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 sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 11, 2019	2018_643111_0024 (A1)	022224-18, 022226-18	Follow up

Licensee/Titulaire de permis

Regional Municipality of Durham
605 Rossland Road East WHITBY ON L1N 6A3

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

Hillsdale Estates
590 Oshawa Blvd. North OSHAWA ON L1G 5T9

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

Amended by LYNDA BROWN (111) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Attention: Administrator,
Please note the changes to the compliance due date for CO #001.
Thanks
Lynda Brown, LTCH Inspector

Issued on this 11st day of March, 2019 (A1)

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

Original report signed by the inspector.

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Long-Term Care Inspections Branch

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

Amended by LYNDA BROWN (111) - (A1)

Amended Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 13 to 15, and 19, 2018

The following inspections related to compliance orders (CO) were completed:

-Log # 022224-18 for CO #002 related to altercations between residents

-Log # 022226-18 for CO #001 related to zero tolerance of abuse and neglect policy compliance.

In addition, critical incident inspections that were identified under inspection #2018_643111_0025 were used to determine compliance with the two follow-ups:

-Log #027751-18 (CIR), Log # 028389-18 (CIR) and Log # 028630-18 (CIR) related to alleged and/or suspected resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Resident Care Coordinator (RCC), Social Worker (SW), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and a Physician.

During the course of the inspection, the inspector reviewed resident health records, observed residents, reviewed investigations and review the following policies: Abuse and Neglect-Prevention, Reporting & Investigating and Resident Intimacy and Sexuality.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 54.	CO #002	2018_643111_0007	111

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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 :

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

Related to Log #022226-18 (follow-up) and Log #028630 (CIR):

A follow-up inspection was completed for a compliance order (CO #002) that was issued on June 26, 2018, during inspection #2018_643111_007 for LTCHA, 2007, s.20(1) with a compliance date of September 27, 2018.

A critical incident report (CIR) was submitted to the Director on a specified date, for an alleged resident to resident abuse incident. The CIR indicated on a specified date and time, police officers arrived at the home to report an allegation of resident to resident abuse towards resident #003 by resident #004. The CIR was amended on a specified date indicating the investigation was completed and the home determined the allegation was deemed unfounded. The CIR indicated the Social Worker (SW), RPN #110 and RN #111 were present or discovered the incident. The CIR was completed by the SW.

Review of the licensee's policy Abuse and Neglect-Prevention, Reporting & Investigating (ADM-01-03-05, revised November 2017), indicated under, Internal Reporting and Investigation Requirements (page 11/18):
-staff members who witness or suspect or who have been notified of alleged abuse will immediately report to a supervisor or manager.
-the investigation process will commence immediately to determine if there are reasonable grounds to suspect that the alleged, suspected or witnessed abuse has occurred.
-Supervisor, manager or delegate is responsible for initiating the investigation commencing with documentation of details including details of the allegation/incident, dates, timing of events, names of witnesses and other involved.

-Supervisor, manager or delegate will notify the DOC or on-call manager of the allegation and investigation.
-Supervisor, manager or delegate will ensure signed statements are provided by all persons involved including residents, family members and staff. All statements are required to be legible, dated and signed.
-Supervisor, manager or delegate will secure all evidence at the site.
Home Department Manager Designate (page 12/18):
-upon receiving notification of abuse allegation, ensures an investigation is underway by the Supervisor/manager/delegate to whom the alleged abuse or neglect was reported.
-ensures completion of all required documentation/forms.

Review of the licensee's investigation into the allegation indicated there were two different investigation forms completed (one was signed as completed by Resident Care Coordinator (RCC) #106 on a specified date and the other was not signed or dated). The first investigation form indicated the allegation was reported and investigated on a specified date, by the SW. The second investigation form indicated the allegation was reported the following day and was investigated by the SW and RCC #106. Both investigations had only one signed statement by the SW. There were no other documented interviews or signed statements available. There was no documented evidence of any investigation by RCC #106, relating to the allegation made by resident #003 of abuse by resident #004, that occurred on a separate date.

Review of the health care record for resident #003 indicated in the written plan of care, the resident required two staff assistance for all transfers and required the use of a mobility aid for mobility. Review of the progress notes for resident #003 indicated there was no documentation on the day that the alleged abuse occurred. A number of days later, at a specified time, a PSW reported to the nurse that resident #003 alleged abuse by resident #004. Approximately a week later, at a specified time, the resident reported alleged abuse by resident #004 again. The police spoke with the resident and the SW. A late entry was completed the following day by the SW, regarding the alleged incident. The SW indicated, the Substitute Decision Maker (SDM) for resident #003 was notified of the allegation and reported to the SW, that resident #003 had ongoing concerns of alleged abuse by resident #004. An alarming device was put in place and a Dementia Observation System (DOS) for close monitoring was initiated for resident #003 the day after the allegation was made. Two days after the allegation was made, the physician was notified of the allegation and ordered specified

diagnostic tests.

Review of the health care record for resident #004 indicated the resident had total weakness to specified areas. The written plan of care indicated the resident required two staff for all transfers and used a mobility aid for mobility. Review of the progress notes for resident #004 indicated there was no documentation to indicate an incident occurred on the day the alleged incident occurred and there was no documentation regarding the allegation of abuse, when the allegation was made. The day after the allegation of abuse was reported, there was a referral and assessment completed by the Occupational Therapist (OT) to assess the resident's transfer status. The OT noted the resident was unable to transfer independently. Four days later, the SDM was notified of the allegation. A number of days later, the SW met with the resident to discuss the allegation and the resident denied all of the allegations of abuse. The resident was encouraged to stay away from resident #003.

During an interview with RCC #106, the RCC indicated they would normally investigate any resident to resident abuse allegations on their assigned units. The RCC indicated when investigating resident to resident abuse, the RCC would review the algorithm to determine whether it would be considered abuse or not, ensure that both residents are safe, assess whether there was any emotional response to the incident, interview all the staff who reported the incident or who were working at the time the incident occurred, document the interviews or get the staff to provide written statements, review the health care records of both residents involved to get all the possible information, review if any prior incidents including reviewing all progress notes during same time frame, for history or pattern, review the care plan and speak with BSO staff. The RCC indicated they would then complete the investigation template, keep copies of progress notes related to incident, care plan to indicate the resident's ability to make decisions and submit the CIR. The RCC confirmed awareness of the alleged resident to resident abuse by resident #004 towards resident #003 and completed one of the investigation forms (that was dated and signed). The RCC indicated the SW submitted the CIR on the day the allegation was made as they were involved in the investigation/interviews. The RCC indicated they became aware of the incident when they received the CIR and assumed the SW was managing the investigation. The RCC confirmed they initiated an investigation the next day and completed the investigation template. The RCC indicated the investigation was completed by reviewing the progress notes of both residents (for the specified time frame), and found nothing unusual. The RCC confirmed they did not conduct

or document any interviews of staff, or obtain any signed statements from staff, who would have been working on either dates. The RCC indicated they usually just used the progress notes as the staff's signed statements for their investigations, despite indicating awareness of the policy requirement to interview and obtain actual statements from staff. The RCC indicated they had staff implement monitoring interventions for resident #003 and resident #004, relocated both resident in a specified area. The RCC indicated they also had the Physiotherapist (PT) assess resident #004's mobility, to determine if the resident was capable of the alleged abuse. The RCC determined it was not possible for the incident to have occurred due to limited mobility of resident #004 and concluded the investigation as unfounded. The RCC confirmed awareness of a second allegation of abuse by resident #003, on a different specified date, by resident #004 and RCC indicated the allegation was not investigated. The RCC indicated no awareness the SDM of resident #003 and #004 were notified of the second allegation.

During an interview with the SW, the SW indicated awareness of the allegation of resident to resident abuse by resident #004 towards resident #003 on a specified date. The SW indicated the SW was involved when they were contacted by the nurse, to speak with both residents and the police officers. The SW indicated they discussed the allegation with both residents and resident #004 had no knowledge of the incident. The SW indicated they completed a progress note regarding the allegation, the interviews with each resident and then submitted the CIR. The SW confirmed they did not complete any investigation forms or interview any of the staff, as per the licensee's abuse policy. The SW assumed the investigation would be completed by RCC #107 as the RCC was also notified of the allegation. The SW indicated it was determined that the allegation of abuse was unfounded due to limited mobility of resident #004. The SW indicated during the investigation, resident #003 then denied that resident #004 was involved in the allegation.

During an interview with the DOC, the DOC confirmed they completed the second investigation form that was not signed and dated. The DOC indicated it was the expectation that registered nursing staff and/or the SW would notify the RCC, who would complete the investigation, interview all staff involved and notify the SDM's regarding the allegation. The DOC confirmed the licensee's abuse and neglect policy was not followed.

The licensee failed to ensure the written policy that promotes zero tolerance of abuse and neglect of residents was complied with, as there was no documented

evidence that the allegation of resident to resident abuse was reported to the supervisor, until the following day, when the RCC initiated the investigation template. There were two separate investigation forms completed with conflicting dates regarding when the investigation was initiated and one form was not dated and signed. There was no documented evidence that all staff who were aware or involved, were either interviewed and/or signed statements received, including RPN #109 and RN #111 that were identified on the CIR. There was also no documented evidence on resident #004 health care record regarding the allegation of abuse made against the resident, until four days later.

2. Related to Log # 027751-18:

A critical incident report (CIR) was submitted to the Director on a specified date, for a suspected resident to resident abuse incident. The CIR indicated on a specified date and time, a PSW witnessed a suspected abuse between resident #002 towards resident #001. Resident #001 was assessed and no injury was noted.

Review of the licensee's policy Abuse and Neglect-Prevention, Reporting & Investigating (ADM-01-03-05, revised November 2017), indicated under: Internal Reporting and Investigation Requirements (page 11/18):
-staff members who witness or suspect or who have been notified of alleged abuse will immediately report to a supervisor or manager.
-Supervisor, manager or delegate will ensure signed statements are provided by all persons involved including residents, family members and staff. All statements are required to be legible, dated and signed.
-Supervisor, manager or delegate will secure all evidence at the site, will ensure integrity of the evidence and will take pictures as necessary.
Home Department Manager Designate (page 12/18):
-upon receiving notification of abuse allegation, ensures an investigation is underway by the Supervisor/manager/delegate to whom the alleged abuse or neglect was reported and ensures completion of all required documentation/forms.

Review of the licensee's investigation indicated the investigation template indicated the staff involved were: RN #100, PSW #104 and PSW #111. The template indicated the conclusion/outcome was left incomplete and the form was not signed or dated to indicate who completed the template. There was a signed and dated statement from the SW, two days after the incident occurred. The SW

was not identified on the investigation template as being involved. There was a written statement from PSW #105 that was signed but not dated, to indicate when the statement was received. This PSW was not identified on the investigation template as being involved. There was a written statement from PSW #104 that was signed but not dated, to indicate when the statement was received. There was a signed and dated statement from RN #100, dated three days after the incident occurred. There was no signed statement from PSW #111 (who was identified on the investigation template) and no indication of which RPN (or a statement/interview) was working on the unit when the incident occurred.

Review of the health care record for resident #001, indicated in the written care plan that the resident was independently mobile, was to be supervised when walking in corridors and to be re-redirected when going into other resident rooms. The progress notes indicated on a specified date and time, PSW #105 had found resident #001 in resident #002's room and suspected abuse. The PSW then returned resident #001 to their own room and notified RN #100. RN #100 then notified the SW and the DOC. Resident #001 had no noted injuries. The RN was unable to get information from resident #001 due to a language barrier. The physician was notified and ordered a specified assessment. The family of resident #001 was notified of the incident and came into the home. The assessment was initiated by Behaviour Support Ontario (BSO) PSW #103, with the family to translate. The police were also notified. Later, the resident became emotional regarding the incident and was provided with reassurance. The resident was relocated and placed on one to one monitoring for the remainder of the shift. RN #100 documented that resident #001 was unable to provide consent.

Review of the health care record for resident #002 indicated in the written care plan that the resident was independently mobile. Review of the progress notes indicated there was no note documented when the incident occurred. There was a late entry completed the day after the allegation was made, regarding the incident. The progress note identified PSW #105 who witnessed the suspected abuse by resident #002 towards resident #001. PSW #015 then reported the incident to PSW #104. Both PSW's then returned to resident #002's room and intervened. Resident #002 denied the abuse. The resident denied any prior interaction with resident #001. The resident indicated no awareness that resident #001 was unable to understand what had occurred. Resident #002 was placed on one to one monitoring and the police were notified. The resident was directed to refrain from engaging in any abuse with co-residents. There were no injuries to resident #002.

During an interview with PSW #105, the PSW indicated on a specified date and time, that PSW #104 and RPN#106 were also working when the incident occurred. The PSW indicated at a specified time, they went into resident #002’s room and discovered suspected abuse towards resident #001. The PSW indicated, the PSW then left both residents before intervening, to report the incident to PSW #104 (who was in close proximity) and requested that PSW #104 come to assist. The PSW indicated both PSW’s then re-entered resident #002's room and resident #001 was already preparing to leave the room. PSW #105 then took resident #001 to their own bathroom to assist with personal care and PSW #104 assisted resident #002 with personal care. The PSW indicated resident #001 was then directed to sit near nursing station. The PSW indicated the alleged abuse incident was then reported to RN #100. The PSW confirmed the RN did not assess either resident prior to the PSW's assisting both residents with personal care. The PSW indicated later in the shift, asked resident #001 how they were feeling and the resident was upset. The PSW indicated the incident was later reported to the RPN. The PSW indicated resident #001 was moved to another unit and resident #002 was placed on one to one monitoring. The PSW confirmed that resident #002 had no prior incidents of responsive behaviours. The PSW indicated resident #001 demonstrated a specified responsive behaviour towards residents. The PSW indicated both residents previously had sat at the same table in the dining room but never saw any abusive behaviours from either resident. The PSW indicated resident #002 would often indicate to staff (regarding resident #001) “I have no idea what [resident #001] is saying”. The PSW indicated resident #002 had not had any further abusive behaviours since that incident.

During an interview with PSW #104, the PSW indicated on a specified date and time, while doing first rounds, PSW #105 reported to the PSW, witnessing a suspected abuse between resident #001 and #002 and asked the PSW to assist. The PSW indicated both residents were found in resident #002's room and suspected abuse by resident #002 towards resident #001. The PSW indicated resident #002 denied that any abuse occurred despite a suspicion by staff that abuse may have occurred. The PSW indicated PSW #105, then took resident #001 to their bathroom to complete personal care. The PSW indicated resident #002 then proceeded to the bathroom to complete personal care. The PSW indicated the incident was then reported to RN #100. The PSW indicated that the RPN on the unit was new and not in the area where the suspected abuse occurred. The PSW indicated when they reported the incident to the RPN, the RPN indicated they had already discovered both residents in suspected abuse

earlier, but did not intervene. The PSW confirmed the RN did not assess the resident prior to both residents completing personal care. The PSW indicated the SW and BSO PSW #103 also came up to the unit later in the shift, to discuss the incident with resident #002. The PSW indicated resident #002 later complained of a headache and asked for analgesic. The PSW confirmed no awareness of any prior incidents of a specified responsive behaviour between both residents or towards other residents and has not had any further incidents. The PSW confirmed that resident #001 was transferred to another unit and resident #002 was placed on one to one monitoring, the same evening.

During an interview with RPN #106, the RPN confirmed they were not familiar with the unit, where resident #001 and #002 resided. The RPN indicated on a specified date, the RPN had come in early to complete narcotic count and get report from previous shift, and then started administering medications shortly after start of the their shift. The RPN indicated the medication pass was started in the hallway where resident #002 resided. The RPN noted at approximately shortly after starting their medication pass, resident #002 was not in their room and continued down the hall to give out medications. The RPN was able to recall that resident #002's room was in close proximity to the nursing station and indicated they were still in the same hall, when the PSWs discovered the suspected abuse in resident #002's room, between resident #001 and resident #002. The RPN was unable to explain how resident #001 and resident #002 were able to re-enter resident #002's room, when the RPN indicated they had just been in resident #002's room and no one was present. The RPN denied reporting to PSW#104, that they witnessed both resident #001 and resident #002 in resident #002 room, involved in suspected abuse prior to being notified of the alleged abuse. The RPN indicated they were not made aware of the suspected resident to resident abuse incident until approximately fifteen minutes after the incident was discovered, when the BSO PSW #103 reported the incident to the RPN. The RPN was unable to explain how the PSWs would walk past the RPN, who was still in the same hall, and report directly to the RN who was at the nursing station. The RPN was unable to indicate why the PSWs would not immediately report the incident to the RPN, who was in charge of the unit first. The RPN also could not recall which PSWs were working when the incident occurred or which staff members they had reported the incident to. The RPN indicated RN #100 was involved with the suspected abuse incident and the RPN continued completing administering their medications. The RPN confirmed they did not document in either resident health record regarding the suspected abuse incident. The RPN indicated resident #001 was upset following the suspected abuse incident, refused to come for their meal

and was moved to another unit later in the shift. The RPN indicated resident #002 was placed on one to one monitoring for the remainder of the shift, was also upset regarding the incident and complained about being unable to sleep. The RPN indicated they then contacted RN #100, who directed the RPN to contact the physician and received a new order for a specified medication.

During an interview with BSO PSW #103, the PSW indicated on a specified date and time, the PSW and SW were called to the unit by RN #100, regarding the suspected abuse incident between resident #001 and #002. The PSW indicated the DOC was also aware of the incident as they were directed by the DOC, to complete the one to one monitoring of resident #002 for the remainder of the shift. The PSW indicated resident #001 was relocated to another unit and was emotional regarding the incident. The PSW confirmed that there were no incidents of a specified responsive behaviour with either resident prior, or after this incident. The PSW indicated resident #001 demonstrated a specified responsive behaviour towards residents. The PSW indicated they attempted to complete a specified assessment on resident #001 (as requested by RN #100) and also contacted the family to assist due to the resident's inability to answer the questions correctly and the assessment was discontinued. The PSW indicated resident #001 was not capable to consent and the family of resident #001 had expressed concerns regarding the incident.

During an interview with the DOC, the DOC indicated they had completed the investigation template regarding the suspected, resident to resident abuse incident that occurred on a specified date. The DOC confirmed that the expectation for any alleged, suspected or witnessed incidents of resident to resident abuse, required the staff to immediately separate the residents, the registered staff to immediately complete a full assessment, notify management and document in both residents progress notes. The DOC confirmed the investigation template was left incomplete. The DOC confirmed the investigation was concluded approximately two weeks later and was determined to be unfounded. The DOC indicated the outcome was considered unfounded as resident #001 was aware and consenting to the activity, resident #002 also indicated that resident #001 was consenting to the activity and resident #002 denied that any abuse actually occurred. The DOC was unable to indicate which RPN was working when the suspected abuse occurred and confirmed RPN #106 (charge nurse) who was working when the incident occurred, was not interviewed as part of the investigation. The DOC indicated no awareness that PSW #105 had left both residents prior to intervening in the suspected abuse and then returned a

short time later, after immediately reporting the incident to another PSW (not the unit charge nurse RPN or RN). The DOC was not aware that both PSW's had already assisted with providing personal care to both residents prior to the RN completing an assessment of both residents. The DOC indicated the investigation was concluded as unfounded based on resident #002 reporting to the SW that no abuse occurred. The DOC confirmed that no further assessments were completed after the incident occurred to rule out actual abuse.

The licensee failed to ensure the ‘Abuse and Neglect-Prevention, Reporting & Investigating’ policy was complied with as staff member (PSW #105) who suspected resident to resident abuse, failed to immediately intervene and then immediately report to their supervisor. The PSWs had also assisted with personal care to both residents, prior to allowing the RN to assess both residents. The charge nurse (RPN #106) did not document their knowledge of the incident in either residents health record. The supervisor/manager or delegate did not ensure signed statements were provided by all persons involved (there were no statements from the RPN and other staff were not identified on the investigation template) and some of the signed statements were not dated. The supervisor, manager or delegate did not secure all evidence at the site, to ensure integrity of the evidence, before being assessed by the RN. The Supervisor/manager/delegate to whom the alleged abuse was reported, did not ensure completion of all required documentation/forms (investigation template).

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

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

Related to log # 028630-18:

A critical incident report (CIR) was submitted to the Director on a specified date, for an alleged resident to resident abuse incident. The CIR indicated on a specified date and time, police officers arrived at the home to report an allegation of resident to resident abuse towards resident #003 by resident #004. The CIR indicated the SDM of resident #003 was notified of the allegation but there was no indication that the SDM of resident #004 was notified. The CIR was completed by the SW.

Review of the progress notes for resident #004 indicated there was no indication the SDM of resident #004 was notified of the allegation until four days after the allegation was made.

During an interview with the SW, the SW indicated awareness of the allegation of resident to resident abuse by resident #004 towards resident #003 on a specified date. The SW indicated they contacted the SDM of resident #003 the same day. The SW confirmed they did not contact or discuss the alleged resident to resident abuse with the SDM of resident #004 until four days later. The SW indicated they assumed the nursing staff would have contacted the family sooner.

The licensee has failed to ensure that resident #004's SDM was immediately notified upon becoming aware of the alleged, resident to resident incident, until four days after the allegation was made.

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 resident's SDM and any other person specified by the resident, are immediately notified upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being., to be implemented voluntarily.

Issued on this 11st day of March, 2019 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	Amended by LYNDA BROWN (111) - (A1)
Inspection No. / No de l’inspection :	2018_643111_0024 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	022224-18, 022226-18 (A1)
Type of Inspection / Genre d’inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 11, 2019(A1)
Licensee / Titulaire de permis :	Regional Municipality of Durham 605 Rossland Road East, WHITBY, ON, L1N-6A3
LTC Home / Foyer de SLD :	Hillsdale Estates 590 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Gina Peragine

To Regional Municipality of Durham, 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: 2018_643111_0007, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s.20(1) of the LTCHA.

Specifically, the licensee shall ensure:
1. The written policy that promotes zero tolerance of abuse and neglect of residents (Abuse and Neglect-Prevention, Reporting & Investigating: ADM-01-03-05), specifically, related to how investigations are to be completed, is complied with when completing any investigations into alleged, suspected or witnessed incidents of abuse towards residents.

2. A review of the licensee's policy relating to Resident Abuse (Abuse and Neglect-Prevention, Reporting & Investigating (ADM-01-03-05) to ensure this policy provides clear directions, specifically with residents involved in alleged, suspected or witnessed abuse, by persons other than staff, to contain specific procedures and interventions to assist and support residents who have been abused and how they will be protected from any further incidents.

Grounds / Motifs :

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

Related to Log #022226-18 (follow-up) and Log #028630 (CIR):

A follow-up inspection was completed for a compliance order (CO #002) that was issued on June 26, 2018, during inspection #2018_643111_007 for LTCHA, 2007, s.20(1) with a compliance date of September 27, 2018.

A critical incident report (CIR) was submitted to the Director on a specified date, for an alleged resident to resident abuse incident. The CIR indicated on a specified date and time, police officers arrived at the home to report an allegation of resident to resident abuse towards resident #003 by resident #004. The CIR was amended on a specified date indicating the investigation was completed and the home determined the allegation was deemed unfounded. The CIR indicated the Social Worker (SW), RPN #110 and RN #111 were present or discovered the incident. The CIR was completed by the SW.

Review of the licensee's policy Abuse and Neglect-Prevention, Reporting & Investigating (ADM-01-03-05, revised November 2017), indicated under, Internal Reporting and Investigation Requirements (page 11/18):
-staff members who witness or suspect or who have been notified of alleged abuse will immediately report to a supervisor or manager.
-the investigation process will commence immediately to determine if there are reasonable grounds to suspect that the alleged, suspected or witnessed abuse has occurred.
-Supervisor, manager or delegate is responsible for initiating the investigation commencing with documentation of details including details of the allegation/incident, dates, timing of events, names of witnesses and other involved.
-Supervisor, manager or delegate will notify the DOC or on-call manager of the allegation and investigation.
-Supervisor, manager or delegate will ensure signed statements are provided by all persons involved including residents, family members and staff. All statements are required to be legible, dated and signed.
-Supervisor, manager or delegate will secure all evidence at the site.
Home Department Manager Designate (page 12/18):
-upon receiving notification of abuse allegation, ensures an investigation is underway by the Supervisor/manager/delegate to whom the alleged abuse or neglect was reported.
-ensures completion of all required documentation/forms.

Review of the licensee's investigation into the allegation indicated there were two different investigation forms completed (one was signed as completed by Resident Care Coordinator (RCC) #106 on a specified date and the other was not signed or dated). The first investigation form indicated the allegation was reported and investigated on a specified date, by the SW. The second investigation form indicated the allegation was reported the following day and was investigated by the SW and RCC #106. Both investigations had only one signed statement by the SW. There were no other documented interviews or signed statements available. There was no documented evidence of any investigation by RCC #106, relating to the allegation made by resident #003 of abuse by resident #004, that occurred on a separate date.

Review of the health care record for resident #003 indicated in the written plan of care, the resident required two staff assistance for all transfers and required the use of a mobility aid for mobility. Review of the progress notes for resident #003 indicated there was no documentation on the day that the alleged abuse occurred. A number of days later, at a specified time, a PSW reported to the nurse that resident #003 alleged abuse by resident #004. Approximately a week later, at a specified time, the resident reported alleged abuse by resident #004 again. The police spoke with the resident and the SW. A late entry was completed the following day by the SW, regarding the alleged incident. The SW indicated, the Substitute Decision Maker (SDM) for resident #003 was notified of the allegation and reported to the SW, that resident #003 had ongoing concerns of alleged abuse by resident #004. An alarming device was put in place and a Dementia Observation System (DOS) for close monitoring was initiated for resident #003 the day after the allegation was made. Two days after the allegation was made, the physician was notified of the allegation and ordered specified diagnostic tests.

Review of the health care record for resident #004 indicated the resident had total weakness to specified areas. The written plan of care indicated the resident required two staff for all transfers and used a mobility aid for mobility. Review of the progress notes for resident #004 indicated there was no documentation to indicate an incident occurred on the day the alleged incident occurred and there was no documentation regarding the allegation of abuse, when the allegation was made. The day after the allegation of abuse was reported, there was a referral and assessment completed by the Occupational Therapist (OT) to assess the resident's transfer status. The OT noted the resident was unable to transfer independently. Four days later, the SDM was notified of the allegation. A number of days later, the SW met with the resident to

discuss the allegation and the resident denied all of the allegations of abuse. The resident was encouraged to stay away from resident #003.

During an interview with RCC #106, the RCC indicated they would normally investigate any resident to resident abuse allegations on their assigned units. The RCC indicated when investigating resident to resident abuse, the RCC would review the algorithm to determine whether it would be considered abuse or not, ensure that both residents are safe, assess whether there was any emotional response to the incident, interview all the staff who reported the incident or who were working at the time the incident occurred, document the interviews or get the staff to provide written statements, review the health care records of both residents involved to get all the possible information, review if any prior incidents including reviewing all progress notes during same time frame, for history or pattern, review the care plan and speak with BSO staff. The RCC indicated they would then complete the investigation template, keep copies of progress notes related to incident, care plan to indicate the resident's ability to make decisions and submit the CIR. The RCC confirmed awareness of the alleged resident to resident abuse by resident #004 towards resident #003 and completed one of the investigation forms (that was dated and signed). The RCC indicated the SW submitted the CIR on the day the allegation was made as they were involved in the investigation/interviews. The RCC indicated they became aware of the incident when they received the CIR and assumed the SW was managing the investigation. The RCC confirmed they initiated an investigation the next day and completed the investigation template. The RCC indicated the investigation was completed by reviewing the progress notes of both residents (for the specified time frame), and found nothing unusual. The RCC confirmed they did not conduct or document any interviews of staff, or obtain any signed statements from staff, who would have been working on either dates. The RCC indicated they usually just used the progress notes as the staff's signed statements for their investigations, despite indicating awareness of the policy requirement to interview and obtain actual statements from staff. The RCC indicated they had staff implement monitoring interventions for resident #003 and resident #004, relocated both resident in a specified area. The RCC indicated they also had the Physiotherapist (PT) assess resident #004's mobility, to determine if the resident was capable of the alleged abuse. The RCC determined it was not possible for the incident to have occurred due to limited mobility of resident #004 and concluded the investigation as unfounded. The RCC confirmed awareness of a second allegation of abuse by resident #003, on a different specified date, by resident #004 and RCC indicated the

allegation was not investigated. The RCC indicated no awareness the SDM of resident #003 and #004 were notified of the second allegation.

During an interview with the SW, the SW indicated awareness of the allegation of resident to resident abuse by resident #004 towards resident #003 on a specified date. The SW indicated the SW was involved when they were contacted by the nurse, to speak with both residents and the police officers. The SW indicated they discussed the allegation with both residents and resident #004 had no knowledge of the incident. The SW indicated they completed a progress note regarding the allegation, the interviews with each resident and then submitted the CIR. The SW confirmed they did not complete any investigation forms or interview any of the staff, as per the licensee's abuse policy. The SW assumed the investigation would be completed by RCC #107 as the RCC was also notified of the allegation. The SW indicated it was determined that the allegation of abuse was unfounded due to limited mobility of resident #004. The SW indicated during the investigation, resident #003 then denied that resident #004 was involved in the allegation.

During an interview with the DOC, the DOC confirmed they completed the second investigation form that was not signed and dated. The DOC indicated it was the expectation that registered nursing staff and/or the SW would notify the RCC, who would complete the investigation, interview all staff involved and notify the SDM's regarding the allegation. The DOC confirmed the licensee's abuse and neglect policy was not followed.

The licensee failed to ensure the written policy that promotes zero tolerance of abuse and neglect of residents was complied with, as there was no documented evidence that the allegation of resident to resident abuse was reported to the supervisor, until the following day, when the RCC initiated the investigation template. There were two separate investigation forms completed with conflicting dates regarding when the investigation was initiated and one form was not dated and signed. There was no documented evidence that all staff who were aware or involved, were either interviewed and/or signed statements received, including RPN #109 and RN #111 that were identified on the CIR. There was also no documented evidence on resident #004 health care record regarding the allegation of abuse made against the resident, until four days later. (111)

2. Related to Log # 027751-18:

A critical incident report (CIR) was submitted to the Director on a specified date, for a suspected resident to resident abuse incident. The CIR indicated on a specified date and time, a PSW witnessed a suspected abuse between resident #002 towards resident #001. Resident #001 was assessed and no injury was noted.

Review of the licensee's policy Abuse and Neglect-Prevention, Reporting & Investigating (ADM-01-03-05, revised November 2017), indicated under: Internal Reporting and Investigation Requirements (page 11/18):
-staff members who witness or suspect or who have been notified of alleged abuse will immediately report to a supervisor or manager.
-Supervisor, manager or delegate will ensure signed statements are provided by all persons involved including residents, family members and staff. All statements are required to be legible, dated and signed.
-Supervisor, manager or delegate will secure all evidence at the site, will ensure integrity of the evidence and will take pictures as necessary.
Home Department Manager Designate (page 12/18):
-upon receiving notification of abuse allegation, ensures an investigation is underway by the Supervisor/manager/delegate to whom the alleged abuse or neglect was reported and ensures completion of all required documentation/forms.

Review of the licensee's investigation indicated the investigation template indicated the staff involved were: RN #100, PSW #104 and PSW #111. The template indicated the conclusion/outcome was left incomplete and the form was not signed or dated to indicate who completed the template. There was a signed and dated statement from the SW, two days after the incident occurred. The SW was not identified on the investigation template as being involved. There was a written statement from PSW #105 that was signed but not dated, to indicate when the statement was received. This PSW was not identified on the investigation template as being involved. There was a written statement from PSW #104 that was signed but not dated, to indicate when the statement was received. There was a signed and dated statement from RN #100, dated three days after the incident occurred. There was no signed statement from PSW #111 (who was identified on the investigation template) and no indication of which RPN (or a statement/interview) was working on the unit when the incident occurred.

Review of the health care record for resident #001, indicated in the written care plan that the resident was independently mobile, was to be supervised when walking in

corridors and to be re-redirected when going into other resident rooms. The progress notes indicated on a specified date and time, PSW #105 had found resident #001 in resident #002's room and suspected abuse. The PSW then returned resident #001 to their own room and notified RN #100. RN #100 then notified the SW and the DOC. Resident #001 had no noted injuries. The RN was unable to get information from resident #001 due to a language barrier. The physician was notified and ordered a specified assessment. The family of resident #001 was notified of the incident and came into the home. The assessment was initiated by Behaviour Support Ontario (BSO) PSW #103, with the family to translate. The police were also notified. Later, the resident became emotional regarding the incident and was provided with reassurance. The resident was relocated and placed on one to one monitoring for the remainder of the shift. RN #100 documented that resident #001 was unable to provide consent.

Review of the health care record for resident #002 indicated in the written care plan that the resident was independently mobile. Review of the progress notes indicated there was no note documented when the incident occurred. There was a late entry completed the day after the allegation was made, regarding the incident. The progress note identified PSW #105 who witnessed the suspected abuse by resident #002 towards resident #001. PSW #015 then reported the incident to PSW #104. Both PSW's then returned to resident #002's room and intervened. Resident #002 denied the abuse. The resident denied any prior interaction with resident #001. The resident indicated no awareness that resident #001 was unable to understand what had occurred. Resident #002 was placed on one to one monitoring and the police were notified. The resident was directed to refrain from engaging in any abuse with co-residents. There were no injuries to resident #002.

During an interview with PSW #105, the PSW indicated on a specified date and time, that PSW #104 and RPN#106 were also working when the incident occurred. The PSW indicated at a specified time, they went into resident #002's room and discovered suspected abuse towards resident #001. The PSW indicated, the PSW then left both residents before intervening, to report the incident to PSW #104 (who was in close proximity) and requested that PSW #104 come to assist. The PSW indicated both PSW's then re-entered resident #002's room and resident #001 was already preparing to leave the room. PSW #105 then took resident #001 to their own bathroom to assist with personal care and PSW #104 assisted resident #002 with personal care. The PSW indicated resident #001 was then directed to sit near

nursing station. The PSW indicated the alleged abuse incident was then reported to RN #100. The PSW confirmed the RN did not assess either resident prior to the PSW's assisting both residents with personal care. The PSW indicated later in the shift, asked resident #001 how they were feeling and the resident was upset. The PSW indicated the incident was later reported to the RPN. The PSW indicated resident #001 was moved to another unit and resident #002 was placed on one to one monitoring. The PSW confirmed that resident #002 had no prior incidents of responsive behaviours. The PSW indicated resident #001 demonstrated a specified responsive behaviour towards residents. The PSW indicated both residents previously had sat at the same table in the dining room but never saw any abusive behaviours from either resident. The PSW indicated resident #002 would often indicate to staff (regarding resident #001) “I have no idea what [resident #001] is saying”. The PSW indicated resident #002 had not had any further abusive behaviours since that incident.

During an interview with PSW #104, the PSW indicated on a specified date and time, while doing first rounds, PSW #105 reported to the PSW, witnessing a suspected abuse between resident #001 and #002 and asked the PSW to assist. The PSW indicated both residents were found in resident #002's room and suspected abuse by resident #002 towards resident #001. The PSW indicated resident #002 denied that any abuse occurred despite a suspicion by staff that abuse may have occurred. The PSW indicated PSW #105, then took resident #001 to their bathroom to complete personal care. The PSW indicated resident #002 then proceeded to the bathroom to complete personal care. The PSW indicated the incident was then reported to RN #100. The PSW indicated that the RPN on the unit was new and not in the area where the suspected abuse occurred. The PSW indicated when they reported the incident to the RPN, the RPN indicated they had already discovered both residents in suspected abuse earlier, but did not intervene. The PSW confirmed the RN did not assess the resident prior to both residents completing personal care. The PSW indicated the SW and BSO PSW #103 also came up to the unit later in the shift, to discuss the incident with resident #002. The PSW indicated resident #002 later complained of a headache and asked for analgesic. The PSW confirmed no awareness of any prior incidents of a specified responsive behaviour between both residents or towards other residents and has not had any further incidents. The PSW confirmed that resident #001 was transferred to another unit and resident #002 was placed on one to one monitoring, the same evening.

During an interview with RPN #106, the RPN confirmed they were not familiar with the unit, where resident #001 and #002 resided. The RPN indicated on a specified date, the RPN had come in early to complete narcotic count and get report from previous shift, and then started administering medications shortly after start of the their shift. The RPN indicated the medication pass was started in the hallway where resident #002 resided. The RPN noted at approximately shortly after starting their medication pass, resident #002 was not in their room and continued down the hall to give out medications. The RPN was able to recall that resident #002's room was in close proximity to the nursing station and indicated they were still in the same hall, when the PSWs discovered the suspected abuse in resident #002's room, between resident #001 and resident #002. The RPN was unable to explain how resident #001 and resident #002 were able to re-enter resident #002's room, when the RPN indicated they had just been in resident #002's room and no one was present. The RPN denied reporting to PSW#104, that they witnessed both resident #001 and resident #002 in resident #002 room, involved in suspected abuse prior to being notified of the alleged abuse. The RPN indicated they were not made aware of the suspected resident to resident abuse incident until approximately fifteen minutes after the incident was discovered, when the BSO PSW #103 reported the incident to the RPN. The RPN was unable to explain how the PSWs would walk past the RPN, who was still in the same hall, and report directly to the RN who was at the nursing station. The RPN was unable to indicate why the PSWs would not immediately report the incident to the RPN, who was in charge of the unit first. The RPN also could not recall which PSWs were working when the incident occurred or which staff members they had reported the incident to. The RPN indicated RN #100 was involved with the suspected abuse incident and the RPN continued completing administering their medications. The RPN confirmed they did not document in either resident health record regarding the suspected abuse incident. The RPN indicated resident #001 was upset following the suspected abuse incident, refused to come for their meal and was moved to another unit later in the shift. The RPN indicated resident #002 was placed on one to one monitoring for the remainder of the shift, was also upset regarding the incident and complained about being unable to sleep. The RPN indicated they then contacted RN #100, who directed the RPN to contact the physician and received a new order for a specified medication.

During an interview with BSO PSW #103, the PSW indicated on a specified date and time, the PSW and SW were called to the unit by RN #100, regarding the suspected abuse incident between resident #001 and #002. The PSW indicated the DOC was

also aware of the incident as they were directed by the DOC, to complete the one to one monitoring of resident #002 for the remainder of the shift. The PSW indicated resident #001 was relocated to another unit and was emotional regarding the incident. The PSW confirmed that there were no incidents of a specified responsive behaviour with either resident prior, or after this incident. The PSW indicated resident #001 demonstrated a specified responsive behaviour towards residents. The PSW indicated they attempted to complete a specified assessment on resident #001 (as requested by RN #100) and also contacted the family to assist due to the resident's inability to answer the questions correctly and the assessment was discontinued. The PSW indicated resident #001 was not capable to consent and the family of resident #001 had expressed concerns regarding the incident.

During an interview with the DOC, the DOC indicated they had completed the investigation template regarding the suspected, resident to resident abuse incident that occurred on a specified date. The DOC confirmed that the expectation for any alleged, suspected or witnessed incidents of resident to resident abuse, required the staff to immediately separate the residents, the registered staff to immediately complete a full assessment, notify management and document in both residents progress notes. The DOC confirmed the investigation template was left incomplete. The DOC confirmed the investigation was concluded approximately two weeks later and was determined to be unfounded. The DOC indicated the outcome was considered unfounded as resident #001 was aware and consenting to the activity, resident #002 also indicated that resident #001 was consenting to the activity and resident #002 denied that any abuse actually occurred. The DOC was unable to indicate which RPN was working when the suspected abuse occurred and confirmed RPN #106 (charge nurse) who was working when the incident occurred, was not interviewed as part of the investigation. The DOC indicated no awareness that PSW #105 had left both residents prior to intervening in the suspected abuse and then returned a short time later, after immediately reporting the incident to another PSW (not the unit charge nurse RPN or RN). The DOC was not aware that both PSW's had already assisted with providing personal care to both residents prior to the RN completing an assessment of both residents. The DOC indicated the investigation was concluded as unfounded based on resident #002 reporting to the SW that no abuse occurred. The DOC confirmed that no further assessments were completed after the incident occurred to rule out actual abuse.

The licensee failed to ensure the 'Abuse and Neglect-Prevention, Reporting &

Investigating' policy was complied with as staff member (PSW #105) who suspected resident to resident abuse, failed to immediately intervene and then immediately report to their supervisor. The PSWs had also assisted with personal care to both residents, prior to allowing the RN to assess both residents. The charge nurse (RPN #106) did not document their knowledge of the incident in either residents health record. The supervisor/manager or delegate did not ensure signed statements were provided by all persons involved (there were no statements from the RPN and other staff were not identified on the investigation template) and some of the signed statements were not dated. The supervisor, manager or delegate did not secure all evidence at the site, to ensure integrity of the evidence, before being assessed by the RN. The Supervisor/manager/delegate to whom the alleged abuse was reported, did not ensure completion of all required documentation/forms (investigation template).

The severity was a level 3 as there was actual harm/risk to one of the residents. The scope was a level 2, a pattern as two out of the three CIR reviewed had non-compliance with s.20(1). The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:
-voluntary pan of correction (VPC) issued January 31, 2017 (2017_598570_0001)
-compliance order (CO) #001 issued June 26, 2018, with a compliance due date of September 27, 2018 (2018_643111_0007. (111)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2019(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

The written request for review must be served personally, by registered mail, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

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 Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

> Directeur
> a/s du coordonnateur/de la coordonnatrice en matière d'appels
> Direction de l'inspection des foyers de soins de longue durée
> Ministère de la Santé et des Soins de longue durée
> 1075, rue Bay, 11e étage
> Toronto ON M5S 2B1
> Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 11st day of March, 2019 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by LYNDA BROWN (111) - (A1)

Service Area Office / Bureau régional de services : Central East Service Area Office