Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 10, 2020	2019_643111_0021 (A1)	008864-19, 011102-19, 013022-19, 014146-19, 016843-19, 017048-19, 018252-19, 018463-19, 019016-19, 019084-19, 019185-19	Critical Incident System

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

Please review the amended Licensee Inspection and Order Report with new Compliance Due Date of March 27, 2020.
thanks
Lynda Brown

Issued on this 10th day of February, 2020 (A1)

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

Original report signed by the inspector.

Ontario

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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 Critical Incident System inspection.

This inspection was conducted on the following date(s): October 7,8, 10, 15-18, 21-23, 2019

The following intakes were completed during this critical incident system inspection:

1. Log #014146-19, 017048-19, 011102-19, 018252-19 and 014146-19 related to falls with an injury.

2. Log #008864-19, 018463-19, 019816-19 and 019857-19 related to alleged staff to resident abuse.

3. Log #016843-19 related to improper transfer.

4. Log #013022-19 and 019185-19 related to bed entrapment.

5. Log #019084-19 related to alleged resident to resident abuse.

A complaint inspection (2019_670571_0015) was completed concurrently during this inspection related to a fall with an injury under Log # 014870-19 and non-compliance was identified in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Resident Care Coordinators (RCC), Administrative Assistant (AA), Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), Social Worker (SW), Manager of Nursing Practice, Behavioural Supports Ontario (BSO), Occupational Therapist (OT), Coordinator of Recreational Therapy, (CRT), Mechanical Maintenance, RAI Coordinator and residents.

During the course of the inspection, the inspector(s) reviewed health care records, observed residents, reviewed bed entrapment tracking records,reviewed the home's investigation records, reviewed employee records, training records, schedules and the following policies: Prevention of Abuse and Neglect, Prevention of Bed Entrapment, Falls Prevention and Management.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

- **11 WN(s)**
- **3 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that resident #001, #002, #003, #004, #005, #006 and #007 were protected from abuse by PSW #101.

Related to resident #001, #002, #003, #004, #005, #006 and #007:

A critical incident report (CIR) was received by the Director on a specified date for

alleged staff to resident abuse towards seven residents (#001, #002, #003, #004, #005, #006 and #007). The CIR indicated the alleged incidents occurred on a specified date and time. There was no after hours call received from the home regarding this incident, despite late reporting. The CIR identified PSW #100 but did not indicate whether this staff member reported the incident or was involved in the incident. The CIR also indicated the investigation was pending and there were no further amendments to the CIR received.

Review of the home's investigation indicated:
- The alleged incidents of staff to resident abuse by PSW #101 towards the seven residents, were actually initially reported by PSW #100 on a specified date to the DOC and the Director was not informed until a number of months later.
- PSW #100 had been reporting to RN #113, witnessing ongoing incidents of abuse by PSW #101 towards seven residents (#001, #002, #003, #004, #005, #006 and #007). PSW #100 alleged that RN #113 had also witnessed incidents of abuse by PSW #101 towards resident #001 and #003. PSW #100 also alleged that Food Service Worker (FSW) #135 had witnessed incidents of staff to resident abuse by PSW #101.
- FSW #135 had reported that they had witnessed PSW #101 being abusive towards resident #001 and #003 in a specified area which upset resident #001. The FSW indicated they could not recall the dates the incidents occurred, almost daily and confirmed they did not report the incidents. The FSW indicated PSW #100, PSW #111 and RPN #123 had also witnessed the incidents.
- PSW #111 reported that PSW #101 was abusive towards resident #001, making the resident upset. PSW #111 confirmed they did not report the incidents.
- RPN #123 reported that PSW #100 had reported to them, that PSW #101 had been abusive towards resident #005 and the resident was upset. The RPN indicated they were unable to recall when the incident occurred, did not document the incident and confirmed they did not report the incident.
- RN #113 reported that they were aware of PSW #100 reporting concerns with PSW #101's treatment of residents and that it was "getting worse". The RN indicated they recalled witnessing resident #005 being upset with PSW #101 and requested PSW #101 not provide their care as a result. The RN was unable to recall when the incidents occurred, did not document the incidents, did not report the incidents at the time they occurred. The RN indicated they had reported "concerns" with PSW #101 to RCC #102 in a specified month.

Review of the progress notes for resident #001, #002, #003, #004, #005, #006 and #007 did not have any documented evidence to indicate the residents were

assessed or provided support, either when the allegations were received or when the incidents occurred, as per the home's Prevention of abuse and neglect policy.

On a specified date, observation and interviews were conducted by Inspector #111, with six of the seven residents involved in the allegations and indicated resident #001 and #002 were not interviewable. Resident #003 and resident #005 both indicated they were unable to recall any incidents involving PSW #101. Resident #004 indicated they had no concerns related to any staff. Resident #006 indicated they had ongoing incidents of staff to resident abuse involving PSW #101, during a specified period and described the abuse. The resident indicated they had reported their concerns to PSW #111 but no one came to speak to them regarding their concerns and had no awareness of the outcome of the investigation. Resident #007 is no longer in the home.

During an interview with PSW #100 by Inspector #111, they indicated they had been reporting their concerns ongoing, of abuse by PSW #101 was towards residents to the RN #113. PSW #100 also indicated RN #113 was aware of ongoing incidents of abuse by PSW #101 towards specific residents, as the RN would reassign care for those specified residents from PSW #101 to PSW #100. The PSW indicated they did not see any actions being taken by RN #113, so they reported their concerns of witnessed, staff to resident abuse by PSW #101 to the DOC on a specified date.

During an interview with PSW #111 by Inspector #111, they indicated they only occasionally worked with PSW #101 and were aware of multiple incidents of staff to resident abuse by PSW #101. The PSW indicated they witnessed PSW #101 be abusive towards resident #001, which would upset the resident. The PSW indicated they witnessed PSW #101 be abusive towards resident #003 and #005. The PSW could not recall the dates and times when the incidents occurred and confirmed they did not report the incidents at the time they occurred until a month later when they reported the abuse in writing to RCC #102. The PSW indicated they were not contacted by anyone regarding their allegations.

During an interview with RN #113 by Inspector #111, they indicated if they witnessed or were notified of an alleged, suspected or witnessed incident of staff to resident abuse, they would immediately intervene, assess the resident and immediately inform their RCC to initiate the investigation and notifications. The RN indicated they would document in the resident’s progress notes to indicate what had occurred, the assessment of the resident and whom they notified. The RN

indicated it was the RCC who would notify the Ministry of Long Term Care (MLTC). The RN confirmed awareness of PSW #100 reporting concerns of abuse by PSW #101 towards residents. The RN indicated they witnessed suspected abuse by PSW #101 towards resident #001 and #003. The RN indicated awareness that RPN #123 had reported allegations of abuse by PSW #101 towards residents and they directed the RPN to report their concerns to RCC #102. The RN was unable to recall when this allegation was received, or which resident was involved. The RN indicated they had reported their allegations of abuse by PSW #101 towards residents to the ESM, during the investigation. The RN confirmed they did not assess the residents or document what had occurred for any of the incidents that they witnessed or were notified of by PSW #100 or RPN #123.

During an interview with the Environmental Services Manager (ESM) by Inspector #111, they indicated they were in the role of Administrative Assistant (AA) during a specified period and confirmed they were involved in the investigation of alleged staff to resident abuse involving PSW #101 towards seven residents. The ESM confirmed they had interviewed RN #113, RPN #123 and FSM #135. The ESM indicated they were not aware that those staff were not identified in the report to the Director.

During an interview with the Resident Care Coordinator (RCC) #102 by Inspector #111, they indicated they first became aware of a concern involving PSW #101, when RPN #123 reported a concern between PSW #100 and PSW #101. The RCC indicated they spoke to PSW #100 and they did not report any allegations of staff to resident abuse involving PSW #101 at that time. The RCC was unable to recall the date and had no documented evidence when this had occurred. The RCC indicated they became aware of the allegations of staff to resident abuse involving PSW #101 after the allegation was reported to the DOC on a specified date. The RCC confirmed they did not notify the SDMs, police or the MLTC when they became aware of the allegations. The RCC also confirmed they did not interview all of the residents or staff who may have been present or aware of the allegations, as per the home’s abuse policy.

During an interview with the DOC by Inspector #111, they indicated they became aware of the staff to resident abuse involving PSW #101 towards seven residents on a specified date. The DOC confirmed the SDMs, police and the MLTC were notified of the allegations approximately two months later. The DOC confirmed they did not inform the SDM's of the results of the investigation.

The licensee failed to ensure that seven residents (#001, #002, #003, #004, #005, #006 and #007) were protected from ongoing abuse by PSW #101 as follows:
-When the licensee's Prevention of Abuse and Neglect policy was not complied with, as there were ongoing incidents of abuse by PSW #101 towards seven residents, that were reported by PSW #100 to RN #113, were not documented in the resident's health records to indicate when the incidents occurred, who was involved and the assessment of the residents; there were no actions taken to ensure the resident's safety when the incidents reoccurred as PSW #101 was not relieved of duty; additional staff (RPN #123, PSW #111 and FSW #135) were also aware of incidents involving PSW #101 towards specified residents and did not report to their immediate supervisor, as per the home's policy, as indicated under LTCHA, 2007, s.20(1) in WN #006.
-When the ongoing, alleged and witnessed incidents of staff to resident abuse by PSW #101 towards seven residents were reported by PSW #100 to the DOC on a specified date, were not immediately investigated, until a number of days later. Appropriate actions were not taken to prevent a recurrence, as the staff member was allowed to continue to provide care to those residents for a number of months, until they were relieved of duty and the results of the investigation were not reported to the Director upon completion of the investigation, as indicated under LTCHA, 2007, s.23(1)(a)(b) and (2) in WN #007.
-When the SDMs of the seven residents involved in the alleged and witnessed incidents of staff to resident abuse by PSW #101 were not made aware of the allegations until a number of months after the allegations were made and the results of the investigation were not reported to the SDMs, as indicated under O.Reg. 79/10, s. 97(1)(a) and (2) in WN #010.
-When the Director was not immediately notified of the alleged staff to resident abuse by PSW #101 towards seven residents until a number of months after the DOC was made aware, as indicated under LTCHA, 2007, s.24(1) in WN #008.
-When the report to the Director did not include a description of the events leading up to the occurrence, the names of all the staff members who were present or aware of the incidents. The report to the Director was not provided within 10 days of receiving the allegation and the report was not amended within 21 days, as to the results of the investigation, as indicated under O.Reg. 79/10, s.104(1)1, 2, (2) and (3) in WN #012.

2. The licensee has failed to ensure that resident #008 was protected from abuse by PSW #149.

Related to resident #008:

During the review of the progress notes for resident #008 for an unrelated critical incident report (CIR), there was a documented incident by RN #147 on a specified date, of an alleged staff to resident abuse. The RN documented the resident was upset regarding the incident and wanted the incident investigated. The RN indicated the allegation was reported to RCC #144. There was no documented evidence the SDM or the Director were notified.

During an interview with resident #008 by Inspector #111, they indicated a PSW on a specified shift, was asked for assistance due to physical limitations and the PSW was then abusive towards them and was witnessed by another PSW. The resident indicated they were not happy about the incident and was unable to recall the date and time the incident occurred, which PSW was involved or which PSW witnessed the incident. The resident indicated a manager came to speak to them about what they reported at a later date and time, but was unable to recall who the manager was and the date they spoke to them. The resident indicated the PSW involved in the incident continued to provide their care. The resident indicated their SDM was not informed of the incident and both the resident or the SDM were never notified of the results of the investigation.

During an interview with RN #147 by Inspector #111, they confirmed they received a complaint from resident #008 alleging staff to resident abuse. The RN indicated PSW #149 was the staff member directly involved in the allegation. The RN indicated the resident informed them that the incident had actually occurred a number of days before they reported the incident and confirmed the resident reported the incident was witnessed by another staff member. The RN confirmed they did not inform the resident's SDM or the Director. The RN indicated they had immediately reported the allegation to RCC #144 and assumed the RCC would be completing those tasks.

Review of the home's investigation indicated the incident actually occurred a number of days before the allegation was reported to RN #147. The investigated was initiated by RCC #144 a number of weeks after the allegation was reported to the RCC by the RN. The investigation confirmed that PSW #149 was directly involved in the allegation and PSW #149 confirmed another PSW would have been present while they were providing care. The investigation was concluded over a month later and there was no documented evidence to indicate any other staff members or the resident was interviewed. There was no indication which

PSW may have witnessed the incident. The investigation did not indicate whether the allegation was reported to the SDM or the Director. The investigation did not indicate whether the results of the investigation were provided to the resident, the resident's SDM or the Director.

The Inspector was unable to interview PSW #149 or RCC #144.

During an interview with the DOC by Inspector #111, they indicated RCC #144 was currently off on leave. The DOC indicated that they were aware of the complaint from resident #008, alleging staff to resident abuse by PSW #149 and RCC #144 was responsible for completing the investigation. The DOC confirmed the investigation was not immediately investigated, there was no documented evidence of an investigation, that PSW #149 who was directly involved in the allegation was allowed to continue to provide care to resident #008, there was no documented evidence the SDM or the Director was notified of the allegation and no documented evidence the resident, the resident's SDM or the Director were made aware or the results of the investigation. The DOC confirmed they became aware of the results of the investigation a number of weeks later, and RCC #144 concluded the investigation was determined to be unfounded, despite no documented investigation. The DOC was unable to indicate which PSW witnessed the incident. The DOC confirmed the resident was not made aware of the results of the investigation, confirmed the resident's SDM and the Director were never informed of the allegation or the results of the investigation and that the investigation should have been documented to indicate when the investigation occurred and which staff were involved.

The licensee failed to ensure that resident #008 was protected from emotional abuse by PSW #149 as follows:
-When the licensee's Prevention of Abuse and Neglect policy was not complied with, as an alleged staff to resident emotional abuse that occurred on a specified date, that was witnessed by another unidentified PSW, was not immediately reported by that staff member and the investigation was not documented, as per the home's policy, as indicated under LTCHA, 2007, s.20(1) in WN #006.
-When the alleged staff to resident emotional abuse incident was reported on a specified date, to RCC #144, the investigation was not immediately initiated, until approximately a number of weeks later and appropriate actions were not taken to prevent a recurrence, as PSW #149 continued to provide care to resident #008; the results of the investigation were not reported to the Director upon completion, when the investigation results were determined on October 8, 2019 as unfounded,

as indicated under LTCHA, 2007, s.23(1)(a)(b) and (2) in WN #007.
-When the SDM of resident #008 was not made aware of the allegation of staff to resident emotional abuse or the results of the investigation, upon the conclusion, as indicated under O.Reg. 79/10, s.97(1)(a) and (2) in WN #010.
-When the Director was not immediately notified of the alleged staff to resident abuse by PSW #149 towards resident #008, as indicated under LTCHA, 2007, s.24(1) in WN #008.

3. The licensee has failed to ensure that resident #010, #011 and #012 were protected from neglect by PSW #107.

Related to resident #010, #011 and #012:

A critical incident inspection (CIR) was submitted to the Director on a specified date, for an alleged staff to resident neglect incident. The CIR indicated on a specified date and time, PSW #104 and #105 suspected PSW #107 failed to provide care to three residents (resident #010, #011 and #012). The CIR indicated the allegation was not reported to the RCC #106 until a number of days later.

Observation of resident #010, #011 and #012 on a specified date, by Inspector #111, indicated all three residents resided on a specified unit. Resident #010 was confined to a mobility aid,was incontinent and not interviewable. Resident #011 was confined to a mobility aid, was incontinent and not interviewable. Resident #012 was walking independently, was continent but unable to recall any previous incidents of care not provided.

Review of the written plan of care for resident #010, indicated the resident required extensive assistance by two staff for toileting, dressing and bathing. The resident was also incontinent.

Review of the written plan of care for resident #011, indicated the resident required assistance of two staff with mobility, toileting and was frequently incontinent.

Review of the written plan of care for resident #012, indicated the resident required verbal cues or minimal physical assistance with toileting and required staff assistance with dressing.

Review of the home's investigation indicated the allegation of staff to resident

neglect involved PSW #107 who was suspected of neglecting to provide care (toileting, bathing and dressing) to three residents (resident #010, #011 and #012) on a specified date and time. The allegation was immediately reported by PSW #103 and #104 to RCC #106 at that time. The investigation was not initiated or reported to the Director by RCC #106, until a number of days later.The Investigation concluded the allegation was determined to be founded.

During an interview with RCC #106 by Inspector #111, they confirmed they were informed of the allegation of staff to resident neglect towards three residents when the incident was discovered. RCC confirmed they did not initiate the investigation or inform the SDM's and the Director until a number of days later.

During an interview with the DOC by Inspector #111, they confirmed the alleged staff to resident neglect involving three residents (#010, #011 and #012) by PSW #107 was reported by PSW #103 on a specified date, to RCC #106. The DOC confirmed the investigation was not initiated until a number of days later and was determined to be founded, as the three residents were not provided care according to their plan of care. The DOC confirmed awareness that the allegation was not reported to the SDMs or the Director until a number of days later.

The licensee failed to ensure that three residents (#010, #011 and #012) were protected from neglect by PSW #107 as follows:
-When the plan of care was not provided to resident #010, #011 and #012 related to toileting, dressing, bathing or continence care on a specified date, resulting in neglect of care, as indicated under LTCHA, 2007, s.6(7) in WN #003.
-When the alleged neglect of care that was immediately reported immediately by PSW #103 to RCC #106 on a specified date and time, the allegation was not immediately investigated until a number of days later, as indicated under LTCHA, 2007, s.23(1)(a) in WN #007.
-When the SDMs of the three residents involved in the alleged staff to resident neglect by PSW #103, were not made aware of the allegations until a number of days after the allegations were made, as indicated under O.Reg. 79/10, s. 97(1)(a) in WN #010.
-When the Director was not immediately notified of the alleged staff to resident abuse by PSW #101 towards seven residents, until a number of months after the DOC was made aware, as indicated under LTCHA, 2007, s.24(1) in WN #008. [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 / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that, where bed rails were used, that the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

The Director provided the following guidance memorandum to the sector, on March 27, 2019, that read:

MOHLTC sent a memo to licensees in 2012 advising them to use the Health Canada Guideline (HCG) “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008” as a guiding best practice document to deal with the risk of bed entrapment and the evaluation of bed systems. Listed below are two very important companion guides referenced throughout the HCG. They outline prevailing practices related to assessing residents and to modifying bed systems—inspectors use these two guides, along with the HCG to determine overall compliance with s. 15(1) of O Reg 79/10.
- Clinical Guidance for the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings, April 2003
- A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment June 21, 2006

Prior to this memo, on August 21, 2012, a notice was issued to the Long-Term Care Home (LTC) Administrators from the Director of the Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, identifying a document produced by Health Canada entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was expected to be used as the best practice document in LTC Homes and provided clear procedures and dimensional criteria with respect to evaluating bed systems using a cone and cylinder tool. The Health Canada Guidance (HCG) document also included a companion guide developed by the Food and Drug Administration (FDA) in the United States entitled "Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006". The guide included information with respect to various options and corrective strategies available to mitigate entrapment zones; a guide to buying beds; how to inventory bed systems, and reviewed the dimensional criteria of bed systems. The documents were considered prevailing practices, which were predominant, generally accepted widespread practice as the basis for clinical decisions with respect to bed safety.

A review of the home's policy, "prevention of Bed Entrapment – ADM-01-03-07” revised June 26, 2017, identified the following:
-All mattresses and the seven zones of the beds used for residents in the home will be tested annually, at admission or if a resident condition changes that warrants an alternate surface to ensure they safe using Health Canada Guidelines.
-Bed rails should only be used after all discussions between the resident and or Substitute Decisions Maker (SDM) and the appropriate procedure followed for

either a PASD or Restraint depending on purpose of the rail.

Related to resident #015:

A Critical Incident Report (CIR) was submitted to the Director on a specified date, which identified a bed entrapment incident that occurred on a specified date and time. The report further indicated the resident sustained an injury to a specified area and reported pain to a specified area.

Review of clinical records for resident #015 indicated the resident received a specified mattress, on a specified date. The record review did not indicate that the resident was assessed and their bed system was re-evaluated for entrapment risks when the new mattress was put in place.

The residents bed was observed at the time of inspection by Inspector #570 and no bed rails were attached to the bed frame. According to bed entrapment tracking records obtained from the Environmental Service Manager (ESM), the resident's bed was tested for entrapment zones with a specified mattress and with two bed rails in place, on a specified date and zone seven was highlighted as passed. The record did not indicate that other zones were tested. The bed entrapment tracking records indicated that the resident’s bed was tested after the assist rails were removed and the mattress was replaced, on a specified date and all zones passed.

A review of the plan of care for resident #015 (at time of entrapment incident), did not indicate that bed rails were used for the resident. The plan of care indicated the resident had a previous incident where the resident raised the head of the bed to 90 degrees and rolled over their quarter bed rail, falling onto a fall mat on the floor.

A review of the home’s investigation related to this incident indicated the investigation was completed by Resident Care Coordinator (RCC) #106, who noted that resident #015 was inappropriately provided with bed rails with no history of consent, physician order, or care planning regarding the use of the bed rails. The home’s investigation concluded that resident #015 was fitted with a specialty air mattress that did not pass standardized entrapment testing with the use of bed rails.

Separate interviews were conducted by Inspector #570 with PSWs #127 and

#128. Both PSWs indicated that resident #015 used to have two bed rails for safety and bed mobility and were removed after the incident (CIR) that occurred on a specified date.

Separate interviews were conducted by Inspector #570 with RPN #124 and RN #149. Both the RPN and RN indicated that resident #015 used to have a specialized air mattress and two bed rails on their bed, until they were removed due to the incident that occurred on a specified date (CIR). Both RPN #124 and RN #149 indicated that they have not assessed the risk of entrapment for resident #015 and they were not aware of any bed system evaluation completed for the resident, specifically when the resident received a specialized air mattress, on a specified date.

During an interview with staff #126 by Inspector #570, the coordinator of recreation and therapy at the home, they indicated they assisted RCC #117 with bed rail program, ensuring that the resident had been assessed and had the equipment they needed. Staff #126 further indicated that the environmental team was responsible in completing bed systems evaluations for risk of entrapment when a surface was changed, if bed rail changed in any way, or with any changes to the bed frame. Staff #126 indicated no awareness when resident #015's bed system was assessed for entrapment as it would fail zone #3 when the bed rails were used with low air loss mattress in place. The coordinator of recreation and therapy indicated that the environmental staff should have all records for completed bed entrapment testing.

During an interview with Environmental Service Manager (ESM) by Inspector #570, they indicated that they had no records that resident #015's bed had been evaluated when the resident received a specified mattress, on a specified date. They added, the bed system was evaluated for resident #015 the following year, as per the bed entrapment tracking sheet. The ESM acknowledged that the bed system was evaluated for resident #015 on a specified date, with the specified therapeutic mattress and two bed rails were in place and that evaluation indicated zone 7 passed. The ESM indicated that no other zones were highlighted as passed and that should have been communicated to the nursing staff and to maintenance supervisors. The ESM indicated that the entrapment zones were tested after the bed rails were removed and the therapeutic mattress was replaced as a result of the incident that occurred a specified date (CIR).

During an interview with Resident Care Coordinator (RCC) #106, they indicated

that the bed rails were improperly matched with a therapeutic mattress on a specified date, for resident #015 as the use of specialty mattress do not pass all entrapment zones, when used with bed rails. The RCC further indicated no awareness that the resident's bed system was evaluated for entrapment risk, as it was the responsibility of the environmental services department. Upon review of the bed entrapment tracking records with the RCC, the RCC indicated the assessment completed on a specified date, for resident #015 indicated that only zone 7 passed and had no information on whether the other zones were tested. The RCC further indicated that all the zones should have been tested.

During an interview with RCC #117, they indicated when bed rails are used in combination with a therapeutic mattress, the bed system assessment will not pass all zones of entrapment and there will be a risk in zone 3.

During an interview with the Director of Care (DOC), they indicated that the home's expectation was that the environmental services department should be doing bed system evaluations for entrapment zones, with any change of mattress, bed rails or changes to the bed frame itself.

The license therefore did not ensure that resident #015 who used bed rails and a therapeutic mattress, was assessed in accordance with prevailing practices to minimize risk to the resident.

2. Related to resident #016:

A Critical Incident Report (CIR) report was submitted to the Director on a specified date, which identified a bed entrapment incident that occurred on a specified date and time. The CIR indicated a specified area of resident #016 was caught in the bed rail. The bed rail was removed and the resident was sent to hospital for assessment. The report further indicated that the resident returned to the home on a specified date with injuries to a specified area.

A review of the clinical records for resident #016, indicated the resident was assessed for a therapeutic mattress on a specified date in 2017. The record review did not indicate that the resident's bed system was re-evaluated for entrapment risks after that date.

Resident #016's bed was observed at the time of inspection and no bed rails were in place. The resident had a specified bed with specified falls prevention

intervention in place. The resident was also using a therapeutic loss mattress. According to bed entrapment tracking records obtained from the ESM, the resident's bed was tested for entrapment zones with a regular mattress and bed rails on a specified date, a number of months before the incident occurred. The record review did not indicate that resident #016's bed system was re-evaluated when resident received a therapeutic mattress and two bed rails. The bed entrapment tracking records indicated that the resident's bed system was re-evaluated for entrapment zones with the therapeutic mattress in place and with no rails on a specified date, after the bed entrapment incident.

A review of plan of care for resident #016, in place at time of incident, did not indicate that the resident used any bed rails or had a therapeutic mattress in place. The plan of care was not updated until a specified date and indicated under bed mobility, bed rails on both sides of bed for bed mobility and repositioning in bed.

A review of the home's investigation related to this incident was conducted and indicated the investigation was completed by RCC #102. They noted that resident #015 was using a therapeutic mattress and had bed rails. The resident and their SDM were made aware of the potential danger of entrapment, that it was not recommended to have bed rails and both the resident and SDM agreed to the risks. On a specified date and time, a specified area of the resident, became entrapped between the mattress and the bed rail and had to be sent to hospital for an assessment. The resident returned the later the same day and agreed to have the bed rails removed.

During an interview with RPN #129 by Inspector #570, they indicated that resident #016 used to have two half bed rails for safety and bed mobility. The resident had a therapeutic mattress for a number of years. RPN #129 indicated bed system evaluations for risk of entrapment was completed by the Occupational Therapist (OT) or maintenance. The RPN indicated no awareness if resident #016's bed system was re-evaluated for risks of entrapment when they received a therapeutic mattress.

During an interview with staff #126 (coordinator of recreation and therapy) by Inspector #570, they indicated that resident #016's became entrapped in the bed rail and the risks of entrapment had been explained to the resident before the incident, but the resident wanted to continue using the bed rails. They indicated the resident only agreed to remove the bed rails after the bed entrapment incident

occurred. Staff #126 further indicated that environmental staff should have documentation of the bed entrapment assessment completed for resident #016, the bed system for resident #016 would have failed the entrapment testing when the bed rails and therapeutic mattress were used. Staff #126 indicated that if a bed system assessment failed entrapment zones, adjustments had to be made, either by finding a new mattress or removing the bed rails.

During an interview with the ESM by Inspector #570, they indicated that resident #016's bed system was evaluated on a specified date (after the bed entrapment incident) and no bed systems evaluations could be located for the resident when the resident previously had the therapeutic mattress and the bed rails in use.

During an interview with RCC #102 by Inspector #570, they indicated that resident #016 always had the bed rails and used low air loss mattress due to skin integrity concerns and for comfort due to their palliative status. The RCC further indicated no awareness if resident #016 bed system was evaluated for risks of entrapment when they received a low air loss mattress.

During an interview with the DOC by Inspector #570, they indicated that the home’s expectation that environmental services department should be doing bed system evaluations for entrapment zones with any change of mattress, rails and any change to the bed it self.

The license did not ensure that resident #016 who used bed rails, was assessed in accordance with prevailing practices to minimize risk to the resident.

3. Related to resident #031:

Resident #031’s bed was observed by Inspector #570 at the time of inspection. The resident used a hi-low bed equipped with two bed rails. The resident was not using a therapeutic mattress at the time of observation. According to bed entrapment tracking records obtained from the ESM, the resident's bed was tested for entrapment zones with a different specified mattress and two bed rails on a specified date, after the incident occurred. The record review did not indicate that resident #031’s bed system was evaluated when resident had a therapeutic mattress in place with two bed rails.

A review of progress notes for resident #031 indicated the resident's bed rails were removed from the bed on a specified date, as per safety precautions while in

use with specialty mattress.

A review of plan of care for resident #031 dated June 24, 2019, did not indicate that grab assist bars were used for the resident until the care plan was updated on July 7, 2019, indicating: allow resident to attempt movements by self before offering assistance. Resident will continue to use both assist bar rails as PASD for bed mobility. The review did not indicate that a bed system evaluation was completed when the mattress was replaced and assist rails were reinstalled.

During separate interviews with PSW #128 and RN #031, they indicated that resident #031 always had assist rails used for bed mobility.

During an interview with RPN #124, they indicated that resident #031 was using two assist rails for bed mobility and that the rails were removed on July 6, 2019, and the resident fell out of bed that day. The resided had specialty mattress that was removed, and the assist rails were reinstalled on July 7, 2019.

During an interview with RCC #106, they indicated that it was the responsibility of the environmental services department to complete bed system evaluations for entrapment zones; and indicated no awareness when resident #031 received a specialty mattress and no awareness if their bed system was evaluated when they received the specialty mattress. The RCC further indicated that upon discovery of resident #015's entrapment incident, the home took action to review every use of bed rail and specialty mattress in the home.

During an interview with the ESM, they indicated that resident #031's bed system was evaluated on a specified date (after the incident occurred) and no other bed systems evaluations could be found for the resident.

During an interview with the DOC, they indicated that the home's expectation that environmental services department should be doing bed system evaluations for entrapment zones with any change of mattress, rails and any change to the bed it self.

The license therefore did not ensure that resident #031 who used bed rails, was assessed in accordance with prevailing practices to minimize risk to the resident.

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee failed to ensure that resident's written plan of care set out the planned care for the resident.

Related to resident #013:

A Critical Incident Report (CIR) was submitted to the Director on a specified date for a fall that resulted in an injury to resident #013. The CIR indicated the fall occurred on a specified date, the resident was transferred to hospital for further assessment and diagnosed with an injury to a specified area.

During an initial observation of resident #013 on a specified date by Inspector #672, the resident was observed with an alarming device attached to the resident bed.

During separate interviews, PSWs #110 and #137 and RPN #132 all indicated that following the fall sustained on a specified date, resident #013 had an alarming device implemented as a fall prevention intervention. The alarming device was supposed to be attached to the resident when the resident was in bed, with the alarm positioned on the resident’s headboard. The personal magnetic alarm had been implemented due to resident #013’s history of sustaining ten falls within the quarter due to the resident frequently attempting to self transfer and mobilize independently.

Inspector #672 completed multiple follow up observations of resident #013 on various dates. Each time Inspector #672 observed resident #013, they were positioned in their bed, with the alarming device attached to the headboard.

During record review, Inspector #672 observed that prior to the fall on a specified date, the written plan of care stated resident #013 required supervision with walking and used a specified mobility aid, and used a different mobility aid for longer distances, was at risk for falls, and had sustained a number of falls within the quarter prior to the specified date. Resident #013 had falls prevention interventions in place, which did not include the use of an alarming device. Following the fall sustained on the specified date, the written plan of care dated after the fall, indicated resident #013 continued to be at an identified risk for falls, but the falls prevention interventions in place had not been revised and did not include the use of an alarming device.

During separate interviews, RPN #132 and RCC #117 indicated the expectation in the home was for every resident's plan of care to be immediately updated when an intervention was implemented, revised in any way or discontinued. RPN #132 and RCC #117 further indicated that when a resident utilizes an alarming device for any purpose, the alarming device should be listed within the resident's plan of care.

The licensee failed to ensure that resident #013's written plan of care set out the planned care for the resident, when it did not include the alarm device which was implemented for fall prevention purposes following the fall and injury sustained on a specified date.

2. Related to resident #015:

A Critical Incident Report (CIR) was submitted to the Director on a specified date, which identified a bed entrapment incident that occurred on a specified date and time. The resident sustained an injury and pain to a specified area.

On a specified date and time, resident #015 was observed in sitting in a mobility aid in their room; there was no bed rails in place on the bed and the resident had a specified mattress in place.

A review of the plan of care for resident #015, in place at the time the incident occurred, did not indicate that bed rails were in place.

During separate interviews with PSW #127 and #128, they both indicated that resident #015 used to have two bed rails in place on their bed for safety and indicated the bed rails were removed.

An interview was conducted with RPN #124 and they indicated that resident #015 used to have half bed rails in place on both side of the bed and installed at the head of bed. The RPN indicated the resident used the bed rails for bed mobility. The RPN indicated that the bed rails were removed due to the entrapment incident. The RPN confirmed the plan of care that was in place at the time of the incident did not include the use of bed rails and should have.

An interview was conducted with RN #146 and they indicated that resident #015 used to have partial bed rails and used them for repositioning in bed. Upon review of resident #015 care plan in place at the time of the incident, the RN

acknowledged that the care plan did not include the use of the bed rails and that they should be included in the care plan.

An interview was conducted with RCC #106 and they acknowledged upon review of resident #015's care plan in place at the time of the incident, that the care plan did not include the use of the bed rails and that they should be included.

An interview was conducted with the DOC and they indicated that bed rails to be used for bed mobility and transfer. The DOC indicated that the expectation is that when bed rails are used, they should be included in the care plan.

The licensee did not ensure that the written care plan for resident #015 set out the planned care for the resident, specific to the use of the two bed rails.

3. Related to resident #016:

A Critical Incident Report (CIR) was submitted to the Director on a specified date for a bed entrapment incident that occurred on a specified date and time. The CIR indicated resident #016 sustained an injury to a specified area and pain as a result and was transferred to the hospital for an assessment.

A review of the plan of care for resident #016 in place at the time of the entrapment incident, did not indicate that the resident used any bed rails.

An observation of resident #016's room and bed system, indicated the resident had a therapeutic mattress in place.

An interview was conducted with resident #016 and they indicated they previously had two bed rails in place to assist in bed mobility but the bed rails were removed after they had a fall from bed.

An interview was conducted with PSW #131 indicated that resident #016 used to have two half bed rails for bed mobility and the bed rails were removed. The PSW confirmed that the resident always had two bed rails in place.

An interview was conducted with RPN #129 indicated that resident #016 used to have two half rails for safety and bed mobility. The RPN indicated the rails were removed after the entrapment incident that occurred on a specified date. Upon review of resident #016's care plan, the RPN confirmed that the half bed rails

were not included in the written care plan.

An interview was conducted with RN #130 and indicated that resident #016 used to have two half bed rails used for bed mobility until the rails were removed after the entrapment incident that occurred on a specified date. Upon review of written care plan for resident #016, the RN acknowledged that the use of bed rails was not included in the care plan.

An interview was conducted with RCC #102 who acknowledged upon review of resident #016's written care plan, it did not include the use of bed rails and should have been.

An interview was conducted with DOC and indicated that bed rails used at the home are not considered restraints, and for the purpose of bed mobility and transfer. The DOC indicated that the expectation is that when bed rails are used, they should be included in written plan of care.

The licensee did not ensure that the written care plan for resident #016 set out the planned care for the resident, specific to the use of bed rails.

4. Related to resident #031:

Resident #031 room observation revealed the resident had two bed rails in place.

A review of the written care plan for resident #031, did not indicate that bed rails were used for the resident until a specified date, when the plan was updated to indicate the resident will continue to use both bed rails as PASD for bed mobility.

An interview was conducted with PSW #128 indicated that resident #031 always had bed rails for bed mobility.

An interview was conducted with RN #146 who indicated that resident #031was using two bed rails for bed mobility. Upon review of the written care plan for resident #031, the RN acknowledged that the care plan did not include the use of bed rails for the resident.

An interview was conducted with RCC #106 who acknowledged upon review of resident #031's written care plan, that the written care plan did not include the use

of two bed rails for resident #031. The RCC indicated that written care plan should have included the use of bed rails.

An interview was conducted with the DOC and they indicated that bed rails used at the home are not considered restraints as the purpose is to be used for bed mobility and transfer. The DOC indicated that the expectation is that when bed rails are used, they should be included in the care plan.

The licensee did not ensure that the written care plan for resident #031 set out the planned care for the resident, specific to the use of the two bed rails.

5. The licensee has failed to ensure that resident #026's care was provided to the resident as set out in the resident's plan of care.

Related to resident #026:

A Critical Incident Report (CIR) was submitted to the Director on a specified date for a fall sustained by resident #026 on a specified date. The CIR indicated that following the fall the resident denied any pain or injury. The following day, the resident complained of pain to a specified area and was transferred to hospital for assessment. The resident was diagnosed with an injury to a specified area.

During record review, Inspector #672 observed that prior to the fall that occurred on a specified date, when the resident sustained an injury to a specified area, the resident was independent with their mobility with the use of a mobility aid. The resident was also demonstrated a responsive behaviour and required the use of an alarming device for safety and was to be applied to a specified area.

Inspector #672 observed resident #026 several times on specified dates and observed that the resident did not have an alarming device in place.

During separate interviews, PSW #150 and RPN #152 indicated that after resident #026 sustained an injury to a specified area from a fall for which the resident was transferred to hospital. PSW #150 and RPN #152 further indicated that after resident #026 returned from the hospital, their mobility status had changed and the resident no longer required the alarming device. RPN #152 indicated they could not recall when resident #026's alarming device had been discontinued and the written plan of care should have been updated to remove the intervention.

During separate interviews, RCC #117 and the DOC indicated the expectation in the home was for every resident to receive the care as outlined within the resident's plan of care. RCC #117 and the DOC further indicated that when interventions were no longer effective or implemented for the resident, the plan of care should be reviewed by the registered staff, with revisions made as required, to ensure each resident received the care as outlined in the plan.

The licensee failed to ensure that resident #026's plan of care was provided to the resident as specified in the plan related to the use of an alarming device.

6. Related to resident #010, #011 and #012:

A critical incident inspection (CIR) was submitted to the Director on a specified date, for an alleged staff to resident neglect incident. The CIR indicated on a specified date and time, PSW #104 suspected PSW #107 failed to provide care to three residents (resident #010, #011 and #012). The CIR indicated the incident was reported to RCC #106 a number of days later.

Review of the written plan of care for resident #010 (in place at time of incident) indicated the resident required extensive assistance by two staff for all personal care, toileting, bathing needs and was incontinent.

Observation of resident #010 on a specified date, by Inspector #111, indicated the resident was confined to a mobility aid, was incontinent and was not interviewable.

Review of the written plan of care for resident #011 (in place at time of incident) indicated the resident required two staff assistance with toileting and was incontinent.

Observation of resident #011 on a specified date, by Inspector #111, indicated the resident was confined to a mobility aid, was incontinent and was not interviewable.

Review of the written plan of care for resident #012 (in place at time of incident) indicated the resident required minimal assistance with toileted but total assistance with dressing with one staff member.

Observation of resident #012 on a specified date, by Inspector #111, indicated the resident was independently mobile and was continent. The resident was not able to recall the incident due to memory impairment.

During an interview with PSW #119 by Inspector #111, they indicated resident #010, #011 both required total care with assistance of two staff for all personal care. The PSW indicated both residents' were also incontinent but were toileted with assistance of two staff. The PSW indicated resident #012 was independently mobile but required one staff assistance with dressing and direction with toileting.

During an interview with RCC #106 by Inspector #111, they indicated they were first notified of the allegation of staff to resident neglect on a specified date and time, by PSW #103 of an alleged staff to resident neglect that was discovered a number of days earlier and witnessed by PSW #104, when resident #010, #011 and #012 appeared to not have received personal care as per their plan of care. The RCC indicated that the care was documented as provided by PSW #107.

The inspector was unable to interview PSW #103, #104 and #107.

During an interview with the DOC by Inspector #111, they indicated the outcome of the investigation confirmed the allegation was determined to be founded as the three residents (#010, #011 and #012) were not provided care according to their plan of care by PSW #107.

The licensee failed to ensure that the care set out in the plan of care for resident #010, #011 and #012, was provided to the resident's as specified in the plan related to dressing, bathing and continence care.

7. The licensee has failed to ensure that when resident #013 was reassessed and the plan of care was revised when care set out in the plan had not been effective, that different approaches were considered in the revision of the plan of care.

Related to resident #013:

A Critical Incident Report (CIR) was submitted to the Director on a specified date, related to a fall sustained by resident #013 on a specified date and time. The CIR stated that following the fall, the resident was transferred to hospital for further assessment and sustained an injury to a specified area.

During a review of the written plan of care (for a specified date) by Inspector #672, stated resident #013 required supervision while utilizing a mobility aid, was at a specified risk level for falls and had sustained a number of falls within the quarter. Resident #013 had a number of falls prevention interventions identified.

During review of resident #013's progress notes during a specified period, Inspector #672 noted that resident #013 had sustained a number of falls during that time period. Inspector #672 then reviewed resident #013's "Incident Reports and Post Fall Huddle" assessments completed during the same period and noted each of the post fall incident reports indicated the resident's care plan had been reviewed but new interventions and fall strategies were not implemented, as the resident had current fall prevention strategies in place. Each post fall incident report included a number of strategies for resident #013, to reduce the risk of another fall from occurring.Each Post fall incident report also identified specified contributing causes of the falls.

Inspector #672 reviewed resident #013's written plan of care following each fall sustained during a specified period and noted that the fall prevention interventions were not revised with the recommendations from the post fall huddles following any of the falls sustained during that time period.

During an interview, RPN #132 indicated the expectation in the home was for every resident's plan of care to be reviewed following every fall sustained but revisions were only required if there was an injury or a significant change for the resident. RPN #132 further indicated the expectation in the home was if a resident sustained more than a specified number of falls with a three month period without injury, the interventions were required to be revised as they had not been effective in preventing the resident from falling. RPN #132 indicated the specified fall prevention interventions in place for resident #013, were not effective interventions for the resident.

During an interview, RCC #117 indicated the expectation in the home was for every resident's plan of care to be reviewed following every fall sustained, with revisions only required when interventions were implemented, discontinued or changed. RCC #117 further indicated that revisions to fall prevention interventions were required when a resident sustained an injury from a fall, a significant change to the resident's status occurred and when an intervention was found to be ineffective. RCC #117 indicated fall prevention interventions would not be considered effective if a resident was sustaining multiple falls, with or without

injury. RCC #117 indicated the specified fall prevention interventions for resident #013 were not effective interventions for preventing the resident from falling. RCC #117 further indicated that resident #013's fall prevention interventions should have been revised prior to the fall sustained on a specified date, due to the number of falls the resident had sustained during a specified period.

During an interview, the DOC indicated the expectation in the home was for every resident's plan of care to be reviewed following every fall sustained, with revisions only required when interventions were implemented, discontinued or changed. The DOC further indicated that resident #013's fall prevention interventions should have been revised during a specified period, due to the number of falls resident #013 had sustained.

The licensee failed to ensure that when resident #013 was reassessed and the plan of care was revised when care set out in the plan had not been effective, that different approaches were considered in the revision of the plan of care, when resident #013 sustained a number of falls during a specified period.

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 plan of care sets out clear directions to staff and others who provide direct care to resident #013, #015, #16, #031 and any other resident, related to pain, use of personal alarming devices, use of bed rails as a PASD; to ensure that the care set out in the plan of care, is provided to resident #026 related to use of a Wanderguard, is provided to resident #010, #011 and #012, and any other resident, as specified in the plan, related to dressing, bathing and continence care; to ensure that when resident #026, and any other resident, is reassessed and the plan of care is revised, when care set out in the plan has not been effective, that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

The licensee has failed to ensure that consent had been provided prior to the usage of tilt wheelchairs for PASD purposes, related to residents #026, #032 and #033.

Related to resident #026:

A Critical Incident Report (CIR) was submitted to the Director on a specified date, for a fall that resulted in an injury to resident #026 for which the resident was transferred to hospital. The CIR indicated the fall occurred on a specified date and

time, but the resident did not have any injuries or pain at the time of the fall, until the following day, when the resident began to complain of pain to a specified area. A number of days later, the resident was transferred to the hospital for further assessment and was admitted to hospital with an injury to a specified area. The resident returned to the home a number of days later.

Inspector #672 observed resident #026 on two identified dates at varied times, seated in a specified mobility aid, that was in a tilted position. The Inspector also noted that the resident was dependent on staff for transfer and mobility needs.

During record review, Inspector #672 observed that in the written plan of care (in place following the fall) and MDS assessment, indicated resident #026 required total assistance from two staff members for all transfer and mobility. The written plan of care further indicated that resident #026 had specific repositioning precautions in place upon return from hospital.

During separate interviews by Inspector #672, PSW #150 and RPN #152 indicated that after resident #026 returned from the hospital, they required the use of a mobility aid and staff assistance with the mobility aid for locomotion/repositioning. Both staff members indicated resident #026 utilized the tilt function of the mobility aid for PASD purposes. PSW #150 indicated resident #026 had moments where they continued to believe they were more physically capable than they were, and would attempt to reposition themselves and mobilize, therefore the tilt function was utilized in an attempt to keep the resident safely seated in the mobility aid. PSW #150 and RPN #152 indicated resident #026's wheelchair was also tilted for comfort purposes. RPN #152 indicated consent had not been received from resident #026's SDM to utilize the tilt function as a PASD, as they were not aware that consent was required.

Inspector #672 then expanded the scope of assessment to include two other residents in the home who utilized tilt mobility aids for PASD purposes, to assess if consent had been received prior to staff utilizing the tilt function. PSW #153 reported to Inspector #672 that resident #032 utilized a tilt mobility aid for PASD purposes. RPN #152 reported to Inspector #672 that resident #033 also utilized a tilt mobility aid for PASD purposes.

Related to resident #032:

Inspector #672 observed resident #032 on a specified date, during a specified

period and a specified area, noted the resident was seated in a tilted position, in a tilt mobility aid and with the use of an alarming device in place.

During record review, Inspector #672 observed that resident #032 required total assistance from two staff members for most activities of daily living and was dependent in a tilt mobility aid for mobility purposes. Inspector #672 reviewed resident #032's entire health care record and there was no documented record of any approval related to the use of a tilt mobility aid for PASD purposes. There was also no documented record of any informed consent from the SDM of resident #032 related to the usage of the tilt mobility aid for PASD purposes, that was in use.

During separate interviews by Inspector #672, PSWs #153, #154 and RPN #151 all indicated that resident #032 was at risk for falls, had several interventions in place to prevent falls, which included the use of tilting the resident in the mobility aid at all times, outside of meals. PSWs #153 and #154 further indicated that resident #032 utilized the tilt function of the mobility aid for PASD purposes. RPN #151 indicated the expectation in the home was for consent to be received from the resident and/or the resident's SDM prior to the usage of a PASD, but was unaware if consent had been received from resident #032's SDM to utilize the tilt mobility aid. RPN #151 confirmed they could not locate any informed consent from resident #032's SDM in the resident's health record, related to the use of the tilt mobility aid being utilized for PASD purposes.

Related to resident #033:

Inspector #672 observed resident #033 on a specified date, during a specified period and a specified area, noted the resident was seated in a tilted position, in a tilt mobility aid.

During record review, Inspector #672 observed that resident #033 required total assistance from two staff members for most activities of daily living, and was dependent in a tilt mobility aid for mobility purposes. Inspector #672 reviewed resident #033's entire health care record and there was no documented record of any approval related to the use of a tilt mobility aid for PASD purposes. There was also no documented record of any informed consent from the SDM of resident #033 related to the usage of the tilt mobility aid for PASD purposes, that was in use.

During separate interviews, PSW #150 and RPN #152 indicated that resident #033 utilized the tilt mobility aid for PASD purposes. PSW #150 and RPN #152 further indicated that resident #033 would frequently attempt to climb from the mobility aid, therefore was also tilted for positioning purposes, in an attempt to keep the resident comfortable and seated in the mobility aid. RPN #152 indicated consent had not been received from resident #033's SDM to utilize the tilt mobility aid as a PASD, as they were not aware that consent was required.

During an interview, the DOC indicated the expectation in the home was for consent to be received from the resident and/or the resident's Substitute Decision Maker (SDM) prior to the usage of any PASD, which included tilt mobility aids utilized for PASD purposes.

The licensee failed to ensure that consent had been received from residents #026, #032 and #033's SDMs prior to the usage of tilt mobility aids, which were utilized for PASD purposes.

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 consent had been provided prior to the usage of any PASDs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting resident #014.

Related to resident #014:

A Critical Incident Report (CIR) was submitted to the Director on a specified date, for an alleged staff to resident neglect incident which occurred on a specified date, by PSW #141 towards resident #014. The CIR description indicated the incident actually improper care of resident as the resident was witnessed by RPN #142 to be improperly transferred by PSW #141. The CIR indicated RPN #142 reported the incident to RCC #106.

During record review by Inspector #672 of resident #014's MDS Assessment, dated a specified date,indicated resident #014 required total assistance from two staff for transfers with the use of a mechanical aid. Review of resident #014's written plan of care in place at the time of the incident, related to transfers, also indicated the resident required assistance of two staff members with the use of a mechanical aid.

During review of resident #014's progress notes by Inspector #672, on a specified date, the documentation indicated the resident was transferred from their mobility aid to their bed with the use of a mechanical aid and only one staff member. The progress notes further stated there were no negative outcomes observed for resident #014 related to the transfer.

During separate interviews by Inspector #672, PSWs #136, #137, #153, #154 and #155 all indicated the expectation in the home was for two staff members to be present and assist with every resident transfer which utilized a mechanical aid.

During an interview with RCC #106 by Inspector #672, they indicated when they interviewed PSW #141 regarding the allegation of improper care towards resident #014, the PSW denied the allegation and indicated the transfer was completed with the assistance of PSW #143. RCC #106 indicated when they interviewed PSW #143, they denied assisting PSW #141 with the transfer of resident #014. The RCC indicated the outcome of the investigation concluded that the allegation was founded related to unsafe transferring of a resident.

PSW #141 was no longer employed at the home.

During an interview, the DOC indicated the expectation in the home was always for all staff members to follow the internal lift and transfer policy and ensure two staff members assisted with every resident transfer which utilized a mechanical lift.

The licensee failed to ensure that PSW #141 used safe transferring and positioning techniques when assisting resident #014 with a transfer.

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 staff used safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #6: 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.

Review of the home's "Abuse and Neglect-Prevention, Reporting & Investigating" policy (ADM-01-03-05) reviewed January 2019, indicated: on page 3 of 18, under Steps to follow upon becoming aware of abuse and/or neglect: Registered

staff/designate must be notified immediately; Registered staff will conduct a head to toe assessment as necessary; The DOC/designate/supervisor/manager will be notified immediately; DOC/designate will assign investigative leads and investigation will commence immediately; An employee who is advised or has first-hand knowledge of abuse and/or neglect or suspected abuse must immediately inform their supervisor/designate or the Registered Nurse; The residents health care record will be updated accordingly. On page 6 of 18, the Investigation Lead will ensure every staff reporting the alleged abuse participate in an investigatory process as required, may be in the form of providing written and/or verbal statements; Endeavour to have residents reporting alleged abuse participate in an investigatory process as required, may be in the form of written and/or verbal statements; Provide summary documentation and report findings to either the DOC or designate. On page 10 of 18, under 'Evaluation', the analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly.

Related to resident #001, #002, #003, #004, #005, #006 and #007:

A critical incident report (CIR) was received by the Director on a specified date, for alleged staff to resident abuse towards seven residents (#001, #002, #003, #004, #005, #006 and #007) that occurred on a specified date.

During an interview with PSW #100 by Inspector #111, they indicated they had been reporting ongoing allegations to RN #113 of staff to resident abuse by PSW #101, towards multiple residents, that had been occurring almost daily. The PSW reported that RPN #126 and FSW #135 were also aware of the alleged abuse by PSW #101. The PSW indicated they did not see any actions being taken by the RN, so they reported the alleged abuse to the DOC on a specified date, a number of weeks later.

During an interview with RN #113 by Inspector #111, they confirmed awareness that any allegations of staff to resident abuse are to have the residents immediately assessed and the assessments of the residents were to be documented in the resident health record. The RN confirmed awareness of ongoing reports by PSW #100 alleging staff to resident abuse by PSW #101 towards multiple residents. The RN also confirmed awareness of suspected staff to resident abuse incidents involving PSW #101 towards resident #001 and #003. The RN indicated RPN #126 was also aware of and had reported to them allegations of abuse by PSW #101 towards residents and the RN directed them to

report their concerns to RCC #102. The RN was unable to recall the date these incidents occurred, confirmed they did not immediately assess the residents involved and did not document the assessments of the residents, as per the home's policy.

During an interview with the Environmental Services Manager (ESM) by Inspector #111, they confirmed they were involved in the investigation of alleged staff to resident abuse of seven residents (#001, #002, #003, #004, #005, #006 and #007) by PSW #101, as they were the acting Administrative Assistant (AA) at the time. The ESM indicated RPN #126, FSW #135 and RN #113 were all aware of the allegations involving PSW #101 and confirmed they did not complete their investigation until a number of months after the allegations were received by the DOC.

During an interview with the DOC by Inspector #111, they confirmed the home's abuse and neglect policy was not followed related to the ongoing allegations of staff to resident abuse by PSW #101, towards seven residents (#001, #002, #003, #004, #005, #006 and #007), as RPN #123 and FSW #135 did not immediately report the allegations to RN #113, RN #113 did not immediately assess or document the assessments of the residents involved, PSW #101 was not immediately relieved of duty and when RCC #102 and the DOC became aware of the allegations, did not take immediate actions to prevent further incidents of staff to resident abuse. The DOC confirmed that RCC #102 did not complete the investigation as per the home's abuse policy as they did not use the investigation template and did not interview, or receive written statements, of all staff and residents who were either involved or who were aware of the incidents. The DOC also confirmed that the investigation was not completed as per the policy until a number of weeks later, when the ESM initiated their investigation. The DOC confirmed that there was no documentation in any of the residents health records related to the allegations by either RPN #126, RN #113, RCC #102 or the DOC. The DOC also confirmed that some of the statements from staff were not obtained until a number of months after the allegations were received by the DOC.

The licensee had failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of seven residents (#001, #002, #003, #004, #005, #006 and #007) by PSW #101, was complied with, as RPN #126 and FSW #135 did not immediately report the alleged staff to resident abuse, RPN #126 and RN #113 did not document any assessments of the residents related to the allegations and they did not report the allegations to their immediate supervisor

(RCC #102). RCC #102 did not immediately interview or obtain written statements of all staff and residents who were either involved or aware of the allegations as per the home's abuse policy. The DOC and ESM also confirmed that some of the statements from residents and staff were not obtained until a number of months after the allegations were received.

2. Related to resident #008:

During a review of the progress notes for resident #008 related to separate critical incident report which involved resident #008, there was a documented incident allegation of staff to resident abuse on a specified date and time by RN #147. The RN documented the resident was upset regarding the incident and wanted the incident investigated and was immediately reported to RCC #144.

During an interview with resident #008 by Inspector #111, they recalled reporting the allegation of staff to resident abuse to the nurse and indicated the incident was witnessed by another PSW. The resident confirmed they were upset regarding the incident and wanted the incident investigated. The resident was unable to recall which staff member was involved, which staff member witnessed the incident or which nurse they reported the incident to.

During an interview with RN #147 by Inspector #111, they confirmed awareness of the allegation of staff to resident abuse by resident #009 and indicated the allegation involved PSW #149. The RN indicated the resident did not report the allegation until a number of days after the incident had occurred but they immediately reported the allegation to RCC #144 as the resident was upset about the incident and wanted it investigated. The RN indicated no awareness that any other staff had witnessed the incident.

RCC #144 was on leave and not able to be interviewed.

During an interview with the DOC by Inspector #111, they indicated awareness of the staff to resident abuse allegation by resident #008 and involved PSW #149. The DOC indicated the incident was not reported until a number of days after the incident had occurred and RCC #144 was responsible for completing the investigation. The DOC confirmed RCC #144 was currently off on leave. The DOC confirmed that the investigation was not initiated until a number of weeks after the allegation was reported, confirmed that PSW #159 and PSW #160 were both working when the incident had occurred and may have had knowledge

regarding the allegation and were not interviewed. The DOC indicated that RCC #144 completed their investigation and determined the allegations were unfounded a number of weeks later, despite not interviewing all staff that may have been present or had knowledge of the incident, as per the home's policy.

The licensee had failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with, the investigation completed by RCC #144 into the alleged staff to resident abuse of resident #008 by PSW #149, did not undertake the investigation immediately, allowed the staff member involved in the allegation to continue to provide care to the resident, did not ensure that all staff involving or that may have had knowledge of the incident, were including in the investigation, as per the home's policy.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

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 :

The licensee has failed to ensure that any alleged, suspected or witnessed incidents of abuse and/or neglect by anyone, that the licensee knew of, or that was reported, was immediately investigated.

Related to resident #001, #002, #003, #004, #005, #006 and #007:

A critical incident report (CIR) was received by the Director on a specified date, for alleged staff to resident abuse towards seven residents (#001, #002, #003, #004, #005, #006 and #007) that occurred on a specified date and was reported by PSW #100. The CIR indicated the investigation was pending.

During an interview with PSW #100 by Inspector #111, they indicated they had been reporting concerns ongoing, of suspected abuse by PSW #101 towards multiple residents to RN #113, during a specified period. The PSW indicated RN #113 was also aware of suspected abuse incidents by PSW #101 towards resident #001 and #003. The PSW indicated FSW #135 also witnessed incidents of staff to resident abuse by PSW #101. The PSW indicated they did not see any actions being taken by RN #113, so they reported the allegations to the DOC on a

specified date.

During an interview with RN #113 by Inspector #111, they confirmed awareness of PSW #100 reporting ongoing concerns of staff to resident abuse by PSW #101 towards residents. The RN also indicated awareness of suspected abuse by PSW #101 towards resident #001 and #003. The RN indicated RPN #123 was also aware of alleged abuse by PSW #101 towards residents and directed them to report their concerns to RCC #102. The RN was unable to recall the date these incidents occurred and confirmed they did not initiate an investigation into any of the reported or suspected staff to resident abuse incidents by PSW #101.

During an interview with Resident Care Coordinator (RCC) #102 by Inspector #111, they confirmed awareness of their obligation to immediately investigate any reported alleged, suspected or witnessed incidents of staff to resident abuse. The RCC indicated they were to immediately interview all staff or residents (if able) that had any knowledge of the incidents as part of the investigation. The RCC indicated they would usually document their investigation and complete the investigation template, as per the home's abuse prevention policy. The RCC could not indicate the specific date they became aware of incidents of alleged staff to resident abuse involving PSW #101. The RCC confirmed they did not immediately investigate the allegations until a number of days after the DOC was notified, confirmed they only interviewed two staff members (PSW #100 and #101) and did not interview all residents involved in the allegations.

During an interview with the Environmental Services Manager (ESM) by Inspector #111, they confirmed they were involved in the investigation of alleged staff to resident abuse of seven residents (#001, #002, #003, #004, #005, #006 and #007) by PSW #101, as they were the acting Administrative Assistant (AA) at the time. The ESM indicated RPN #126, FSW #135 and RN #113 were all aware of the allegations involving PSW #101 and confirmed they did not complete their investigation until a number of months after the allegations were received by the DOC.

During an interview with the DOC by Inspector #111, they indicated the alleged staff to resident abuse involving seven residents (#001, #002, #003, #004, #005, #006 and #007), was initially reported to them on a specified date by PSW #100. The DOC confirmed the investigation was not initiated until a number of days later. The DOC indicated the staff member involved in the allegation was PSW #101, the investigation concluded that the allegations were determined to be

founded and actions were to be taken towards PSW #101 but had not yet been completed, a number of months later.

The licensee failed to ensure that alleged or witnessed incidents of abuse of seven residents (#001, #002, #003, #004, #005, #006 and #007) that was reported by PSW #100 and RPN #123, to RN #113, RCC #102 and the DOC, were immediately investigated, as the investigation was not initiated until a number of days after the DOC was notified.

2. Related to resident #010, #011 and #012:

A critical incident inspection (CIR) was submitted to the Director on a specified date, for an alleged staff to resident neglect incident. The CIR indicated on a specified date and time, PSW #103 reported suspected staff to resident neglect of three residents (#010, #011 and #012) that was witnessed by PSW #104 and was not reported to RCC #106 until a number of days later. The CIR indicated PSW #107 was directly involved in the allegation.

During an interview with RCC #106 by Inspector #111, they indicated awareness of their obligation to immediately investigate any reported allegations, suspicions or witnessed incidents of staff to resident neglect by anyone. The RCC confirmed they were notified of an alleged staff to resident neglect incident involving three residents (#010, #011 and #012) by PSW #103 on a specified date and time and did not initiate the investigation until a number of days later.

The licensee has failed to ensure that an alleged incident of neglect of three residents (#010, #011 and #012) by PSW #107, that was immediately reported to RCC #106, was not investigated until a number of days later.

3. Related to resident #008:

A critical incident report (CIR) was submitted to the Director on a specified date, for a separate resident to resident abuse incident involving resident #008.

During a review of resident #008 progress notes, the Inspector noted that on a specified date and time, RN #147 documented the resident had reported an alleged staff to resident abuse incident that had occurred on a specified shift. The RN documented the incident was upsetting to the resident and the resident was requesting that "something should be done about it". The RN documented the

RCC #144 was notified of the allegation.

During an interview with resident #008 by Inspector #111, they indicated a PSW on a specified shift had been abusive towards them and the incident was witnessed by another PSW. The resident indicated they were not happy about the incident and reported the incident to the nurse and then a manager later came to speak to them about it. The resident was unable to recall when the incident occurred, when the incident was reported to the nurse, which staff member was involved or which staff member witnessed the incident, or which nurse and manager who spoke to them. The resident indicated the PSW that had been abusive towards them continued to provide their care but did not have any further incidents.

During an interview with RN #147 by Inspector #111, they confirmed they received a complaint from resident #008, alleging staff to resident abuse, on a specified date and time and the allegation involved PSW #149. The RN indicated the resident indicated at that time that the incident had occurred a number of days before it was reported. The RN confirmed the resident was upset about the incident and wanted it investigated. The RN indicated they immediately reported the allegation to RCC #144 to be investigated.

Review of the home's investigation indicated the incident occurred on a specified date, was completed by RCC #1444, was not investigated until a number of weeks later after the allegation was reported. There was also no indication of the outcome of the investigation.

During an interview with the DOC by Inspector #111, they indicated that they were aware of the complaint from resident #008, alleging staff to resident abuse by PSW #149. The DOC indicated RCC #144 was responsible for completing the investigation and RCC #144 was currently off on leave. The DOC confirmed the investigation was not completed until a number of weeks after the allegation was reported. The DOC indicated RCC #144 reported to them on a specified date via email that the investigation was concluded as unfounded, a number of months after the allegation was reported.

The licensee had failed to ensure that an alleged staff to resident abuse incident reported by resident #008 was immediately investigated, as the allegation was not investigated until a number of weeks later and the outcome of the investigation was not completed until a number of months after the allegation was received.

4. The licensee has failed to ensure that appropriate action was taken in response to every such incident.

Related to resident #008:

During an interview with the DOC by Inspector #111, they indicated that whenever there is an allegation of staff to resident abuse, the staff member would be relieved of duty pending the investigation. The DOC confirmed they were aware of the complaint from resident #008, alleging staff to resident abuse by PSW #149. The DOC indicated RCC #144 was responsible for completing the investigation and RCC #144 was currently off on leave. The DOC confirmed the investigation was not completed until a number of weeks after the allegation was reported. The DOC indicated RCC #144 reported to them on a specified date via email that the investigation was concluded as unfounded, a number of months after the allegation was reported. The DOC was not aware that PSW #149 continued to provide care to resident #008 for a number of weeks leading up to the investigation, after the allegation was received.

The licensee had failed to ensure that appropriate action was taken in response to an alleged staff to resident abuse incident towards resident #008 and involving PSW #149, as the staff member was allowed to continue to provide care to the resident for a number of weeks.

5. The licensee has failed to ensure that the report to the Director included the results of the investigation.

Related to resident #014:

A Critical Incident Report (CIR) was submitted to the Director on a specified date, related to an alleged incident of staff to resident neglect which occurred on a specified date, by PSW #141 towards resident #014. The CIR indicated RPN #142 witnessed the incident, there was no negative outcome to the resident and reported the incident to RCC #106.

During an interview with RCC #106 by Inspector #672, they indicated the incident for staff to resident neglect of resident #014 by PSW #141 was actually improper care that was provided by PSW #141 and because the same PSW had previously been involved in similar incidents, they reported the incident as staff to resident

neglect. RCC #106 indicated the incident was investigated, indicated awareness that the Director was to be notified of the outcome of the investigation and confirmed the Director was not notified of the outcome.

During a review of the investigation by Inspector #672, the documentation indicated the investigation was completed on a specified date, determined the allegation was founded and the PSW no longer worked in the home as a result. The CIR was amended a number of days later and did not include the outcome of the investigation or what actions were taken.

The licensee failed to ensure that the report to the Director included the outcome of the investigation into the allegation of staff to resident neglect involving resident #014 by PSW #141 and what actions were taken, as a result of the investigation.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 :

The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of seven residents by a staff member had occurred and that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

Related to resident #001, #002, #003, #004, #005, #006 and #007:

A critical incident report (CIR #M539-000023-19) was received by the Director on a specified date, for alleged staff to resident abuse towards seven residents (#001, #002, #003, #004, #005, #006 and #007) that occurred on a specified date and time.

During an interview with PSW #100 by Inspector #111, they indicated they had been reporting their concerns with PSW #101 towards other residents to RN #113 ongoing and that the same RN was also aware of incidents of suspected staff to resident abuse by PSW #101. The PSW indicated they did not see any actions being taken by the RN, so they then reported their concerns to the DOC on a specified date.

During an interview with RN #113 by Inspector #111, they confirmed awareness of staff to resident abuse by PSW #101 towards residents and confirmed awareness of PSW #100 reporting alleged staff to resident abuse by PSW #101 towards residents. The RN confirmed they did not report the allegations to the Director.

During an interview with the Resident Care Coordinator (RCC) #102 by Inspector #111, they indicated they were involved in the investigation of the alleged staff to resident abuse towards seven residents and involved PSW #101. The RCC could not recall the specific date they were notified of the allegation, but confirmed they initiated their investigation on a specified date, a number of weeks after the allegations were reported to the DOC. The RCC also confirmed they did not report the allegations to the Director.

During an interview with the DOC by Inspector #111, they indicated they were informed of the alleged staff to resident abuse towards seven residents (#001, #002, #003, #004, #005, #006 & #007) on a specified date by PSW #100 and involved PSW #101. The DOC confirmed they did not inform the Director until the

CIR was submitted, a number of months after the allegations were received.

The licensee failed to ensure that the DOC, who had reasonable grounds to suspect abuse of seven residents by PSW #101, that resulted in harm or a risk of harm, immediately reported the suspicion and the information upon which it was based, to the Director as the allegations were not reported until a number of months after the allegations were received.

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that neglect of three residents (#010, #011 and #012) by staff, that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based, to the Director.

Related to resident # 010, #011 and #012:

A critical incident inspection (CIR) was submitted to the Director on a specified date, for an alleged staff to resident neglect incident. The CIR indicated on a specified date and time, PSW #103 reported suspected staff to resident neglect towards three residents (resident #010, #011 and #012). The CIR indicated the incident was reported to RCC #106 a number of days later and there was no after hours call received when the incident was discovered.

During an interview with RCC #106 by Inspector #111, they confirmed they were informed of the alleged staff to resident neglect involving PSW #107 towards resident #010, #011 and #012 on specified date and time and the allegation was not report to the Director until a number of days later.

The licensee failed to ensure that a suspected neglect of care of three residents (#010, #011 and #012) by PSW #107, was immediately reported to the Director, as it was not reported until a number of days later.

3. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of resident #008 by the staff and resulted in a risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

Related to resident #008:

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

for a separate resident to resident abuse incident involving resident #008.

During a review of resident #008 progress notes, the Inspector noted that on a specified date and time, RN #147 documented the resident had reported an alleged staff to resident abuse incident that had occurred on a specified shift. The RN documented the incident was upsetting to the resident and the resident was requesting that "something should be done about it". The RN documented the RCC #144 was notified of the allegation. There was no indication the Director was notified.

During an interview with RN #147 by Inspector #111, they confirmed they received a complaint from resident #008,on a specified date, alleging PSW #149 had been abusive towards them and was upset about the incident and wanted it investigated. The RN confirmed they did not report the incident to the Director and assumed when they reported the allegation to RCC #144, they would have reported it.

During an interview with the DOC by Inspector #111, they indicated that they were aware of the complaint from resident #008, alleging staff to resident abuse. The DOC confirmed the Director was not informed of the allegation.

The licensee had failed to ensure that the person who had reasonable grounds to suspect that abuse of resident #008 by PSW #149, that resulted in a risk of harm, was immediately reported to the Director.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

There is currently an outstanding Compliance Order under O. .Reg. 79/10, s.52(2) with a compliance date of December 16, 2019.

Related to resident #029:

A critical incident report (CIR) was submitted to the Director for an alleged staff to resident abuse incident. The CIR indicated on a specified date and time, resident #029 reported an alleged staff to resident abuse involving PSW #116.

The resident also reported a complaint on a specified date, of staff to resident abuse that resulted in pain.

During an interview with resident #029 by Inspector #111, they indicated they had daily, moderate daily pain to a specified area and also had limited use of a specified area. The resident indicated they received routine analgesics and analgesics as needed (PRN), but they do not relieve the pain. The resident indicated they also received analgesic ointment daily. The resident indicated they are supposed to receive non-pharmacological pain interventions to a specified area but does not always occur. The resident indicated the cause of the pain and what aggravated the pain. During a later interview with resident #029, they indicated they were still having moderate pain to a specified area and was upset that they had still not received the non-pharmacological intervention that they were supposed to receive.

During an interview with RPN #132 by Inspector #111, they indicated the current practice in the home for residents having pain, included a pain scale that was to

be completed prior to the administration of any PRN analgesic and following the administration,to assess the effectiveness. The RPN indicated the clinically appropriate assessment tool used in the home was the ‘comprehensive pain assessment tool’ that is completed electronically. The RPN confirmed resident #029 had moderate pain daily to a specified area. The RPN confirmed the resident received both routinely administered analgesics and PRN analgesics for breakthrough pain. The RPN indicated the resident also received non-pharmacological interventions at specified times for pain relief. The RPN confirmed a comprehensive pain assessment tool was not completed for resident #029 until after the resident reported staff to resident abuse.

During an interview with RCC #117 by Inspector #111, they confirmed resident #029 had complained on two separate dates, related to lack of pain management. The RCC confirmed a clinically appropriate assessment instrument (comprehensive pain tool) had not yet been completed for the resident, despite the resident’s pain not being relieved.

During an interview with the DOC by Inspector #111, they indicated the expectation in the home is that the registered staff would complete a pain scale before and after a PRN analgesic is administered to determine the severity of the pain, the most appropriate analgesic to be offered and the effectiveness of the analgesic. The DOC indicated the clinically appropriate assessment instrument to assess pain that was used in the home was the electronic comprehensive pain assessment tool that was to be completed when pain management was not effective. The DOC was not aware that no pain assessment tools had been completed for resident #029, despite two complaints related to ineffective pain management and should have been.

Review of the pain assessments for resident #029, indicated there was only one comprehensive pain assessment tool that was completed over a specified period of time and had been completed as a result of the inspection.

The licensee has failed to ensure that when resident's #029’s pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically, the comprehensive pain assessment tool that was designed for this purpose.

WN #10: 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).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

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 an alleged incident of abuse of the resident that caused distress to the resident and that could potentially be detrimental to the resident's health or well-being.

Related to resident #008:

A critical incident report (CIR) was submitted to the Director on a specified date, for a separate resident to resident abuse incident involving resident #008.

During a review of resident #008 progress notes, the Inspector noted that on a specified date and time, RN #147 documented the resident had reported an

alleged staff to resident abuse incident that had occurred on a specified shift. The RN documented the incident was upsetting to the resident and the resident was requesting action to be taken. The RN documented the RCC #144 was notified of the allegation. There was no documented evidence the SDM was notified.

During an interview with resident #008 by Inspector #111, they confirmed reporting an allegation of staff to resident abuse that occurred on a specified shift and reported the incident to the nurse and a manager, who later came to speak with them about the incident. The resident was unable to recall which nurse or manager spoke to them regarding their concern. The resident indicated their family was never informed of the allegation and should have been.

During an interview with RN #147 by Inspector #111, they confirmed they received a complaint from resident #008 alleging a staff to resident abuse incident that had occurred on a specified date and shift an the resident was upset as a result. The RN indicated PSW #149 was the staff member involved in the allegation. The RN confirmed they did not report the allegation to the resident's SDM. The RN indicated that they immediately reported the allegation to RCC #144 and assumed they would notify the SDM.

RCC #144 was on leave and unable to be interviewed.

Review of the investigation had no documented evidence the SDM was notified of the allegation of staff to resident abuse.

During an interview with the DOC by Inspector #111, they confirmed they were aware of the allegation of staff to resident abuse by PSW #149 towards resident #008 that was reported on a specified date. The DOC indicated RCC #147 was in charge of the investigation and was currently on leave of absence. The DOC confirmed there was no documented evidence to indicate the resident's SDM was notified of the allegation.

The licensee has failed to ensure that resident #008's SDM was immediately notified, of an alleged staff to resident abuse incident, as the home was unable to determine that the SDM was informed.

2. The licensee has failed to ensure that the SDM of seven residents (#001, #002, #003, #004, #005, #006 and #007), were notified within 12 hours upon becoming aware of an alleged staff to resident abuse incident.

Related to resident #001, #002, #003, #004, #005, #006 and #007:

A critical incident report (CIR #M539-000023-19) was received by the Director on a specified date for alleged staff to resident abuse towards seven residents (#001, #002, #003, #004, #005, #006 and #007). The CIR indicated the alleged incident occurred on a specified date and time.

During an interview with the Resident Care Coordinator (RCC) #102 by Inspector #111, they indicated if they receive any allegations, suspicions or witnessed incidents of resident abuse by anyone, they would have informed the Substitute Decision Makers (SDM) and indicate this on their investigation template. The RCC confirmed they were involved in the investigation of the alleged staff to resident abuse towards seven residents (#001, #002, #003, #004, #005, #006 and #007) by PSW #101. The RCC could not recall the specific date they were notified of the allegation, but confirmed they initiated their investigation on a specified date. The RCC confirmed they did not inform any of the resident's SDMs of the allegations.

During an interview with the DOC by Inspector #111, they indicated they were aware of the alleged staff to resident abuse towards seven residents (#001, #002, #003, #004, #005, #006 and #007) by PSW #100 on a specified date. The DOC confirmed they notified the SDMs of all seven residents, a number of months after the allegations were received.

The licensee has failed to ensure that seven resident's (#001, #002, #003, #004, #005, #006 and #007) SDM's were notified within 12 hours upon becoming aware, of alleged incidents of staff to resident abuse,as the SDM's were notified a number of months later.

3. The licensee has failed to ensure that the SDM of three residents (#010, #011 and #0012), were notified within 12 hours upon becoming aware of a staff to resident neglect incident.

Related to resident #010, #011 and #012:

A critical incident inspection (CIR) was submitted to the Director on a specified date, for an alleged staff to resident neglect incident that occurred on a specified date and shift. The CIR indicated PSW #104 suspected neglect of three residents

(#010, #011 and #012). The CIR indicated the SDMs of all three residents were informed of the allegation.

During an interview with RCC #106 by Inspector #111, they indicated they were notified of the alleged staff to resident neglect of three residents (#010, #011 and #012) on a specified date and time and did not inform the SDMs until a number of days later.

The licensee has failed to ensure that three resident's (#010, #011 and #012) SDM's were notified, within 12 hours upon becoming aware of alleged incidents of staff to resident neglect, as the SDM's were notified a number of days later.

4. The licensee has failed to ensure that the SDMs of seven residents (#001, #002, #003, #004, #005, #006 & #007), were notified of the results of an alleged abuse investigation immediately upon the completion.

Related to resident #001, #002, #003, #004, #005, #006 and #007:

A critical incident report (CIR) was received by the Director on a specified date for alleged staff to resident abuse towards seven residents (#001, #002, #003, #004, #005, #006 and #007) that occurred on a specified date and time.

During an interview with the Resident Care Coordinator (RCC) #102 by Inspector #111, they confirmed they were involved in the investigation of the alleged staff to resident abuse, towards seven residents and involving PSW #101. The RCC confirmed they did not inform the residents' SDMs of the results of the investigation immediately upon the completion.

During an interview with the DOC by Inspector #111, they indicated they were informed by PSW #100, of the alleged staff to resident abuse by PSW #101 towards seven residents (#001, #002, #003, #004, #005, #006 and #007) on a specified date. The DOC indicated they notified all seven of the residents' SDMs of the allegations a number of months after the allegations were received. The DOC confirmed the investigation was concluded as founded on a specified date and the SDMs were not informed of the results of the investigation.

The licensee has failed to ensure that seven resident's (#001, #002, #003, #004, #005, #006 and #007) SDM's were notified of the results of the investigation immediately upon completion.

5. The licensee has failed to ensure that resident #008 and the resident's SDM, were notified of the results of an alleged abuse investigation immediately upon the completion.

Related to resident #008:

Review of the progress notes for resident #008 indicated on a specified date and time, RN #147 documented the resident reported an alleged staff to resident abuse incident and was upsetting to the resident. There was no documented evidence the SDM was notified of the results of the investigation.

Review of the investigation into the allegation, indicated RCC #144 had completed the investigation and had no documented evidence the results of the investigation were reported the SDM.

During an interview with resident #008 by Inspector #111, they indicated both the resident or their SDM, was never informed of the results of the investigation and should have been.

RCC #144 was on leave and unable to be interviewed.

During an interview with the DOC by Inspector #111, they confirmed the investigation was completed on a specified date and there was no indication of the outcome of the investigation. The DOC indicated they later received an email from RCC #144 on a specified date, indicating the outcome of the investigation was unfounded. The DOC was unable to indicate why the investigation was not concluded until approximately a number of weeks later. The DOC confirmed that their was no documented evidence that the resident or the residents' SDM were notified of the results of the investigation, immediately upon its completion.

The licensee has failed to ensure that resident #008 and the resident's SDM, were immediately notified of the results of the investigation into an alleged staff to resident abuse incident.

6. The licensee has failed to ensure that resident #014’s SDM was notified of the results of the alleged neglect investigation, immediately upon the completion of the internal investigation.

Related to resident #014:

A Critical Incident Report (CIR) was submitted to the Director on a specified date, related to an alleged incident of staff to resident neglect which occurred on a specified date, by PSW #141 towards resident #014.

During a review of the investigation notes, Inspector #672 noted the investigation was completed on a specified date, determined to be founded and the PSW #141 no longer worked in the home as a result.

Inspector #672 reviewed resident #014's health care record during a specified period and there was no documented evidence to indicate resident #014's SDM was notified of the outcome of the investigation.

During an interview with RCC #106, they confirmed they submitted the CIR for staff to resident neglect involving resident #104 and PSW #141 and could not recall if they had notified resident #014's SDM of the outcome of the internal investigation. During a later interview with RCC #106, they indicated they had just informed resident #014's SDM of the outcome of the internal investigation, a number of months after the investigation was completed.

During an interview with the DOC, they indicated they were unsure if resident #014's SDM had been notified of the outcome of the investigation upon its completion, as RCC #106 was in charge of conducting the investigation into the incident and was responsible for completing the notifications of the SDM. The DOC further indicated the expectation in the home was for the resident and/or the resident's SDMs to be immediately notified of the outcome of any investigation into allegations of resident abuse or neglect.

The licensee failed to ensure that resident #014's SDM was immediately notified of the outcome of the internal investigation into the alleged staff to resident neglect, as the investigation was completed on a specified date and the SDM was not notified of the outcome until a number of weeks later.

WN #11: 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:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up 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:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

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

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

Findings/Faits saillants :

The licensee has failed to ensure that the report to the Director included the following description of the incident: date and time of the incident and events leading up to the incident.

Related to resident #001, #002, #003, #004, #005, #006 and #007:

A critical incident report (CIR) was received by the Director on a specified date, for alleged staff to resident abuse incidents towards seven residents (#001, #002, #003, #004, #005, #006 and #007). The CIR indicated that all of the alleged incidents occurred on a specified date and was discovered by PSW #100.

During an interview with the DOC by Inspector #111, they indicated the alleged staff to resident abuse involving seven residents, occurred over a period of time but was initially reported to the DOC on a specified date, by PSW #100. The DOC confirmed those details were not provided in the CIR.

The licensee has failed to ensure that the report to the Director included a description of the events leading up to the event, as the actual date and time of the incident and events leading up to the incident were not included.

2. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident: names of any staff members or other persons who were present at or discovered the incident, and names of staff members who responded or are responding to the incident.

A critical incident report (CIR) was received by the Director on a specified date for alleged staff to resident abuse incidents towards seven residents (#001, #002, #003, #004, #005, #006 and #007) did not indicate the staff member involved in the allegation or any other staff who were involved or responded to the incident.

During an interview with PSW #100 by Inspector #111, they indicated they had been reporting their concerns to RN #113 regarding how PSW #101 was being abusive towards residents on their unit. The PSW indicated RPN #123 and FSW #135 were also aware of the abuse by PSW #101 towards certain residents.

During an interview with the DOC by Inspector #111, they indicated the alleged staff to resident abuse involving seven residents by PSW #101, was initially reported to them on a specified date but RCC #102 was involved in the investigation.

Review of the home's investigation indicated a written complaint was received by the DOC and RCC #102 on a specified date, approximately a month after the initial allegation was received and alleged staff to resident abuse of several

residents by PSW #101. The investigation was completed by the DOC and RCC #102.

During an interview with RCC #102 by Inspector #111, they confirmed they were directly involved in the investigation of staff to resident abuse by PSW #101 towards seven residents.

During a later interview with the DOC by Inspector #111, they confirmed the CIR did not include the names of the staff members who were involved in the allegation or present (PSW #101, RCC #102, RN #113, RPN #125 and Food Service Worker (FSW) #135 who was the staff member who responded to the incident.

The licensee failed to ensure the report to the Director included the names of all the staff (PSW #101, RCC #102, RN #113, RPN #125 and FSW #135) who were either directly involved or present when the incidents of staff to resident verbal and emotional abuse occurred.

3. The licensee has failed to ensure that a report to the Director was made within 10 days of becoming aware, of alleged incidents of staff to resident abuse.

A critical incident report (CIR) was received by the Director on a specified date, for alleged staff to resident abuse towards seven residents (#001, #002, #003, #004, #005, #006 and #007). The CIR indicated all of the alleged incidents occurred on a specified date.

During an interview with the DOC by Inspector #111, they confirmed the allegation of staff to resident abuse involving seven residents, was initially reported to the DOC on a specified date by PSW #100. The DOC also confirmed the investigation was concluded approximately a month later and the allegation was determined to be founded. The DOC confirmed that report to the Director was not provided until approximately two months after the allegation was received and did not include the outcome of the investigation.

The licensee failed to ensure that the report of an alleged staff to resident abuse by PSW #101 towards seven residents, was made to the Director within 10 days of becoming aware of the allegation as the report was not provided until approximately two months after the allegation was received.

4. Related to resident #008:

A critical incident report (CIR) was submitted to the Director on a specified date, for a separate resident to resident abuse incident involving resident #008.

During a review of resident #008 progress notes, the Inspector noted that on a specified date and time, RN #147 documented the resident had reported an alleged staff to resident abuse incident that had occurred on a specified shift. The RN documented the incident was upsetting to the resident and the resident was requesting that actions to be taken. The RN documented the RCC #144 was notified of the allegation.

During an interview with RN #147 by Inspector #111, they confirmed they received a complaint of staff to resident abuse from resident #008, on a specified date and confirmed the resident was upset about the incident and wanted it investigated. The RN confirmed they did not submit a report to the Ministry of Long-Term Care (MLTC) and assumed RCC #144 would have completed the report.

During an interview with the DOC by Inspector #111, they indicated that they were aware of the complaint from resident #008, alleging staff to resident abuse on a specified date. The DOC confirmed a report to the Director was not submitted to the MLTC related to the allegation.

The licensee failed to ensure that the report made to the Director of an alleged staff to resident abuse by PSW #149 towards resident #008, was made to the Director within 10 days of becoming aware of the allegation, as the report was not provided to the Director.

5. The licensee has failed to ensure that the final report to the Director was provided within 21 days, regarding the allegation of staff to resident neglect by PSW #141 towards resident #014.

A Critical Incident Report (CIR) was submitted to the Director on specified date, related to an alleged incident of staff to resident neglect which occurred on a specified date, by PSW #141 towards resident #014. The CIR indicated in the description of the incident, that RPN #142 witnessed an incident of improper care by PSW #141 towards resident #014 (and was not neglect) and reported the incident to RCC #106.

During record review, Inspector #672 reviewed the internal investigation notes, which indicated the internal investigation was completed on a specified date and the investigation was concluded as founded and PSW #141 no longer works in the home. Inspector #672 reviewed the CIR which was last amended on a specified date, by RCC #106 and the CIR did not provide a final report to the Director within the 21 day time frame, as specified within the legislation.

During an interview, RCC #106 indicated they submitted a critical incident report related to PSW #141 alleging staff to resident neglect despite the incident being providing improper care to resident #014, as PSW #141 had been involved in previous incidents of staff to resident abuse and /or neglect. The RCC #106 indicated they were aware that final reports were expected to be provided to the Director within 21 days following the incident. RCC #106 further indicated they had been unable to conclude the resolution of the internal investigation within the 21 day time frame as they had provided their recommendations to the Human Resources department following completion of the internal investigation, but had not received a response regarding how the licensee was going to proceed with PSW #141 during that time frame.

The licensee failed to ensure that the final report regarding the allegation of staff to resident neglect by PSW #141 towards resident #014 was submitted to the Director within 21 days as the report was not provided to the Director until approximately a number of weeks after the 21 days and the final report did not include the outcome of the investigation or what actions were taken as a result of the investigation.

Issued on this 10th day of February, 2020 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by LYNDA BROWN (111) - (A1)
Inspection No. / No de l'inspection :	2019_643111_0021 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	008864-19, 011102-19, 013022-19, 014146-19, 016843-19, 017048-19, 018252-19, 018463-19, 019016-19, 019084-19, 019185-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 10, 2020(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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Regional Municipality of Durham, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall comply with LTCHA, 2007, s.19(1).

Specifically,

1.The licensee shall educate all staff on how to recognize abuse. The education must include each disciplines roles and responsibilities related to how to respond to any alleged, suspected and witnessed incidents of staff to resident abuse and neglect as per the home's policy. A record is to be kept of the training.

2. The licensee shall develop a monitoring process to ensure that:
- every incident of alleged, suspected or witnessed incident of abuse and or neglect is immediately investigated.
- the resident's SDM is immediately notified of every incident of alleged, suspected or witnessed incident of abuse and/or neglect and the outcome of the investigation immediately upon its completion.
- the Director is immediately notified when there are reasonable grounds to suspect abuse and/or neglect of a resident that resulted in harm or risk of harm to a resident.
- a written report is submitted to the Director within 10 days, with respect to the alleged, suspected or witnessed incident of abuse and/or neglect of a resident by anyone, which shall include: a description of the incident and the individuals involved; the names of all staff that were aware of present of the incident and the report shall be amended within 21 days of the outcome of the investigation.

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

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001, #002, #003, #004, #005, #006 and #007 were protected from abuse by PSW #101.

Related to resident #001, #002, #003, #004, #005, #006 and #007:

A critical incident report (CIR) was received by the Director on a specified date for alleged staff to resident abuse towards seven residents (#001, #002, #003, #004, #005, #006 and #007). The CIR indicated the alleged incidents occurred on a specified date and time. There was no after hours call received from the home regarding this incident, despite late reporting. The CIR identified PSW #100 but did not indicate whether this staff member reported the incident or was involved in the incident. The CIR also indicated the investigation was pending and there were no further amendments to the CIR received.

Review of the home's investigation indicated:
- The alleged incidents of staff to resident abuse by PSW #101 towards the seven residents, were actually initially reported by PSW #100 on a specified date to the DOC and the Director was not informed until a number of months later.
- PSW #100 had been reporting to RN #113, witnessing ongoing incidents of abuse by PSW #101 towards seven residents (#001, #002, #003, #004, #005, #006 and #007). PSW #100 alleged that RN #113 had also witnessed incidents of abuse by PSW #101 towards resident #001 and #003. PSW #100 also alleged that Food Service Worker (FSW) #135 had witnessed incidents of staff to resident abuse by PSW #101.
- FSW #135 had reported that they had witnessed PSW #101 being abusive towards resident #001 and #003 in a specified area which upset resident #001. The FSW indicated they could not recall the dates the incidents occurred, almost daily and confirmed they did not report the incidents. The FSW indicated PSW #100, PSW #111 and RPN #123 had also witnessed the incidents.
- PSW #111 reported that PSW #101 was abusive towards resident #001, making the resident upset. PSW #111 confirmed they did not report the incidents.
- RPN #123 reported that PSW #100 had reported to them, that PSW #101 had been abusive towards resident #005 and the resident was upset. The RPN indicated they were unable to recall when the incident occurred, did not document the incident and confirmed they did not report the incident.
- RN #113 reported that they were aware of PSW #100 reporting concerns with PSW

#101's treatment of residents and that it was "getting worse". The RN indicated they recalled witnessing resident #005 being upset with PSW #101 and requested PSW #101 not provide their care as a result. The RN was unable to recall when the incidents occurred, did not document the incidents, did not report the incidents at the time they occurred. The RN indicated they had reported "concerns" with PSW #101 to RCC #102 in a specified month.

Review of the progress notes for resident #001, #002, #003, #004, #005, #006 and #007 did not have any documented evidence to indicate the residents were assessed or provided support, either when the allegations were received or when the incidents occurred, as per the home's Prevention of abuse and neglect policy.

On a specified date, observation and interviews were conducted by Inspector #111, with six of the seven residents involved in the allegations and indicated resident #001 and #002 were not interviewable. Resident #003 and resident #005 both indicated they were unable to recall any incidents involving PSW #101. Resident #004 indicated they had no concerns related to any staff. Resident #006 indicated they had ongoing incidents of staff to resident abuse involving PSW #101, during a specified period and described the abuse. The resident indicated they had reported their concerns to PSW #111 but no one came to speak to them regarding their concerns and had no awareness of the outcome of the investigation. Resident #007 is no longer in the home.

During an interview with PSW #100 by Inspector #111, they indicated they had been reporting their concerns ongoing, of abuse by PSW #101 was towards residents to the RN #113. PSW #100 also indicated RN #113 was aware of ongoing incidents of abuse by PSW #101 towards specific residents, as the RN would reassign care for those specified residents from PSW #101 to PSW #100. The PSW indicated they did not see any actions being taken by RN #113, so they reported their concerns of witnessed, staff to resident abuse by PSW #101 to the DOC on a specified date.

During an interview with PSW #111 by Inspector #111, they indicated they only occasionally worked with PSW #101 and were aware of multiple incidents of staff to resident abuse by PSW #101. The PSW indicated they witnessed PSW #101 be abusive towards resident #001, which would upset the resident. The PSW indicated they witnessed PSW #101 be abusive towards resident #003 and #005. The PSW could not recall the dates and times when the incidents occurred and confirmed they

did not report the incidents at the time they occurred until a month later when they reported the abuse in writing to RCC #102. The PSW indicated they were not contacted by anyone regarding their allegations.

During an interview with RN #113 by Inspector #111, they indicated if they witnessed or were notified of an alleged, suspected or witnessed incident of staff to resident abuse, they would immediately intervene, assess the resident and immediately inform their RCC to initiate the investigation and notifications. The RN indicated they would document in the resident's progress notes to indicate what had occurred, the assessment of the resident and whom they notified. The RN indicated it was the RCC who would notify the Ministry of Long Term Care (MLTC). The RN confirmed awareness of PSW #100 reporting concerns of abuse by PSW #101 towards residents. The RN indicated they witnessed suspected abuse by PSW #101 towards resident #001 and #003. The RN indicated awareness that RPN #123 had reported allegations of abuse by PSW #101 towards residents and they directed the RPN to report their concerns to RCC #102. The RN was unable to recall when this allegation was received, or which resident was involved. The RN indicated they had reported their allegations of abuse by PSW #101 towards residents to the ESM, during the investigation. The RN confirmed they did not assess the residents or document what had occurred for any of the incidents that they witnessed or were notified of by PSW #100 or RPN #123.

During an interview with the Environmental Services Manager (ESM) by Inspector #111, they indicated they were in the role of Administrative Assistant (AA) during a specified period and confirmed they were involved in the investigation of alleged staff to resident abuse involving PSW #101 towards seven residents. The ESM confirmed they had interviewed RN #113, RPN #123 and FSM #135. The ESM indicated they were not aware that those staff were not identified in the report to the Director.

During an interview with the Resident Care Coordinator (RCC) #102 by Inspector #111, they indicated they first became aware of a concern involving PSW #101, when RPN #123 reported a concern between PSW #100 and PSW #101. The RCC indicated they spoke to PSW #100 and they did not report any allegations of staff to resident abuse involving PSW #101 at that time. The RCC was unable to recall the date and had no documented evidence when this had occurred. The RCC indicated they became aware of the allegations of staff to resident abuse involving PSW #101 after the allegation was reported to the DOC on a specified date. The RCC confirmed

they did not notify the SDMs, police or the MLTC when they became aware of the allegations. The RCC also confirmed they did not interview all of the residents or staff who may have been present or aware of the allegations, as per the home's abuse policy.

During an interview with the DOC by Inspector #111, they indicated they became aware of the staff to resident abuse involving PSW #101 towards seven residents on a specified date. The DOC confirmed the SDMs, police and the MLTC were notified of the allegations approximately two months later. The DOC confirmed they did not inform the SDM's of the results of the investigation.

The licensee failed to ensure that seven residents (#001, #002, #003, #004, #005, #006 and #007) were protected from ongoing abuse by PSW #101 as follows:
-When the licensee's Prevention of Abuse and Neglect policy was not complied with, as there were ongoing incidents of abuse by PSW #101 towards seven residents, that were reported by PSW #100 to RN #113, were not documented in the resident's health records to indicate when the incidents occurred, who was involved and the assessment of the residents; there were no actions taken to ensure the resident's safety when the incidents reoccurred as PSW #101 was not relieved of duty; additional staff (RPN #123, PSW #111 and FSW #135) were also aware of incidents involving PSW #101 towards specified residents and did not report to their immediate supervisor, as per the home's policy, as indicated under LTCHA, 2007, s.20(1) in WN #006.
-When the ongoing, alleged and witnessed incidents of staff to resident abuse by PSW #101 towards seven residents were reported by PSW #100 to the DOC on a specified date, were not immediately investigated, until a number of days later. Appropriate actions were not taken to prevent a recurrence, as the staff member was allowed to continue to provide care to those residents for a number of months, until they were relieved of duty and the results of the investigation were not reported to the Director upon completion of the investigation, as indicated under LTCHA, 2007, s.23(1)(a)(b) and (2) in WN #007.
-When the SDMs of the seven residents involved in the alleged and witnessed incidents of staff to resident abuse by PSW #101 were not made aware of the allegations until a number of months after the allegations were made and the results of the investigation were not reported to the SDMs, as indicated under O.Reg. 79/10, s. 97(1)(a) and (2) in WN #010.
-When the Director was not immediately notified of the alleged staff to resident abuse

by PSW #101 towards seven residents until a number of months after the DOC was made aware, as indicated under LTCHA, 2007, s.24(1) in WN #008.
-When the report to the Director did not include a description of the events leading up to the occurrence, the names of all the staff members who were present or aware of the incidents. The report to the Director was not provided within 10 days of receiving the allegation and the report was not amended within 21 days, as to the results of the investigation, as indicated under O.Reg. 79/10, s.104(1)1, 2, (2) and (3) in WN #012. (111)

2. The licensee has failed to ensure that resident #008 was protected from abuse by PSW #149.

Related to resident #008:

During the review of the progress notes for resident #008 for an unrelated critical incident report (CIR), there was a documented incident by RN #147 on a specified date, of an alleged staff to resident abuse. The RN documented the resident was upset regarding the incident and wanted the incident investigated. The RN indicated the allegation was reported to RCC #144. There was no documented evidence the SDM or the Director were notified.

During an interview with resident #008 by Inspector #111, they indicated a PSW on a specified shift, was asked for assistance due to physical limitations and the PSW was then abusive towards them and was witnessed by another PSW. The resident indicated they were not happy about the incident and was unable to recall the date and time the incident occurred, which PSW was involved or which PSW witnessed the incident. The resident indicated a manager came to speak to them about what they reported at a later date and time, but was unable to recall who the manager was and the date they spoke to them. The resident indicated the PSW involved in the incident continued to provide their care. The resident indicated their SDM was not informed of the incident and both the resident or the SDM were never notified of the results of the investigation.

During an interview with RN #147 by Inspector #111, they confirmed they received a complaint from resident #008 alleging staff to resident abuse. The RN indicated PSW #149 was the staff member directly involved in the allegation. The RN indicated the resident informed them that the incident had actually occurred a number of days before they reported the incident and confirmed the resident reported the incident

was witnessed by another staff member. The RN confirmed they did not inform the resident's SDM or the Director. The RN indicated they had immediately reported the allegation to RCC #144 and assumed the RCC would be completing those tasks.

Review of the home's investigation indicated the incident actually occurred a number of days before the allegation was reported to RN #147. The investigated was initiated by RCC #144 a number of weeks after the allegation was reported to the RCC by the RN. The investigation confirmed that PSW #149 was directly involved in the allegation and PSW #149 confirmed another PSW would have been present while they were providing care. The investigation was concluded over a month later and there was no documented evidence to indicate any other staff members or the resident was interviewed. There was no indication which PSW may have witnessed the incident. The investigation did not indicate whether the allegation was reported to the SDM or the Director. The investigation did not indicate whether the results of the investigation were provided to the resident, the resident's SDM or the Director.

The Inspector was unable to interview PSW #149 or RCC #144.

During an interview with the DOC by Inspector #111, they indicated RCC #144 was currently off on leave. The DOC indicated that they were aware of the complaint from resident #008, alleging staff to resident abuse by PSW #149 and RCC #144 was responsible for completing the investigation. The DOC confirmed the investigation was not immediately investigated, there was no documented evidence of an investigation, that PSW #149 who was directly involved in the allegation was allowed to continue to provide care to resident #008, there was no documented evidence the SDM or the Director was notified of the allegation and no documented evidence the resident, the resident's SDM or the Director were made aware or the results of the investigation. The DOC confirmed they became aware of the results of the investigation a number of weeks later, and RCC #144 concluded the investigation was determined to be unfounded, despite no documented investigation. The DOC was unable to indicate which PSW witnessed the incident. The DOC confirmed the resident was not made aware of the results of the investigation, confirmed the resident's SDM and the Director were never informed of the allegation or the results of the investigation and that the investigation should have been documented to indicate when the investigation occurred and which staff were involved.

The licensee failed to ensure that resident #008 was protected from emotional abuse

by PSW #149 as follows:
-When the licensee's Prevention of Abuse and Neglect policy was not complied with, as an alleged staff to resident emotional abuse that occurred on a specified date, that was witnessed by another unidentified PSW, was not immediately reported by that staff member and the investigation was not documented, as per the home's policy, as indicated under LTCHA, 2007, s.20(1) in WN #006.
-When the alleged staff to resident emotional abuse incident was reported on a specified date, to RCC #144, the investigation was not immediately initiated, until approximately a number of weeks later and appropriate actions were not taken to prevent a recurrence, as PSW #149 continued to provide care to resident #008; the results of the investigation were not reported to the Director upon completion, when the investigation results were determined on October 8, 2019 as unfounded, as indicated under LTCHA, 2007, s.23(1)(a)(b) and (2) in WN #007.
-When the SDM of resident #008 was not made aware of the allegation of staff to resident emotional abuse or the results of the investigation, upon the conclusion, as indicated under O.Reg. 79/10, s.97(1)(a) and (2) in WN #010.
-When the Director was not immediately notified of the alleged staff to resident abuse by PSW #149 towards resident #008, as indicated under LTCHA, 2007, s.24(1) in WN #008. (111)

3. The licensee has failed to ensure that resident #010, #011 and #012 were protected from neglect by PSW #107.

Related to resident #010, #011 and #012:

A critical incident inspection (CIR) was submitted to the Director on a specified date, for an alleged staff to resident neglect incident. The CIR indicated on a specified date and time, PSW #104 and #105 suspected PSW #107 failed to provide care to three residents (resident #010, #011 and #012). The CIR indicated the allegation was not reported to the RCC #106 until a number of days later.

Observation of resident #010, #011 and #012 on a specified date, by Inspector #111, indicated all three residents resided on a specified unit. Resident #010 was confined to a mobility aid,was incontinent and not interviewable. Resident #011 was confined to a mobility aid, was incontinent and not interviewable. Resident #012 was walking independently, was continent but unable to recall any previous incidents of care not provided.

Review of the written plan of care for resident #010, indicated the resident required extensive assistance by two staff for toileting, dressing and bathing. The resident was also incontinent.

Review of the written plan of care for resident #011, indicated the resident required assistance of two staff with mobility, toileting and was frequently incontinent.

Review of the written plan of care for resident #012, indicated the resident required verbal cues or minimal physical assistance with toileting and required staff assistance with dressing.

Review of the home's investigation indicated the allegation of staff to resident neglect involved PSW #107 who was suspected of neglecting to provide care (toileting, bathing and dressing) to three residents (resident #010, #011 and #012) on a specified date and time. The allegation was immediately reported by PSW #103 and #104 to RCC #106 at that time. The investigation was not initiated or reported to the Director by RCC #106, until a number of days later.The Investigation concluded the allegation was determined to be founded.

During an interview with RCC #106 by Inspector #111, they confirmed they were informed of the allegation of staff to resident neglect towards three residents when the incident was discovered. RCC confirmed they did not initiate the investigation or inform the SDM's and the Director until a number of days later.

During an interview with the DOC by Inspector #111, they confirmed the alleged staff to resident neglect involving three residents (#010, #011 and #012) by PSW #107 was reported by PSW #103 on a specified date, to RCC #106. The DOC confirmed the investigation was not initiated until a number of days later and was determined to be founded, as the three residents were not provided care according to their plan of care. The DOC confirmed awareness that the allegation was not reported to the SDMs or the Director until a number of days later.

The licensee failed to ensure that three residents (#010, #011 and #012) were protected from neglect by PSW #107 as follows:
-When the plan of care was not provided to resident #010, #011 and #012 related to toileting, dressing, bathing or continence care on a specified date, resulting in neglect of care, as indicated under LTCHA, 2007, s.6(7) in WN #003.

-When the alleged neglect of care that was immediately reported immediately by PSW #103 to RCC #106 on a specified date and time, the allegation was not immediately investigated until a number of days later, as indicated under LTCHA, 2007, s.23(1)(a) in WN #007.
-When the SDMs of the three residents involved in the alleged staff to resident neglect by PSW #103, were not made aware of the allegations until a number of days after the allegations were made, as indicated under O.Reg. 79/10, s. 97(1)(a) in WN #010.
-When the Director was not immediately notified of the alleged staff to resident abuse by PSW #101 towards seven residents, until a number of months after the DOC was made aware, as indicated under LTCHA, 2007, s.24(1) in WN #008. [s. 19. (1)].

The severity of this issue was determined to be a level 2, as there was a potential for harm to 11 residents from three different staff, with either verbal abuse, emotional abuse or neglect. The scope was determined to be widespread, at level 3, as three out of three incidents reviewed, demonstrated that residents were not being protected from abuse and neglect. The history related to non-compliance with LTCHA, 2007, s.19(1) was determined to be a level 4, as a Compliance Order (CO) has been re-issued to the same subsection on three or fewer COs (complied or not; same or different) as follows:
-A CO was issued on October 24, 2018 during inspection #2018_578672_0009 and was complied on February 12, 2019.
-A CO was issued on October 10, 2017 during inspection # 2017_578672_0013 and was complied on May 22, 2018. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 27, 2020(A1)

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall be compliant with O. Reg. 79/10, s.15(1)(a).

Specifically, the licensee must complete the following:

1) Ensure that bed rail use by any resident in the home is assessed and implemented in full accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (FDA, 2003)" which is recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008". This includes, but is not limited to:

a) A documented individual resident assessment by an interdisciplinary team, including all specified factors prior to any decision regarding bed rail use or removal from use. The specified factors are: medical diagnosis, conditions, symptoms, and/or behavioral symptoms; sleep habits; medication; acute medical or surgical interventions; underlying medical conditions; existence of delirium; ability to toilet self safely; cognition;

communication; mobility (in and out of bed); risk of falling.

b) A documented risk benefit assessment, following the resident assessment by the interdisciplinary team, where bed rails are in use. The documented risk benefit assessment, as prescribed, is to include: identification of why other interventions are not appropriate, or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident; a final conclusion, if bed rails are used, indicating that clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination that
the risk of bed rail use is lower that of other interventions or of not using them.

c) Documented approval of the use of bed rails for an individual resident by the interdisciplinary team that conducted the resident's assessment and the final risk benefit assessment. The names of the team members are to be documented.

2)All registered staff who participate in the assessment of residents where bed rails are used shall receive education so that they have an understanding of and are able to apply the expectations identified in both the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008" and the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) in order to establish and document the rationale for or against the implementation of bed rails as it relates to safety risks.

3) Update the written plan of care based on the resident's assessment/ reassessment by the interdisciplinary team. Provide clear directions as to how the bed rails on a resident's bed are to be used, when they are to be used, and in what position they are to be used. Include in the written plan of care any necessary accessories or interventions that are required to mitigate any identified bed safety hazards.

4) Re-evaluate all resident's bed systems where bed rails are used in the home, in accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" to minimize risk to the resident. Ensure that bed rails with intermediate locking and stopping positions are evaluated in all positions, as per the above referenced document. Immediately address any entrapment zone failures that are identified, and document actions taken.

5) Take steps to prevent resident entrapment, taking into consideration all potential zones of entrapment on a bed system. This includes, but is not limited to, bed systems that include an air mattress that cannot pass entrapment zone testing by function of their design.

Grounds / Motifs :

1. The licensee has failed to ensure that, where bed rails were used, that the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

The Director provided the following guidance memorandum to the sector, on March 27, 2019, that read:

MOHLTC sent a memo to licensees in 2012 advising them to use the Health Canada Guideline (HCG) "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" as a guiding best practice document to deal with the risk of bed entrapment and the evaluation of bed systems. Listed below are two very important companion guides referenced throughout the HCG. They outline prevailing practices related to assessing residents and to modifying bed systems—inspectors use these two guides, along with the HCG to determine overall compliance with s. 15(1) of O Reg 79/10.
- Clinical Guidance for the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings, April 2003
- A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment June 21, 2006

Prior to this memo, on August 21, 2012, a notice was issued to the Long-Term Care Home (LTC) Administrators from the Director of the Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, identifying a

document produced by Health Canada entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was expected to be used as the best practice document in LTC Homes and provided clear procedures and dimensional criteria with respect to evaluating bed systems using a cone and cylinder tool. The Health Canada Guidance (HCG) document also included a companion guide developed by the Food and Drug Administration (FDA) in the United States entitled "Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006". The guide included information with respect to various options and corrective strategies available to mitigate entrapment zones; a guide to buying beds; how to inventory bed systems, and reviewed the dimensional criteria of bed systems. The documents were considered prevailing practices, which were predominant, generally accepted widespread practice as the basis for clinical decisions with respect to bed safety.

A review of the home's policy, "prevention of Bed Entrapment – ADM-01-03-07" revised June 26, 2017, identified the following:
-All mattresses and the seven zones of the beds used for residents in the home will be tested annually, at admission or if a resident condition changes that warrants an alternate surface to ensure they safe using Health Canada Guidelines.
-Bed rails should only be used after all discussions between the resident and or Substitute Decisions Maker (SDM) and the appropriate procedure followed for either a PASD or Restraint depending on purpose of the rail.

Related to resident #015:

A Critical Incident Report (CIR) was submitted to the Director on a specified date, which identified a bed entrapment incident that occurred on a specified date and time. The report further indicated the resident sustained an injury to a specified area and reported pain to a specified area.

Review of clinical records for resident #015 indicated the resident received a specified mattress, on a specified date. The record review did not indicate that the resident was assessed and their bed system was re-evaluated for entrapment risks when the new mattress was put in place.

The residents bed was observed at the time of inspection by Inspector #570 and no bed rails were attached to the bed frame. According to bed entrapment tracking

records obtained from the Environmental Service Manager (ESM), the resident's bed was tested for entrapment zones with a specified mattress and with two bed rails in place, on a specified date and zone seven was highlighted as passed. The record did not indicate that other zones were tested. The bed entrapment tracking records indicated that the resident's bed was tested after the assist rails were removed and the mattress was replaced, on a specified date and all zones passed.

A review of the plan of care for resident #015 (at time of entrapment incident), did not indicate that bed rails were used for the resident. The plan of care indicated the resident had a previous incident where the resident raised the head of the bed to 90 degrees and rolled over their quarter bed rail, falling onto a fall mat on the floor.

A review of the home's investigation related to this incident indicated the investigation was completed by Resident Care Coordinator (RCC) #106, who noted that resident #015 was inappropriately provided with bed rails with no history of consent, physician order, or care planning regarding the use of the bed rails. The home's investigation concluded that resident #015 was fitted with a speciality air mattress that did not pass standardized entrapment testing with the use of bed rails.

Separate interviews were conducted by Inspector #570 with PSWs #127 and #128. Both PSWs indicated that resident #015 used to have two bed rails for safety and bed mobility and were removed after the incident (CIR) that occurred on a specified date.

Separate interviews were conducted by Inspector #570 with RPN #124 and RN #149. Both the RPN and RN indicated that resident #015 used to have a specialized air mattress and two bed rails on their bed, until they were removed due to the incident that occurred on a specified date (CIR). Both RPN #124 and RN #149 indicated that they have not assessed the risk of entrapment for resident #015 and they were not aware of any bed system evaluation completed for the resident, specifically when the resident received a specialized air mattress, on a specified date.

During an interview with staff #126 by Inspector #570, the coordinator of recreation and therapy at the home, they indicated they assisted RCC #117 with bed rail program, ensuring that the resident had been assessed and had the equipment they needed. Staff #126 further indicated that the environmental team was responsible in

completing bed systems evaluations for risk of entrapment when a surface was changed, if bed rail changed in any way, or with any changes to the bed frame. Staff #126 indicated no awareness when resident #015's bed system was assessed for entrapment as it would fail zone #3 when the bed rails were used with low air loss mattress in place. The coordinator of recreation and therapy indicated that the environmental staff should have all records for completed bed entrapment testing.

During an interview with Environmental Service Manager (ESM) by Inspector #570, they indicated that they had no records that resident #015's bed had been evaluated when the resident received a specified mattress, on a specified date. They added, the bed system was evaluated for resident #015 the following year, as per the bed entrapment tracking sheet. The ESM acknowledged that the bed system was evaluated for resident #015 on a specified date, with the specified therapeutic mattress and two bed rails were in place and that evaluation indicated zone 7 passed. The ESM indicated that no other zones were highlighted as passed and that should have been communicated to the nursing staff and to maintenance supervisors. The ESM indicated that the entrapment zones were tested after the bed rails were removed and the therapeutic mattress was replaced as a result of the incident that occurred a specified date (CIR).

During an interview with Resident Care Coordinator (RCC) #106, they indicated that the bed rails were improperly matched with a therapeutic mattress on a specified date, for resident #015 as the use of speciality mattress do not pass all entrapment zones, when used with bed rails. The RCC further indicated no awareness that the resident's bed system was evaluated for entrapment risk, as it was the responsibility of the environmental services department. Upon review of the bed entrapment tracking records with the RCC, the RCC indicated the assessment completed on a specified date, for resident #015 indicated that only zone 7 passed and had no information on whether the other zones were tested. The RCC further indicated that all the zones should have been tested.

During an interview with RCC #117, they indicated when bed rails are used in combination with a therapeutic mattress, the bed system assessment will not pass all zones of entrapment and there will be a risk in zone 3.

During an interview with the Director of Care (DOC), they indicated that the home's expectation was that the environmental services department should be doing bed

system evaluations for entrapment zones, with any change of mattress, bed rails or changes to the bed frame itself.

The license therefore did not ensure that resident #015 who used bed rails and a therapeutic mattress, was assessed in accordance with prevailing practices to minimize risk to the resident.

3. Related to resident #031:

Resident #031's bed was observed by Inspector #570 at the time of inspection. The resident used a hi-low bed equipped with two bed rails. The resident was not using a therapeutic mattress at the time of observation. According to bed entrapment tracking records obtained from the ESM, the resident's bed was tested for entrapment zones with a different specified mattress and two bed rails on a specified date, after the incident occurred. The record review did not indicate that resident #031's bed system was evaluated when resident had a therapeutic mattress in place with two bed rails.

A review of progress notes for resident #031 indicated the resident's bed rails were removed from the bed on a specified date, as per safety precautions while in use with speciality mattress.

A review of plan of care for resident #031 dated June 24, 2019, did not indicate that grab assist bars were used for the resident until the care plan was updated on July 7, 2019, indicating: allow resident to attempt movements by self before offering assistance. Resident will continue to use both assist bar rails as PASD for bed mobility. The review did not indicate that a bed system evaluation was completed when the mattress was replaced and assist rails were reinstalled.

During separate interviews with PSW #128 and RN #031, they indicated that resident #031 always had assist rails used for bed mobility.

During an interview with RPN #124, they indicated that resident #031 was using two assist rails for bed mobility and that the rails were removed on July 6, 2019, and the resident fell out of bed that day. The resided had speciality mattress that was removed, and the assist rails were reinstalled on July 7, 2019.

During an interview with RCC #106, they indicated that it was the responsibility of the environmental services department to complete bed system evaluations for entrapment zones; and indicated no awareness when resident #031 received a speciality mattress and no awareness if their bed system was evaluated when they received the speciality mattress. The RCC further indicated that upon discovery of resident #015's entrapment incident, the home took action to review every use of bed rail and speciality mattress in the home.

During an interview with the ESM, they indicated that resident #031's bed system was evaluated on a specified date (after the incident occurred) and no other bed systems evaluations could be found for the resident.

During an interview with the DOC, they indicated that the home's expectation that environmental services department should be doing bed system evaluations for entrapment zones with any change of mattress, rails and any change to the bed it self.

The license therefore did not ensure that resident #031 who used bed rails, was assessed in accordance with prevailing practices to minimize risk to the resident. (570)

2. 2. Related to resident #016:

A Critical Incident Report (CIR) report was submitted to the Director on a specified date, which identified a bed entrapment incident that occurred on a specified date and time. The CIR indicated a specified area of resident #016 was caught in the bed rail. The bed rail was removed and the resident was sent to hospital for assessment. The report further indicated that the resident returned to the home on a specified date with injuries to a specified area.

A review of the clinical records for resident #016, indicated the resident was assessed for a therapeutic mattress on a specified date in 2017. The record review did not indicate that the resident's bed system was re-evaluated for entrapment risks after that date.

Resident #016's bed was observed at the time of inspection and no bed rails were in place. The resident had a specified bed with specified falls prevention intervention in

place. The resident was also using a therapeutic loss mattress. According to bed entrapment tracking records obtained from the ESM, the resident's bed was tested for entrapment zones with a regular mattress and bed rails on a specified date, a number of months before the incident occurred. The record review did not indicate that resident #016's bed system was re-evaluated when resident received a therapeutic mattress and two bed rails. The bed entrapment tracking records indicated that the resident's bed system was re-evaluated for entrapment zones with the therapeutic mattress in place and with no rails on a specified date, after the bed entrapment incident.

A review of plan of care for resident #016, in place at time of incident, did not indicate that the resident used any bed rails or had a therapeutic mattress in place. The plan of care was not updated until a specified date and indicated under bed mobility, bed rails on both sides of bed for bed mobility and repositioning in bed.

A review of the home's investigation related to this incident was conducted and indicated the investigation was completed by RCC #102. They noted that resident #015 was using a therapeutic mattress and had bed rails. The resident and their SDM were made aware of the potential danger of entrapment, that it was not recommended to have bed rails and both the resident and SDM agreed to the risks. On a specified date and time, a specified area of the resident, became entrapped between the mattress and the bed rail and had to be sent to hospital for an assessment. The resident returned the later the same day and agreed to have the bed rails removed.

During an interview with RPN #129 by Inspector #570, they indicated that resident #016 used to have two half bed rails for safety and bed mobility. The resident had a therapeutic mattress for a number of years. RPN #129 indicated bed system evaluations for risk of entrapment was completed by the Occupational Therapist (OT) or maintenance. The RPN indicated no awareness if resident #016's bed system was re-evaluated for risks of entrapment when they received a therapeutic mattress.

During an interview with staff #126 (coordinator of recreation and therapy) by Inspector #570, they indicated that resident #016's became entrapped in the bed rail and the risks of entrapment had been explained to the resident before the incident, but the resident wanted to continue using the bed rails. They indicated the resident only agreed to remove the bed rails after the bed entrapment incident occurred. Staff

#126 further indicated that environmental staff should have documentation of the bed entrapment assessment completed for resident #016, the bed system for resident #016 would have failed the entrapment testing when the bed rails and therapeutic mattress were used. Staff #126 indicated that if a bed system assessment failed entrapment zones, adjustments had to be made, either by finding a new mattress or removing the bed rails.

During an interview with the ESM by Inspector #570, they indicated that resident #016's bed system was evaluated on a specified date (after the bed entrapment incident) and no bed systems evaluations could be located for the resident when the resident previously had the therapeutic mattress and the bed rails in use.

During an interview with RCC #102 by Inspector #570, they indicated that resident #016 always had the bed rails and used low air loss mattress due to skin integrity concerns and for comfort due to their palliative status. The RCC further indicated no awareness if resident #016 bed system was evaluated for risks of entrapment when they received a low air loss mattress.

During an interview with the DOC by Inspector #570, they indicated that the home's expectation that environmental services department should be doing bed system evaluations for entrapment zones with any change of mattress, rails and any change to the bed it self.

The license did not ensure that resident #016 who used bed rails, was assessed in accordance with prevailing practices to minimize risk to the resident. (570)

3. 3.Related to resident #031:

Resident #031's bed was observed by Inspector #570 at the time of inspection. The resident used a hi-low bed equipped with two bed rails. The resident was not using a therapeutic mattress at the time of observation. According to bed entrapment tracking records obtained from the ESM, the resident's bed was tested for entrapment zones with a different specified mattress and two bed rails on a specified date, after the incident occurred. The record review did not indicate that resident #031's bed system was evaluated when resident had a therapeutic mattress in place with two bed rails.

A review of progress notes for resident #031 indicated the resident's bed rails were

removed from the bed on a specified date, as per safety precautions while in use with specialty mattress.

A review of plan of care for resident #031 dated June 24, 2019, did not indicate that grab assist bars were used for the resident until the care plan was updated on July 7, 2019, indicating: allow resident to attempt movements by self before offering assistance. Resident will continue to use both assist bar rails as PASD for bed mobility. The review did not indicate that a bed system evaluation was completed when the mattress was replaced and assist rails were reinstalled.

During separate interviews with PSW #128 and RN #031, they indicated that resident #031 always had assist rails used for bed mobility.

During an interview with RPN #124, they indicated that resident #031 was using two assist rails for bed mobility and that the rails were removed on July 6, 2019, and the resident fell out of bed that day. The resided had specialty mattress that was removed, and the assist rails were reinstalled on July 7, 2019.

During an interview with RCC #106, they indicated that it was the responsibility of the environmental services department to complete bed system evaluations for entrapment zones; and indicated no awareness when resident #031 received a specialty mattress and no awareness if their bed system was evaluated when they received the specialty mattress. The RCC further indicated that upon discovery of resident #015's entrapment incident, the home took action to review every use of bed rail and specialty mattress in the home.

During an interview with the ESM, they indicated that resident #031's bed system was evaluated on a specified date (after the incident occurred) and no other bed systems evaluations could be found for the resident.

During an interview with the DOC, they indicated that the home's expectation that environmental services department should be doing bed system evaluations for entrapment zones with any change of mattress, rails and any change to the bed it self.

The license therefore did not ensure that resident #031 who used bed rails, was assessed in accordance with prevailing practices to minimize risk to the resident.

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

The severity of this issue was determined to be a level 3, as there was actual harm to resident #015 and #016 in relation to bed rail use and air mattresses. The scope was determined to be widespread, at level 3, as three out of three residents reviewed were not assessed in accordance with prevailing practices. The history related to non-compliance with O. Reg. 79/10, s.15(1)(a) was determined to be a level 2, as non-compliance was issued in other non-related areas over the last three years. (570)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 27, 2020(A1)

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

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 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 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 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

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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 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 10th day of February, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by LYNDA BROWN (111) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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