Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 9, 2019	2019_695156_0004	011080-19, 011203-19, 011649-19, 013190-19, 013573-19, 014121-19, 014493-19, 015099-19, 015353-19, 016256-19, 016486-19, 016880-19	Critical Incident System

Licensee/Titulaire de permis

Corporation of the City of Brantford and the Corporation of the County of Brant
97 Mount Pleasant Street BRANTFORD ON N3T 1T5

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

John Noble Home
97 Mount Pleasant Street BRANTFORD ON N3T 1T5

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

CAROL POLCZ (156), LESLEY EDWARDS (506)

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): September 5, 6, 10, 11, 12, 13, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, 2019

During the course of the inspection, the inspectors reviewed resident clinical records, the home's policiies and procedures, the homes investigative notes and staff education and training records.

The following critical incident system (CIS) inspections were conducted during this CIS inspection:
016880-19 related to falls
011080-19 related to abuse
015353-19 related to falls
011203-19 related to responsive behaviours
013573-19 related to abuse
014493-19 related to responsive behaviours
015099-19 related to abuse
016486-19 related to responsive behaviours

013190-19 related to responsive behaviours

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Care Coordinator (RCC), Resident Assessment Instrument (RAI) Coordinator, physician, registered staff (registered nurses and registered practical nurses), personal support workers (PSW's), residents and family members.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

8 WN(s)
7 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 :

1. The licensee failed to ensure that resident #011 was protected from abuse by resident #010.

A) The home submitted a Critical Incident Systems (CIS) report in June, 2019, identifying abuse of resident #011 from resident #010.

Review of resident #010's clinical record confirmed that resident #010 had previous documented incidents with resident #011. Both residents had a Cognitive Performance Score (CPS) indicating cognitive impairment and resident #011 could not physically remove them self from resident #010.

The following documented incidents were in resident #010's clinical record between resident #010 and #011:

i. In January, 2019, resident #010 was witnessed approaching resident #011. Staff were able to separate residents before any contact was made.

ii. On an identified date in February, 2019, resident #010 was observed in a specific area with resident #011. Staff separated the residents, monitored the resident and kept them separated.

iii. On an identified date in February, 2019, resident #010 went to resident #011. Staff intervened and removed resident #010 away from resident #011.

iv. On an identified date in February, 2019, resident #010 was seen in another area of the unit and was witnessed going toward resident #011 and staff were able to redirect the resident away from resident #011.

v. On an identified date in February, 2019, resident #010 was witnessed with resident #011 and the residents were separated.

vi. On an identified date in February, 2019, staff witnessed resident #010 made multiple attempts to go towards resident #011. Resident #010 was redirected away by staff.

In February 2019, the Physician ordered medications to help manage responsive behaviours for resident #010. Registered staff had also created a care plan for resident #011 in February, 2019, that directed staff to implement a specific intervention.

There were no further documented incidents of responsive behaviours towards residents or staff after an identified date in February until an identified date in April, 2019; after a medication change. Specifically, resident #010 started to display responsive behaviours towards staff and resident #011 and resident #013 after the medications were discontinued.

The following incidents were documented in resident #010's clinical record when the resident started to display responsive behaviours after the medication was discontinued:

i. In May, 2019, it was documented that resident #010 displayed responsive behaviours towrad resident #011. Resident #010 was removed and told their behaviour was inappropriate. Interview with RPN #128 confirmed that resident #010's actions met the definition of abuse toward resident #011.

ii. On an identified date in May, 2019, resident #010 was witnessed displaying responsive behaviours toward resident #011. The resident was immediately removed from resident #011. RPN #122 confirmed they assessed resident #011 and there were no injuries noted. RPN #122 confirmed that resident #010's actions met the definition of abuse towards resident #011.

iii.On an identified date in May, 2019, resident #010 approached and displayed responsive behaviours toward resident #011. Resident was immediately removed from resident #011. RPN #122 confirmed that they assessed resident #011 and there were no injuries noted. RPN #122 confirmed that resident #010's actions met the definition of abuse towards resident #011.

iv. On an identified date in May 20, 2019, resident #010 was witnessed displaying

responsive behaviours toward resident #011. The resident was immediately removed from resident #011. RPN #123 confirmed that they assessed resident #011 and there were no injuries noted. RPN #123 confirmed that resident #010's actions met the definition of abuse towards resident #011 and resident #011.

v. On an identified date in May, 2019, resident #010 was witnessed by RPN #127 displaying responsive behaviours toward resident #011. The RPN separated the residents and told resident #010 that their behaviour was inappropriate.

vi. On an identified date in June, 2019, PSW #120 and PSW #121 witnessed resident #010 displaying responsive behaviours toward resident #011. Resident #010 was immediately removed from resident #011 and taken to their room. Resident #011 was assessed and there were no injuries noted to resident #011 and resident #011 did not have the capacity to consent.

The DOC confirmed that resident #011 was not protected from abuse as per the definition of Ontario Regulation 79/10 from resident #010. The licensee failed to protect resident #011 from abuse by resident #010.

B) The licensee failed to ensure that resident #013 was protected from abuse by resident #010.

Review of resident #010's clinical record confirmed that resident #010 had three documented incidents of displaying responsive behaviours with resident #013. Both residents had a CPS identifying cognitive impairment.

i. In May, 2019, it was reported to RPN #124 that resident #010 was observed displaying responsive behaviours toward resident #013 and the residents were immediately separated. RPN #124 confirmed that they assessed the resident and there were no injuries to resident #013. RPN #124 confirmed that resident #010's actions met the definition of abuse towards resident #013.

ii. On an identified date in May, 2019, clinical record review confirmed that resident #010 was witnessed displaying responsive behaviours toward resident #013. Interview with RPN #123, confirmed that the incident occurred and that they assessed resident #013. RPN #123 confirmed that resident #010's actions met the definition of abuse towards resident #013.

iii. On an identified date in May, 2019, resident #010 was observed displaying responsive behaviours toward resident #013. The resident was immediately redirected from resident #013. RPN #122 confirmed they assessed resident #013 and there were no injuries noted. RPN #122 confirmed that resident #010's actions met the definition of abuse towards resident #013.

The licensee failed to protect resident #013 from abuse by resident #010. [s. 19.]

2. The licensee failed to ensure that resident #003 was protected from abuse by resident #002.

The home submitted a CI report in July, 2019, identifying abuse of resident #003 from resident #002 on an identified date in June, 2019.

Review of resident #002's clinical record confirmed that resident #002 had a history of responsive behaviours toward other residents.

i. In March, 2019 resident #002 was observed by staff having an altercation with resident #014. When staff attended to the area, resident #002 was no longer there. Staff followed up with resident #014 and no injuries were noted.

ii. On an identified date in April, 2019, there was an incident in which resident #002 was abusive toward resident #015. The residents were redirected from each other.

iii. On an identified date in April, 2019, there was an incident between resident #002 and resident #016. When staff approached the area to discuss the incident with the resident, resident #002 left the area.

iv. On an identified date in May, 2019, resident #002 made an action toward resident #003 to get their attention and then made an inappropriate gesture. Resident #002 was redirected away from the resident.

v. On identified dates in June, 2019, resident #002 approached a resident and began being abusive. Resident #002 then proceeded to leave the area.

The responsive behaviours care plan in place for resident #002 included specific directions to staff if the resident was displaying behaviours.

The home's investigative records and the resident's clinical records were reviewed. It was confirmed that the resident reported feeling afraid at the time of the incident.

The DOC confirmed that the incident met the definition of abuse and that the home did not ensure that resident #003 was protected from abuse by resident #002. The licensee failed to protect resident #003 from abuse by resident #002. [s. 19. (1)]

3. The licensee failed to ensure that resident #007 was protected from abuse by resident #003.

Progress notes indicated a history of inappropriate behaviour of resident #003 where the resident made inappropriate comments towards staff on two occasions in May and one in August, 2019.

The home submitted a CI report in July, 2019, identifying abuse of resident #007 from resident #003.

Review of resident #003's clinical record confirmed that a PSW witnessed resident #003 displaying responsive behaviours toward resident #007. The PSW intervened and resident #003 left the area.

RPN #112 confirmed that they assessed resident #007 and there were no injuries noted following the incident. RPN #112 confirmed that resident #003's actions met the definition of abuse toward resident #007 and therefore, the home did not ensure that resident #007 was protected from abuse by resident #003.

The licensee failed to protect resident #007 from abuse by resident #003. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

A review of the clinical record for resident #007 identified that the resident displayed a number of responsive behaviours towards residents, staff and visitors which required interventions by staff. The common behavioural trigger was identified for resident #007. The documented plan of care and the kardex that was currently in place and was used by staff to provide direct care to the resident, identified a focus statement that read that the resident had responsive behaviours; however, there was no focus statement that included a specific behaviour towards residents, staff and visitors and did not include identified interventions nor specifically the identified trigger for the resident. It did not include any recommendations identified on how to approach the resident when the resident appeared upset and did not include another identified intervention that had been able to deescalate these behaviours. Interviews with RN #111 and RPN #112, confirmed that these interventions were used by staff when the resident was displaying responsive behaviours but were not added to the plan of care. The DOC confirmed that the plan of care did not set out the planned care for the resident in managing responsive behaviours.

[s. 6. (1) (a)]

2. A) The licensee failed to ensure that care set out in the plan of care was provided to resident #002 as specified in the plan.

Review of the written plan of care for resident #002 identified under interventions under the the responsive behaviours focus statement that staff were implement specific interventions.

The home submitted CI report in July, 2019, identifying abuse of resident #003 from resident #002 in June, 2019.

Interview with the Resident Care Coordinator reported that there was no documentation to support that the interventions had been completed as per the care plan of resident #002. Interview with PSW #119 who was working with resident #002 on the identified date in June, 2019, reported that they did not recall ever having completed interventions on resident #002. PSW #119 and the RCC confirmed that care set out in the plan of care was not provided to the resident as specified in the plan.

B) The licensee failed to ensure that the care set out in the plan of care was provided to resident #010 and #013 as specified in the plan.

Review of the written plan of care for resident #010 and #011 that had been put in place in February 2019, identified under interventions under the responsive behaviour focus statement that resident #010 had displayed responsive behaviours toward resident #011 and to keep both residents separated. On an identified date in May, 2019, a new intervention was put in place for resident #010 which identified that resident #010 was to be taken out of a specific area. The following documented incidents were in resident #010's clinical record:

i. In June, 2019, resident #010 and #011 were left unattended in an identified area. When PSW #120 and PSW #121 returned to the area, they witnessed resident #010 displaying responsive behaviours toward resident #011. Resident #010 was not removed from the area immediately .

The DOC confirmed that resident #010's plan of care was not followed.

ii. On identified dates in May, 2019, resident #010 was witnessed displaying responsive

behaviours toward resident #011. The DOC confirmed that the plan of care for resident #010 and #011 was not followed as the licensee did not keep both residents separated.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #010 and #011 as specified in the plan. [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan was no longer necessary.

The plan of care for resident #012 indicated that the resident #012 had behaviours towards resident #003. An intervention had been initiated. These interventions were initiated on an identified date in July, 2019.
Resident #003 was moved to a different home area in July, 2019.

A review of the plan of care on on September 23, 2019 still indicated the intervention as above. Interview with RN #126 confirmed that the plan of care was not reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary in relation to the resident #003. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care for each resident set out the planned care for the resident and to ensure that care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with.

In accordance with Ontario Regulation 79/10 section 48 (1) the licensee was required to ensure that written policies and procedure are developed for the falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the licensee's policy "Risk Assessment/Fall Prevention, Nursing Manual, policy number 3-I-20" dated May 2019, which required staff to complete follow up documentation in the progress notes every shift for 72 hours post fall, monitoring for pain and injuries that may not have been immediately apparent.

A) Resident #006's clinical record confirmed that resident #006 sustained an unwitnessed fall in August, 2019. Review of the clinical record identified that staff did not complete follow up documentation in the progress notes on an identified date in August, 2019, on identified shifts. Interview with the RCC confirmed that staff did not follow the licensee's policy for risk assessment/ fall prevention and document on the resident's progress notes for 72 hours post fall to monitor for pain and injuries that may not have been immediately apparent.

B) Resident #005's clinical record confirmed that resident #005 sustained a witnessed fall in August, 2019. Review of the clinical record identified that staff did not complete follow up documentation in the progress notes on an identified date in August, 2019, on identified shifts. Interview with RCC confirmed that staff did not follow the licensee's policy for risk assessment/ fall prevention and document on the resident's progress notes

for 72 hours post fall to monitor for pain and injuries that may not have been immediately apparent. [s. 8. (1) (b)]

2. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with.

In accordance with Ontario Regulation 79/10 section 55 (1) the licensee was required to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Specifically, staff did not comply with the licensee's policy "Responsive Behaviour – policy 3-K-60" dated December 2017, which identified under “follow-up and evaluation” that staff were to refer the resident to the Risk Management Team. Interview with the DOC confirmed that residents exhibiting responsive behaviours were referred under the Risk Management team and then discussed at the weekly meetings in order to prevent and reduce the severity of adverse events.

The home submitted CI report in July, 2019 identifying abuse of resident #007 from resident #003.

A review of the clinical record and CI confirmed that resident #003 displayed responsive behaviours toward resident #007 in July, 2019. Following the incident, progress notes for resident #003 indicated that they would be added to risk management. Interview with the Administrator confirmed that the resident was not added to risk management as per the policy. The licensee failed to ensure that the policy was complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #4: 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 :

1. The licensee failed to ensure that when a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident resulted in harm or risk of harm to the resident shall immediately report this suspicion to the Director.

A) A Critical Incident System report was submitted to the Director in August, 2019, reporting an allegation of abuse towards resident #005 by resident #007 that took place in August, 2019. A review of the licensee's clinical records and the CIS confirmed that RPN #113 and RN#117 were aware of the incident that took place on the identified date in August, 2019. RN #111 confirmed that staff did not immediately report the allegation of

abuse to the Director.

B) i. Review of the progress notes on an identified date in May, 2019 and documented by RPN #122 identified that resident #010 was observed by PSW staff displaying responsive behaviours toward resident #013. RPN #122 confirmed that this incident met the definition of abuse. It was reported that they assessed the resident and there were no injuries noted to resident #013. They acknowledged they reported it to RN #126; however RN #126 confirmed that they did not recall being notified of the incident. RPN #122 confirmed that they did not report it to the Director.

ii. Review of the progress notes on an identified date in May, 2019 and documented by RPN #123 identified that resident #010 was observed by PSW staff displaying responsive behaviours toward resident #011. RPN #123 confirmed that this incident met the definition of abuse. It was reported that they assessed the resident and there were no injuries noted to resident #013. They acknowledged they reported it to RN #126; however RN #126 confirmed that they did not recall being notified of the incident. RPN #123 confirmed that they did not report it to the Director.

iii. Review of the progress notes on an identified date in May, 2019 and documented by RPN #123 identified that resident #010 was observed by staff displaying responsive behaviours toward resident #013. RPN #123 confirmed that this incident met the definition of abuse. It was reported that they assessed the resident and there were no injuries noted to resident #013. RPN #123 confirmed that they did not report it to the Director.

iv. Review of the progress notes on an identified date in May, 2019 and documented by RPN #122 identified that resident #010 was observed displaying responsive behaviours toward resident #011. RPN #122 confirmed that this incident met the definition of abuse. It was reported that they assessed the resident and there were no injuries noted to resident #011. They acknowledged they reported it to RN #126; however, RN #126 confirmed that they did not recall being notified of the incident. RPN #122 confirmed that they did not report it to the Director.

v. Review of the progress notes on an identified date in May, 2019 and documented by RPN #124 identified that resident #010 was observed by staff displaying responsive behaviours toward resident #013. RPN #124 confirmed that this incident met the definition of abuse. It was reported that they assessed the resident and there were no injuries noted to resident #013. They acknowledged they reported it to RN #117; however

RN #117 was not available at the time of this inspection. RPN #124 confirmed that they did not report it to the Director.

vi. Review of the progress notes on an identified date in May, 2019 and documented by RPN #122 identified that resident #010 was observed by PSW staff displaying responsive behaviours toward resident #011. RPN #122 confirmed that this incident met the definition of abuse. It was reported that they assessed the resident and there were no injuries noted to resident #011. They acknowledged they reported it to RN #126; however, RN #126 confirmed that they did not recall being notified of the incident. RPN #122 confirmed that they did not report it to the Director.

The DOC confirmed that these incidents of alleged abuse were not reported to the Director.

C) A Critical Incident System report was submitted to the Director on an identified date in July, 2019, reporting an allegation of abuse towards resident #012 by resident #003 that took place two days prior. Interview with the DOC and review of the licensee's clinical records confirmed that RPN #129 was aware of the incident and had reported it RN #118 who had left two messages with the on-call Administrator's voice mail. The DOC reported that the on-call Administrator had their phone on "airplane" mode and therefore, had not received the messages. The DOC reported the incident to the Director when made aware of the incident after listening to their voicemail when they came back to work. The DOC confirmed that staff did not immediately report the allegation of abuse to the Director.

D) A Critical Incident System report was submitted to the Director on an identified date in July, 2019, reporting an incident of abuse between resident #002 and resident #003 that took place on an identified date in June, 2019. The Resident Care Coordinator (RCC) confirmed that they were the Administrator on call on the identified date in June, 2019 and were made aware of the incident after receiving a call from RN #130 who was working at the time of the incident. The RCC confirmed that they did not immediately report the allegation of abuse to the Director (156). [s. 24.]

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 when a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident resulted in harm or risk of harm to the resident shall immediately report this suspicion to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) Review of the clinical record revealed that on an identified date in May, 2019, resident #010 exhibited responsive behaviours towards resident #013, which met the definition of abuse. RPN #122 confirmed the incident was documented in resident #010's clinical record and that they had completed an assessment of resident #013, to ensure there were no injuries from the incident; however, the incident and the assessment were not documented in the clinical record of resident #013.

B) Review of the clinical record revealed that on an identified date in May, 2019, resident #010 exhibited responsive behaviours towards resident #011, which met the definition of abuse. RPN #123 confirmed the the incident was documented in resident #010's clinical record and that they had completed an assessment of resident #011, to ensure there were no injuries from the incident; however, the incident and the assessment were not

documented in the clinical record of resident #011.

C) Review of the clinical record revealed that on an identified date in May, 2019, resident #010 exhibited responsive behaviours towards resident #011, which met the definition of abuse. RPN #122 confirmed that the incident was documented in resident #010's clinical record and that they had completed an assessment of resident #011, to ensure there were no injuries from the incident; however, the incident and the assessment were not documented in the clinical record of resident #011.

D) Review of the clinical record revealed that on an identified date in May, 2019, resident #010 exhibited responsive behaviours towards resident #013, which met the definition of abuse. RPN #124 confirmed the incident was documented in resident #010's clinical record and that they had completed an assessment of resident #013, to ensure there were no injuries from the incident; however, the incident and the assessment were not documented in the clinical record of resident #013.

E) Review of the clinical record revealed that on an identified date in May, 2019, resident #010 exhibited responsive behaviours towards resident #011, which met the definition of abuse. RPN #122 confirmed the the incident was documented in resident #010's clinical record and that they had completed an assessment of resident #011, to ensure there were no injuries from the incident; however, the incident and the assessment were not documented in the clinical record of resident #011.

An interview with the DOC confirmed that all actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented in the above incidents and should have been documented in both the residents' charts. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: 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 :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The home submitted a CIS report in August, 2019, identifying inappropriate treatment of resident #004.

On an identified date in August, 2019, PSW #109 and #114 were transferring resident #004 when the resident sustained a fall and resident #004 was injured. Review of the investigation notes and incident report provided by the licensee confirmed that the PSW's had used the proper equipment and had two people present for the entire process. PSW #109 reported to RN #111 that they thought that a part of the equipment came out and the resident fell to the floor.
The DOC confirmed that PSW #109 and #114 did not use safe transferring and positioning techniques when assisting resident #004. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, behavioural triggers were identified, strategies were developed, implemented and actions were taken to respond to the needs of the resident, including assessments and reassessments.

Progress notes indicated a history of responsive behaviours of resident #003 where the resident displayed responsive behaviours towards staff on two occasions in May, 2019 and one in August, 2019.

A CIS was submitted to the Director in July, 2019, reporting an allegation of abuse between resident #003 and resident #007. The CIS indicated that PSW #131 witnessed resident #003 display responsive behaviours toward resident #007.

Interview with the Administrator and a review of the clinical record for resident #003 confirmed that the written plan of care did not include a responsive behaviour focus, identify triggers, strategies or interventions to manage responsive behaviours by resident #003. [s. 53. (4)]

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 for each resident demonstrating responsive behaviours, behavioural triggers ae identified, strategies are developed, implemented and actions are taken to respond to the needs of the resident, including assessments and reassessments, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. A) The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, identifying and implementing interventions.

A review of the clinical record confirmed that resident #007 had incidents of responsive behaviours with co-residents on multiple occasions which did not cause injury. Record review also confirmed that resident #007 had an intervention in place on and off on several occasions due to their responsive behaviours.

A) On an identified date in August, 2019, resident #007 displayed responsive behaviours toward resident #005. At the time of this incident, the intervention had been removed. A review of the plan of care in place did not include interventions to prevent altercations with co-residents. Interview with the DOC confirmed at the time of the incident the home did not take steps to minimize the risk of altercations and potentially harmful interactions between and among resident. [s. 54. (b)]

2. B) The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Resident #017 had a history of responsive behaviours that did not result in injury including:
i. On an identified date in May, 2019, resident #007 had an altercation with resident

#017.
ii. On an identified date in May, 2019, progress notes indicated that resident #017 expressed that they did not like resident #018 but there was no interaction noted.
Later that day, progress notes indicated that resident #017 was still displaying responsive behaviours toward resident #018.
Less than an hour later, resident #017 had an altercation with resident #018. A short while later, another incident occurred with the same resident.
iii. On an identified date in June, 2019, progress notes indicated that resident #017 had an altercation with resident #018. Both residents were redirected.
Later that day, another altercation took place with resident #018 and resident #017.

On an identified date in June, 2019, a CIS was submitted to the Director reporting an allegation of abuse between resident #017 and residents #019 and #020. The CIS indicated that resident #017 entered the area where resident #020 was and proceeded to have an altercation with them. Staff removed resident #017 from the area and into another area where the resident entered into an altercation with resident #019. Resident #020 sustained an injury as a result of the incident.

Interview with the RCC confirmed that there were no new interventions put in place to prevent altercations with co-residents identified during the incidents identified above.
The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, identifying and implementing interventions, to be implemented voluntarily.

Issued on this 7th day of November, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROL POLCZ (156), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2019_695156_0004
Log No. / No de registre :	011080-19, 011203-19, 011649-19, 013190-19, 013573-19, 014121-19, 014493-19, 015099-19, 015353-19, 016256-19, 016486-19, 016880-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 9, 2019
Licensee / Titulaire de permis :	Corporation of the City of Brantford and the Corporation of the County of Brant 97 Mount Pleasant Street, BRANTFORD, ON, N3T-1T5
LTC Home / Foyer de SLD :	John Noble Home 97 Mount Pleasant Street, BRANTFORD, ON, N3T-1T5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jennifer Miller

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Corporation of the City of Brantford and the Corporation of the County of Brant, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

The licensee must be compliant with s. 19(1) of the LTCHA.

Specifically the licensee must:
1. Protect all residents, including residents #011, #013, #003, and #007 from abuse by anyone.
2. Review and revise the policies and procedures for prevention of abuse and neglect and to ensure that these documents provide clear direction to staff related to what constitutes abuse and neglect, as well as, actions they are to take to prevent abuse; including their role and responsibilities when an alleged, suspected or witnessed abuse takes place.
3. Provide re-training for all staff in the home including the Resident Care Coordinator and staff #128, #122, #123, #127, #124, #112, #130 related to the revised policies and procedures noted above. All documentation related to the content of the training program and attendance at those programs is to be maintained by the home.
4. Develop and implement an auditing/monitoring tool to ensure the above noted policies and procedures are complied with.

Grounds / Motifs :

1. The licensee failed to ensure that resident #011 was protected from abuse by resident #010.

A) The home submitted a Critical Incident Systems (CIS) report in June, 2019, identifying abuse of resident #011 from resident #010.

Review of resident #010's clinical record confirmed that resident #010 had previous documented incidents with resident #011. Both residents had a Cognitive Performance Score (CPS) indicating cognitive impairment and resident #011 could not physically remove them self from resident #010.

The following documented incidents were in resident #010's clinical record between resident #010 and #011:

i. In January, 2019, resident #010 was witnessed approaching resident #011. Staff were able to separate residents before any contact was made.

ii. On an identified date in February, 2019, resident #010 was observed in a specific area with resident #011. Staff separated the residents, monitored the resident and kept them separated.

iii. On an identified date in February, 2019, resident #010 went to resident #011. Staff intervened and removed resident #010 away from resident #011.

iv. On an identified date in February, 2019, resident #010 was seen in another area of the unit and was witnessed going toward resident #011 and staff were able to redirect the resident away from resident #011.

v. On an identified date in February, 2019, resident #010 was witnessed with resident #011 and the residents were separated.

vi. On an identified date in February, 2019, staff witnessed resident #010 made multiple attempts to go towards resident #011. Resident #010 was redirected away by staff.

In February 2019, the Physician ordered medications to help manage responsive behaviours for resident #010. Registered staff had also created a care plan for resident #011 in February, 2019, that directed staff to implement a specific intervention.

There were no further documented incidents of responsive behaviours towards residents or staff after an identified date in February until an identified date in April, 2019; after a medication change. Specifically, resident #010 started to display responsive behaviours towards staff and resident #011 and resident #013 after the medications were discontinued.

The following incidents were documented in resident #010's clinical record when

the resident started to display responsive behaviours after the medication was discontinued:

i. In May, 2019, it was documented that resident #010 displayed responsive behaviours toward resident #011. Resident #010 was removed and told their behaviour was inappropriate. Interview with RPN #128 confirmed that resident #010's actions met the definition of abuse toward resident #011.

ii. On an identified date in May, 2019, resident #010 was witnessed displaying responsive behaviours toward resident #011. The resident was immediately removed from resident #011. RPN #122 confirmed they assessed resident #011 and there were no injuries noted. RPN #122 confirmed that resident #010's actions met the definition of abuse towards resident #011.

iii.On an identified date in May, 2019, resident #010 approached and displayed responsive behaviours toward resident #011. Resident was immediately removed from resident #011. RPN #122 confirmed that they assessed resident #011 and there were no injuries noted. RPN #122 confirmed that resident #010's actions met the definition of abuse towards resident #011.

iv. On an identified date in May 20, 2019, resident #010 was witnessed displaying responsive behaviours toward resident #011. The resident was immediately removed from resident #011. RPN #123 confirmed that they assessed resident #011 and there were no injuries noted. RPN #123 confirmed that resident #010's actions met the definition of abuse towards resident #011 and resident #011.

v. On an identified date in May, 2019, resident #010 was witnessed by RPN #127 displaying responsive behaviours toward resident #011. The RPN separated the residents and told resident #010 that their behaviour was inappropriate.

vi. On an identified date in June, 2019, PSW #120 and PSW #121 witnessed resident #010 displaying responsive behaviours toward resident #011. Resident #010 was immediately removed from resident #011 and taken to their room. Resident #011 was assessed and there were no injuries noted to resident #011 and resident #011 did not have the capacity to consent.

The DOC confirmed that resident #011 was not protected from abuse as per the definition of Ontario Regulation 79/10 from resident #010. The licensee failed to protect resident #011 from abuse by resident #010.

B) The licensee failed to ensure that resident #013 was protected from abuse by resident #010.

Review of resident #010's clinical record confirmed that resident #010 had three documented incidents of displaying responsive behaviours with resident #013. Both residents had a CPS identifying cognitive impairment.

i. In May, 2019, it was reported to RPN #124 that resident #010 was observed displaying responsive behaviours toward resident #013 and the residents were immediately separated. RPN #124 confirmed that they assessed the resident and there were no injuries to resident #013. RPN #124 confirmed that resident #010's actions met the definition of abuse towards resident #013.

ii. On an identified date in May, 2019, clinical record review confirmed that resident #010 was witnessed displaying responsive behaviours toward resident #013. Interview with RPN #123, confirmed that the incident occurred and that they assessed resident #013. RPN #123 confirmed that resident #010's actions met the definition of abuse towards resident #013.

iii. On an identified date in May, 2019, resident #010 was observed displaying responsive behaviours toward resident #013. The resident was immediately redirected from resident #013. RPN #122 confirmed they assessed resident #013 and there were no injuries noted. RPN #122 confirmed that resident #010's actions met the definition of abuse towards resident #013.

The licensee failed to protect resident #013 from abuse by resident #010. (506)

2. The licensee failed to ensure that resident #003 was protected from abuse by resident #002.

The home submitted a CI report in July, 2019, identifying abuse of resident #003 from resident #002 on an identified date in June, 2019.

Review of resident #002's clinical record confirmed that resident #002 had a history of responsive behaviours toward other residents.

i. In March, 2019 resident #002 was observed by staff having an altercation with resident #014. When staff attended to the area, resident #002 was no longer there. Staff followed up with resident #014 and no injuries were noted.

ii. On an identified date in April, 2019, there was an incident in which resident #002 was abusive toward resident #015. The residents were redirected from each other.

iii. On an identified date in April, 2019, there was an incident between resident #002 and resident #016. When staff approached the area to discuss the incident with the resident, resident #002 left the area.

iv. On an identified date in May, 2019, resident #002 made an action toward resident #003 to get their attention and then made an inappropriate gesture. Resident #002 was redirected away from the resident.

v. On identified dates in June, 2019, resident #002 approached a resident and began being abusive. Resident #002 then proceeded to leave the area.

The responsive behaviours care plan in place for resident #002 included specific directions to staff if the resident was displaying behaviours.

The home's investigative records and the resident's clinical records were reviewed. It was confirmed that the resident reported feeling afraid at the time of the incident.

The DOC confirmed that the incident met the definition of abuse and that the home did not ensure that resident #003 was protected from abuse by resident #002. The licensee failed to protect resident #003 from abuse by resident #002. (156)

3. The licensee failed to ensure that resident #007 was protected from abuse by resident #003.

Progress notes indicated a history of inappropriate behaviour of resident #003 where the resident made inappropriate comments towards staff on two occasions in May and one in August, 2019.

The home submitted a CI report in July, 2019, identifying abuse of resident #007 from resident #003.

Review of resident #003's clinical record confirmed that a PSW witnessed resident #003 displaying responsive behaviours toward resident #007. The PSW intervened and resident #003 left the area.

RPN #112 confirmed that they assessed resident #007 and there were no injuries noted following the incident. RPN #112 confirmed that resident #003's actions met the definition of abuse toward resident #007 and therefore, the home did not ensure that resident #007 was protected from abuse by resident #003.

The licensee failed to protect resident #007 from abuse by resident #003.

The severity of the issue was determined to be a level 2 potential for actual harm to residents. The scope of the issue was determined to be a level 3 as it was widespread. The home had a level 3 history with one or more related non-compliance in the last 36 months which included:
Voluntary Plan of Correction (VPC) issued January 2, 2019 (2018_570528_0009) (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 09, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 9th day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CAROL POLCZ

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