2014_281542_0024 with a WN issued. Pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) in relation to failing to immediately report abuse of a resident by anyone that resulted in harm or risk of harm to the resident and the information upon which it is based to the Director.

The FJ Davey Home submitted four critical incident reports to the Director over a six month period involving abuse towards residents in the home by other residents and staff members. On all four occasions, the CI was reported between one to four days after the incident occurred. [s. 24. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector reviewed a Critical Incident (CI) report in which PSW #127 independently transferred resident #034 who required two person assist to transfer. This resulted in an injury to resident #034.

Inspector reviewed the investigation notes and noted that PSW #127 confirmed that they transferred resident #034 independently despite knowing that resident required two person assist to transfer. This was confirmed by the manager #118 and the EDON. PSW #127 was disciplined for not following facility policy and resident #034's plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #021 as specified in the plan.

Inspector reviewed a Critical Incident (CI) report that was submitted to the Director April, 2015. The CI was submitted as resident #021 sustained a fall and was found sitting on the floor in the hallway, beside the dining room March, 2015. Resident #021 had self-transferred from their wheelchair and attempted to ambulate unassisted.

During the home's initial investigation, it was identified that the alarm for resident #021's wheelchair was turned off. Resident did not sustain any injury as a result of the fall.

In April, 2015, PSW #112 informed the Executive Director of Nursing (EDON) that they had turned off the wheelchair alarm when they assisted resident #021 with personal care and did not turn the alarm on when returned the resident to their wheelchair.

The Inspector reviewed resident #021's care plan. Under the 'Risk for falls' focus, the interventions identified that they were to have the alarm in place when in bed or in their wheelchair.

The Inspector interviewed PSW #112 who confirmed they did not follow resident #021's care plan and did not ensure the alarm was turned on and in place while in wheelchair on the date of the incident.

The Inspector interviewed the EDON who confirmed that PSW #112 did not ensure that the care set out in the plan of care was provided to resident #012 as specified in the plan as PSW #112 did not turn the alarm on when resident was in their wheelchair. [s. 6. (7)]

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 care set out in the plan of care is provided to all residents as specified in the plan, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with specifically related to internal reporting of suspected or witnessed abuse towards residents.

A Critical Incident (CI) was submitted to the Director May, 2015 related to a reported incident of staff to resident abuse. During an interview with Inspector #593, manager #115 reported that the staff member who witnessed the alleged abuse did not report it to the home until four days after the abuse was alleged to have occurred. Manager #115 further reported that the staff member who reported the incident, received additional training on the home's reporting requirements.

A CI was submitted to the Director July, 2015 related to a reported incident of staff to resident abuse. During an interview with Inspector #593, manager #115 reported that the staff member who received the report of alleged abuse from the resident, did not report it to the home until the day after the abuse was alleged to have occurred.

A CI was submitted to the Director July, 2015 related to a reported incident of staff to resident abuse. During an interview with Inspector #593, manager #115 reported that the staff member who witnessed the alleged abuse did not report it to the home until three days after the abuse was alleged to have occurred. Manager #115 further reported that the staff member who reported the incident, received additional training on the home's reporting requirements.

A CI was submitted to the Director October, 2015 related to a reported incident of resident to resident abuse. During an interview with Inspector #593, manager #115 reported that the staff member who witnessed the alleged abuse then reported it to their team lead and the team lead reported it to another team lead at shift changeover, neither team leads who were both RPN's reported it further to the home. Manager #115 further reported that the staff members who failed to report the incident, were disciplined related to failing to report.

A review of the home's policy #OPER-02-02-04 Resident Abuse- staff to resident dated March 2013, found that all staff are to immediately report verbally, any suspected or witnessed abuse to the Administrator, Director of Care or their designate.

A review of the home's policy #OPER-02-02-04 Resident Abuse by persons other than staff dated March 2013, found that all persons in the home are to immediately report verbally, any suspected or witnessed abuse to the Administrator, Director of Care or their designate. [s. 20. (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 the home's policy to promote zero tolerance of abuse and neglect is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the applicant's admission to the home was approved unless the home lacked the physical facilities necessary to meet the applicant's care requirements, the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements or circumstances exist which are provided for in the regulations as being a ground for withholding approval.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) indicating that the home denied admission of several applicants due to smoking.

A review of the home's refusal letters from July 31, 2015 to September 15, 2015 verified that the licensee had declined four applicants for admission due to smoking.

On December 3, 2015, Inspector #542 interviewed a clerk who verified that the home had refused applicants that smoked. The Administrator also indicated that the home was no longer refusing applicants for this reason and had overturned the previous refusals. [s. 44. (7)]

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 an applicant's admission to the home was approved unless the home lacked the physical facilities necessary to meet the applicant's care requirements, the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements or circumstances exist which are provided for in the regulations as being a ground for withholding approval, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 162. Approval by licensee

Specifically failed to comply with the following:

s. 162. (3) Subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following:
1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act. O. Reg. 79/10, s. 162 (3).
2. If the licensee is withholding approval for the applicant's admission, give the written notice required under subsection 44 (9) of the Act to the persons mentioned in subsection 44 (10) of the Act. O. Reg. 79/10, s. 162 (3).

Findings/Faits saillants :

1. The licensee has failed to respond to the placement co-ordinator within five business days after receiving the application as to whether the licensee accepted or withheld the approval for the applicant's admission.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) indicating that the home takes an excess of five business days to either accept or reject an applicant.

Inspector reviewed the complaint and verified the timelines regarding three applications with a clerk in the home. The clerk was able to verify that the home did not respond within the five business day for three of the applicants. [s. 162. (3)]

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 responds to the placement coordinator within five business days after receiving the application as to whether the licensee accepts or withholds the approval for the applicant's admission, to be implemented voluntarily.

WN #7: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation was reported to the Director.

Inspector reviewed Critical Incident (CI) report which alleged PSW #134 and PSW #135 neglected to toilet resident #039 when they requested assistance.

Inspector was unable to locate any information indicating the outcome of the investigation in the CI report.

An interview with the EDON confirmed that the outcome of the investigation was not reported to the Director. [s. 23. (2)]

WN #8: 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. (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:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

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:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under

subsection 23 (2) of the Act, the following information was included in writing with respect to the alleged, suspected or witnessed abuse of a resident by anyone: Names of any staff members who were present.

A Critical Incident (CI) was submitted to the Director October 2014 related to a reported incident of staff to resident abuse occurring October 2014. Resident #009 reported to PSW #105 that another staff member was rough when providing care and complained to the resident about their life when providing care.

A review of the CI report by Inspector #593, found that the home did not name the accused staff member in the report. There was also no further amendment of this CI report that included this information.

During an interview with Inspector #593 the EDON reported that they are unsure why this information was not included in the CI report and why the report was not amended at a later date with this information. [s. 104. (1) 2.]

2. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the following information was included in writing with respect to the alleged, suspected or witnessed abuse of a resident by anyone: whether a family member, person of importance or a SDM of the resident involved in the incident was contacted and the name of such person and the outcome or current status of the individual who was involved in the incident.

A Critical Incident (CI) was submitted to the Director October 2014 related to a reported incident of staff to resident abuse occurring October 2014. Resident #009 reported to PSW #105 that another staff member was rough when providing care and complained to the resident when providing care.

A review of the CI report by Inspector #593, found that the home did not include the POA of the resident or whether the POA was contacted, nor did they include the outcome of the staff member accused of abuse toward resident #009. There was also no further amendment of this CI report that included this information.

During an interview with Inspector #593, the EDON reported that they were unsure why this information was not included in the CI report and why the report was not amended at a later date with this information. [s. 104. (1) 3.]

3. The licensee has failed to ensure that in making a report to the Director under

subsection 23 (2) of the Act, the following information was included in writing with respect to the alleged, suspected or witnessed abuse of a resident by anyone: the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.

A Critical Incident (CI) was submitted to the Director October 2014 related to a reported incident of staff to resident abuse occurring October 2014. Resident #009 reported to PSW #105 that another staff member was rough when providing care and complained to the resident about their life when providing care.

A review of the CI report by Inspector #593, found that the home did not include the immediate actions that had been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence. The CI report indicated that further investigation was pending. There was also no further amendment of this CI report that included this information.

During an interview with Inspector #593, the EDON reported that they are unsure why this information was not included in the CI report and why the report was not amended at a later date with this information. [s. 104. (1) 4.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to inform the Director of an incident under subsection (1), (3) or (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 3. Actions taken in response to the incident, including, v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 107 (4).

Inspector #613 reviewed a Critical Incident (CI) report that was reported to the Director on April 2015. The CI identified that PSW #112 did not turn on resident #021's wheelchair alarm which resulted with resident sustaining a fall with no injuries.

The Director requested the home amend the CI to include information in regards to any injuries noted to the resident, resident's ambulatory status and level of assistance with transfers and the outcome of the investigation and if any disciplinary actions were taken.

The Inspector interviewed the EDON who confirmed that the requested amendments were not included in the CI. The EDON reported they did not know where the amended information was but would endeavour to locate the missing information. The EDON was unable to provide documentation that the amendment requested had been completed and submitted to the Director. [s. 107. (4) 3. v.]

2. The licensee failed to inform the Director of an incident under subsection (1), (3) or (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, to make a report in writing to the Director setting out the following with respect to the incident: 4. Analysis and follow-up action, including, ii. The long-term care action planned to correct the situation and prevent reoccurrence.

Inspector #613 reviewed a Critical Incident (CI) report that was reported to the Director on April 2, 2015. The CI identified that PSW #112 did not turn on resident #021's wheelchair alarm which resulted with resident sustaining a fall with no injuries.

The Director requested the home amend the Critical Incident and include information in regards to strategies to prevent reoccurrence.

The Inspector interviewed the EDON who confirmed that the requested amendments were not on the CI. The EDON reported they did not know where the amended information was but would endeavour to locate the missing information. The EDON was unable to provide documentation that the amendment requested had been completed and submitted to the Director. [s. 107. (4) 4. ii.]

Issued on this 28 day of January 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SARAH CHARETTE (612) - (A1)

Inspection No. / No de l'inspection : 2015_320612_0026 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 031722-15 (A1)

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

Report Date(s) / Date(s) du Rapport : Jan 28, 2016;(A1)

Licensee / Titulaire de permis :
F. J. DAVEY HOME
733 Third Line East, Box 9600, Sault Ste Marie, ON, P6A-7C1

LTC Home / Foyer de SLD :
F. J. DAVEY HOME
733 Third Line East, Sault Ste Marie, ON, P6A-7C1

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Barbara Harten

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To F. J. DAVEY HOME, 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)

Linked to Existing Order / Lien vers ordre existant: 2015_281542_0014, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee shall ensure that every resident is protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee shall specifically ensure that all resident s are protected from abuse by resident #037.

Grounds / Motifs :

1. The licensee has failed to protect resident #001 from abuse by resident #037.

A Critical Incident (CI) report was submitted to the Director in October, 2015 related to a reported incident of resident to resident abuse occurring in October, 2015. It was reported by PSW #106 that resident #037 abused resident #001.

During an interview with Inspector #593, PSW #106 reported that resident #001 was

sitting in their wheelchair in the common area of the home. As PSW #106 was walking down the corridor, they saw resident #037 abuse resident #001. PSW #106 separated the two residents and reported that resident #001 was visibly upset by this incident. PSW #106 further reported that at the time of the incident, there were interventions in place as there had been previous incidents of resident #037 abusing resident #001.

During an interview with Inspector #593, RPN #114 reported that they were aware of resident #037's specific responsive behaviours. They further reported that the incidents usually happened when resident #037 believed that no one was watching and that prior to the incident, resident #037 had abused resident #001. Interventions were put into place including regular documented checks of resident #037's location as well as staff were to sit resident #001 in the lounge where staff were able to see resident #001.

During an interview with Inspector #593, PSW #117 reported that resident #037 seemed to be aware of their behaviours and would wait until they believed that no one was looking before they exhibited specific responsive behaviours. Previously, PSW #117 reported that they saw resident #037 exhibit specific responsive behaviours towards resident #001. As an intervention, they have to keep resident #001 seated at the nurses' station where they can be monitored and staff are also to keep watch for resident #037.

During an interview with Inspector #593, PSW #116 reported that they were aware of resident #037's specific responsive behaviours. They further reported that they were with PSW #106 and witnessed resident #037 abusing resident #001.

During an interview with Inspector #593, manager #115 reported that interventions were put into place to keep resident #037 away from resident #001 after two occasions where they exhibited specific responsive behaviours. They further reported that the interventions were added to resident #001's care plan as a precaution to ensure that no abuse occurred toward resident #001.

A review of resident #037's health care record revealed three entries related specific responsive behaviours toward female residents in the home.

Inspector #593 reviewed resident #037's current care plan and found the resident had a history of specific responsive behaviour. The goal related to these behaviours

indicated that resident #037 will have no episodes of exhibiting specific responsive behaviours towards other residents.

Inspector #593 reviewed resident #001's current care plan and found that resident #001 was to be seated on the outer aspect of the lounge away from co-resident #037 for closer monitoring.

Non-compliance was previously identified under inspections 2015_281542_0014, 2015_281542_0002 and 2015_281542_0024. A compliance order was issued during each inspection pursuant to 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.

As evidenced by documented progress notes, staff interviews and documented plans of care, resident #037 was known to exhibit specific responsive behaviours towards female residents in the home. Furthermore, after two witnessed incidents occurring with resident #001, resident #037's care plan was updated to include interventions to prevent any further responsive behaviours toward resident #001. The licensee has failed to protect resident #001 within the home from resident #037 with known and documented specific responsive behaviours. (593)

2. The licensee of the long-term care home failed to protect resident #023 from abuse by resident #022.

Inspector #613 reviewed a Critical Incident (CI) report related to physical abuse by resident #022 that resulted in an injury to resident #023. Both residents were walking in the lounge area when the altercation occurred. Resident #022 grabbed resident #023 then proceeded to forcefully push resident #023, causing them to fall to the floor.

Under O.Reg. 79/10, physical abuse is defined as "the use of physical force by a resident that causes physical injury to another resident".

The Inspector completed a health care record review for resident #023 which identified that resident #023 sustained an injury and a significant change to their health status.

The Inspector reviewed resident #022's health care record. It identified that the resident had a cognitive impairment and an Aggressive Behaviour Score (ABS) which indicated a very high risk of aggressive behaviour occurring. The Inspector reviewed the resident's behaviour progress notes for the past year, which identified that the resident had a history of verbally and physically responsive behaviours with other residents and staff. There was documentation from March, 2015 which indicated that the staff had observed the resident be physically aggressive towards a co-resident, another incident in March, 2015 which indicated that the resident was striking out at staff, and in July, 2015 where the resident was physically aggressive towards a co-resident.

The Inspector reviewed resident #022's care plan which identified that the resident had responsive behaviours. There was no documentation to support that resident #022 was reassessed and new interventions documented after resident was first observed to be physically aggressive to a co-resident in March 2015.

The Inspector met with manager #115 who reported that they did not know why the incident between resident #022 and #023 had occurred. Manager #115 identified that the internal Behavioural Supports Ontario (BSO) staff did not become involved with resident #022 until after the incident between residents #022 and #023 had occurred. The manager did not know why there was no BSO referral for resident #022 and stated, "that is a good question." Manager #115 reported that after the incident in October, 2015 where resident #022 caused injury to resident #023, the BSO team become involved with resident #022 but that they only monitored the resident's behaviours and that no new interventions were attempted.

The Inspector met with RPN #132 who confirmed that there was no BSO referral for resident #22 prior to the incident in October, 2015. RPN #132 reported that they received a referral in November, 2015 and reviewed resident #022's documentation but felt that no update to the care plan were required at that time.

Inspector reviewed the home's policy titled, 'Responsive Behaviours (#009-05-01) which indicated that a resident whose behaviour changes, or their response to interventions change, should be re-assessed regarding their behaviour and possible contributing factors. Following the re-assessment, the interdisciplinary team is to meet to review the outcome of the assessments and the care plan is to be reviewed, revised and updated accordingly.

The home failed to protect resident #022 from resident #023's responsive behaviours and as a result they sustained an injury and significant change to their health status.

Non-compliance was previously identified under inspections 2015_281542_0014, 2015_281542_0002 and 2015_281542_0024. A compliance order was issued during each inspection pursuant to 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.

The decision to issue this compliance order was based on the previous history of non-compliance with an issued compliance order, as well as the severity, which was actual harm to residents. (613)

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

Jan 28, 2016

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall ensure that a person who has reasonable grounds to suspect that 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 is immediately reported to the Director.

The licensee shall ensure that education and training is provided to all staff of the home regarding immediate reporting as per the LTCHA, 2007, s. 24(1).

Grounds / Motifs :

1. The licensee has failed to ensure that abuse of a resident by anyone that resulted in harm or risk of harm to the resident and the suspicion and the information upon which it is based was immediately reported to the Director.

A Critical Incident (CI) report was submitted to the Director May, 2015 related to a reported incident of staff to resident abuse. During an interview with Inspector #593, manager #115 reported that the staff member who witnessed the alleged abuse did not report it to the home until four days after the abuse was alleged to have occurred.

The CI was submitted to the Director four days after the incident occurred.

A CI was submitted to the Director July, 2015 related to a reported incident of staff to resident abuse. During an interview with Inspector #593, manager #115 reported that

the staff member received the report of alleged abuse from the resident, and did not report it to the home until the day after the abuse was alleged to have occurred.

The CI was submitted to the Director one day after the incident occurred.

A CI was submitted to the Director July, 2015 related to a reported incident of staff to resident abuse. During an interview with Inspector #593, manager #115 reported that the staff member who witnessed the alleged abuse did not report it to the home until three days after the abuse was alleged to have occurred. Manager #115 further reported that the home did not report the alleged abuse to the Director until one day after the abuse was reported to the home.

The CI was submitted to the Director four days after the alleged incident occurred.

A CI was submitted to the Director October, 2015 related to a reported incident of resident to resident abuse. During an interview with Inspector #593, manager #115 reported that the staff member who witnessed the alleged abuse reported it to their RPN team lead who reported it to another RPN team lead at shift changeover. Neither team leads reported the witnessed abuse further to the home.

The CI was submitted to the Director two days after the incident occurred.

Non-compliance was previously identified under inspection 2015_281542_0016 with a VPC issued and inspection 2014_281542_0024 with a WN issued. Pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) in relation to failing to immediately report abuse of a resident by anyone that resulted in harm or risk of harm to the resident and the information upon which it is based to the Director.

The FJ Davey Home submitted four critical incident reports to the Director over a six month period involving abuse towards residents in the home by other residents and staff members. On all four occasions, the CI was reported between one to four days after the incident occurred. (593)

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

Inspector reviewed a Critical Incident (CI) report that was submitted to the Director on April, 2015 regarding staff to resident abuse. The CI indicated that PSW #139 was verbally abusive towards resident #019.

A review of the home's investigation file revealed that the same staff member was also verbally abusive towards resident #019 the day prior. According to the documentation, PSW #105 reported the incident to RPN #140. There was no further documentation to indicate that this incident was reported to the Director immediately.

An interview with manager #118 confirmed that the incident that occurred on the previous day was not reported to the Director at any time and the incident referred to in the CI report was not reported immediately to the Director. (542)

3. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse or neglect occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector reviewed a Critical Incident (CI) report which alleged PSW #134 and PSW #135 neglected to toilet resident #039 when they requested assistance.

Resident #039 reported the incident to manager #115 immediately, however the CI report was not submitted to the Director until the next day.

Inspector reviewed the CI report with the Executive Director of Nursing (EDON) who stated that expectation is that the incident is immediately reported to the Director of the Ministry of Health and Long-Term Care. The EDON confirmed that it this incident was not immediately reported.

The decision to issue a compliance order was based on the severity, potential for minimal harm and the scope which was a pattern as late reporting was found in multiple critical incident reports. Non-compliance was previously identified under inspection 2015_281542_0016 with a VPC and inspection 2014_281542_0024 with a WN. (612)

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

Jan 28, 2016

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
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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
Direction de l'amélioration de la performance et de la conformité
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 28 day of January 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SARAH CHARETTE - (A1)

Service Area Office /
Bureau régional de services : Sudbury