Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 1, 2019	2019_788721_0009	000105-19, 001088-19, 003348-19, 003531-19, 003805-19, 005187-19, 005549-19, 006124-19	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Health Care, London
268 Grosvenor Street P.O. Box 5777 LONDON ON N6A 4V2

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

Mount Hope Centre for Long Term Care
21 Grosvenor Street P.O. Box 5777 LONDON ON N6A 1Y6

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

MEAGAN MCGREGOR (721), AMBERLY COWPERTHWAITE (435), HELENE DESABRAIS (615)

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): March 18, 19, 20 and 21, 2019.

The following Critical Incident (CI) reports were inspected during the course of this inspection:

CI #C596-000001-19/Log #000105-19 related to resident to resident abuse;
CI# C596-000006-19/Log #001088-19 related to resident to resident abuse;
CI# C596-000021-19/Log #003348-19 related to resident to resident abuse;
CI# C596-000033-19/Log #005187-19 related to resident to resident abuse;
CI# C596-000040-19/Log #006124-19 related to resident to resident abuse;
CI# C596-000025-19/Log #003805-19 related to alleged staff to resident abuse;
CI# C596-000022-19/Log #003531-19 related to falls prevention and management;
CI# C596-000036-19/Log #005549-19 related to an injury of unknown cause.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Associate Directors of Care, a Registered Nurse, Registered Practical Nurses and Personal Care Providers.

The inspector(s) also observed residents and the care provided to them and staff interactions with residents, reviewed clinical records and plans of care for identified residents and reviewed documentation related to the home's internal investigation records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

4 WN(s)
1 VPC(s)
3 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 has failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

Ontario Regulation 79/10 s. 2 (1) defines sexual abuse as "(a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member;

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident where resident #015 sexually abused resident #014.

The CIS report stated that a Personal Care Provider (PCP) had heard noises coming from resident #014's room and upon investigation, the PCP found resident #015 sitting on the floor in resident #014's room with their clothing removed and resident #014 was found with their face at resident #015's groin area. The CIS report continued to state that there were three prior incidents occurring involving this behavior.

A review of resident #015's progress notes in Point Click Care (PCC) showed the following:
- A Behaviour Note on a specific date that documented an incident where resident #015 was found in resident #014's bedroom, was half naked and leaning towards resident #014. Resident #014 was trying to push resident #015 away.
- A Behaviour Note on a specific date that documented an incident where resident #015 was found taking resident #014 to the washroom, locking the door and when staff

unlocked the door resident #015 was found with their clothing removed.
- A Behaviour Note on a specific date that documented an incident where resident #015 was found with their hands on resident #014's chest and stated that resident #014 was distressed by resident #015's actions.
- An Incident/Patient Safety Reporting System (PSRS) Note on a specific date that documented an incident where resident #015 was found naked in resident #014's room sitting on the floor with resident #014's face in resident #015's groin area.

During an interview with a PCP, when asked when resident #015's sexually inappropriate behaviours began towards resident #014, they stated they began when resident #014 was first moved to the floor. When asked if they considered the four identified incidents between resident #015 and resident #014 to be sexual abuse, the PCP stated yes. When asked what interventions were put in place after the first incident of sexual abuse occurred, the PCP stated that nothing was put in place.

During an interview with an Assistant Director of Care (ADOC), when asked what they considered to be sexual abuse, the ADOC stated they would consider non-consensual touching, distress of the resident, including pushing away, to be signs of sexual abuse. When asked when the first incident between resident #015 and #014 occurred related to inappropriate sexual behavior, the ADOC stated that the first incident occurred on a specific date, the second incident occurred on the following day, and two incidents occurred on a third consecutive date. When asked when they first became aware of the incidents, the ADOC stated they first became aware of these incidents two days after the first incident occurred. When asked if they considered these incidents to be sexual abuse, the ADOC stated yes. When asked what interventions were put in place at the time that the identified incidents occurred, the ADOC stated that interventions were not put in place as they did not know about these incidents until two days after the first incident occurred, when one to one monitoring, behavioural support, assessments and safety monitoring of residents #015 and #014 were implemented. The ADOC stated it was their expectation that staff should have reported the first identified incident on the date that it occurred, and that if the incident had been reported, the three incidents of sexual abuse that followed would not have happened. The ADOC stated they were continuing their investigation into staff member's knowledge of these incidents and their reporting requirement.

The licensee had failed to ensure that resident #014 was protected from abuse by resident #015 when the first documented incident occurred on a specific date, and continued three more identified times in the two consecutive days following, when

interventions were initiated. [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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident that occurred on a specific date, where resident #015 sexually abused resident #014. The CIS report stated that a Personal Care Provider (PCP) had heard noises coming from resident #014's room and upon investigation, the PCP found resident #015 sitting on the floor in resident #014's room with their clothing removed and resident #014 was found with their face at resident #015's groin area. The CIS report continued to state that there were three prior incidents that had occurred which involved the same behaviours.

A review of resident #015's progress notes in Point Click Care (PCC) showed the following:
- A Behaviour Note on a specific date that documented an incident where resident #015 was found in resident #014's bedroom, was half naked and leaning towards resident #014. Resident #014 was trying to push resident #015 away.
- A Behaviour Note on a specific date that documented an incident where resident #015 was found taking resident #014 to the washroom, locking the door and when staff unlocked the door resident #015 was found with their clothing removed.

- A Behaviour Note on a specific date that documented an incident where resident #015 was found with their hands on resident #014's chest and stated that resident #014 was distressed by resident #015's actions.
- An Incident/Patient Safety Reporting System (PSRS) Note on a specific date that documented an incident where resident #015 was found naked in resident #014's room sitting on the floor with resident #014's face in resident #015's groin area.

During an interview with a PCP, when asked what they would do if they had witnessed or suspected abuse of a resident, the PCP stated they would go directly to the charge nurse to report the incident and they would contact the Associate Director of Care (ADOC) to inform them of an incident.

During an interview with a Registered Practical Nurse (RPN), when asked what they would do if they had witnessed or suspected abuse of a resident or abuse was reported to them by staff, the RPN stated that they would report the incident to their boss and receive direction from there.

During an interview another RPN, when asked what they considered to be sexual abuse, the RPN stated that it would be non-consensual touching. When asked what process they were to follow if a resident is sexually inappropriate with another resident, the RPN stated that they would create a progress note, report to the Registered Nurse (RN) and then the RN would contact family members, the Ministry and leadership of the home. When asked if they were present during the incidents outlined in resident #115's progress notes on four identified occurrences, the RPN they stated that they witnessed the two incidents which occurred on the third consecutive day, and that is when it was reported. When asked about resident #015's behaviour towards resident #014 which was noted in their progress notes on PCC, the RPN stated that they considered their behaviour to be sexual abuse.

During an interview with an ADOC, when asked what they considered to be sexual abuse, they stated they would consider non-consensual touching, distress of the resident including pushing away to be signs of sexual abuse. When asked what process staff were expected to follow if a resident was sexually inappropriate with another resident, the ADOC stated that staff were expected to report this to the RN and consult the on-call manager to initiate an immediate investigation. When asked when the first incident between resident #015 and #014 occurred related to inappropriate sexual behavior, the ADOC stated that the first incident occurred on a specific date, the second incident occurred on the day following, and two incidents occurred on a third consecutive date.

When asked when they first became aware of the incidents, the ADOC stated they first became aware of these incidents two days after the first incident occurred. When asked if they considered these incidents to be sexual abuse, the ADOC stated yes. When asked if the MOHLTC was made aware of the incidents that occurred on the first and second consecutive dates, the ADOC stated that the MOHLTC was made aware of the incidents on the third consecutive date, when they were first notified. The ADOC stated that it was upon the initiation of their investigation into resident #015's clinical records that they became aware of the incidents which occurred on the first and second consecutive dates. The ADOC told Inspector #435 that if staff had reported the incident to management on the date which the first incident occurred, the three subsequent incidents would not have happened.

A review of the homes policy "Abuse and Neglect of Residents: Zero Tolerance" last revised September 27, 2016, and last reviewed November 8, 2016, stated the following:
1.1 "Staff/affiliates will ensure that they take appropriate actions in response to any alleged, suspected or witnessed incident of abuse or neglect of a resident as outlined in the procedure.
1.2 staff/affiliates must immediately report to the Ministry of Health and Long-Term Care (MOHLTC) every alleged, suspected or witnessed incidents of:
1.2.1 Abuse of a resident by anyone; and/or
1.2.2 Neglect of a resident by the licensee, a staff/affiliate of Mount Hope"

The licensee has failed to ensure that the home's Abuse and Neglect of Residents Policy was complied with when staff failed to immediately report to the Ministry of Health and Long-Term Care the incidents of sexual abuse of resident #014 by resident #015 on two consecutive dates. [s. 20. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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 has failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments and reassessments, and that the resident's responses to interventions were documented.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident that occurred on a specific date, where resident #002 had physically abused another resident. The CIS report stated that at the time of the incident resident #002 had one to one staffing in place to monitor and prevent altercations. Prior to the incident with the other resident, resident #002 had been showing aggression towards their one to one staff member.

A CIS report was also submitted to the MOHLTC related to an incident that occurred on a specific date, where resident #002 had physically abused another resident. The CIS report stated that a Personal Care Provider (PCP) witnessed resident #002 punch another resident in the face.

A review of resident #002's Minimum Data Set (MDS) Quarterly review assessment completed prior to the first reported incident of physical abuse involving resident #002, under the Resident Assessment Protocols (RAPs), stated that resident #002's mood state and behaviours tend to fluctuate and that their behaviours had declined. The RAPs also stated that resident #002 exhibited changes in mood at a specific time of day and that if not monitored by staff they may exhibit physically responsive behaviours towards other residents.

The care plan in Point Click Care (PCC) for resident #002 was reviewed for the period prior to the first reported incident of physical abuse, which showed that they had one to one monitoring in place at a specific time of day to monitor and redirect the resident related to resident #002 exhibiting verbally and physically aggressive behaviours.

The Documentation Survey Report v2 for resident #002's behaviour was reviewed for the three month period following the first reported incident of physical abuse involving resident #002, which showed that resident #002 predominantly exhibited verbally and physically aggressive behaviours at a time of day when they did not have one to one staffing in place.

The progress notes in PCC for resident #002 were reviewed for the three month period prior to and following the first reported incident of physical abuse, which showed that during the specific time of day when one to one staffing was not in place, they had exhibited verbally or physically aggressive behaviours towards staff on 13 occurrences, had exhibited verbally or physically aggressive behaviours towards other residents on 14 occurrences and had wandered the home unattended entering other residents rooms on five occurrences.

The care plan in Point Click Care (PCC) for resident #002 was reviewed for the period following the last reported incident of physical abuse, which showed that resident #002 had one to one monitoring in place at a specific time of day to monitor and redirect the resident related to resident #002 exhibiting verbally and physically aggressive behaviours. The one to one monitoring that was in place at this time was for a shorter duration of time than the one to one monitoring that was in place prior to the first reported incident of physical abuse involving resident #002.

During an interview, a PCP told Inspector #721 that resident #002 had aggressive behaviours and that these behaviours were getting worse. The PCP stated that resident #002 had one to one staffing in place at a specific time of day to monitor their behaviours. They also stated that resident #002 had exhibited aggressive behaviours when one to one staffing was not in place and that they felt one to one staffing should always be in place for this resident.

During an interview, another PCP stated that resident #002 had one to one staffing in place at a specific time of day and that they felt when one to one staffing was in place this was effective in managing this residents behaviours. They stated that during the time

when one to one staffing was not in place resident #002 did not have any increased supervision in place to monitor their behaviours.

During an interview, a Registered Nurse (RN) told Inspector #721 that resident #002 had been exhibiting physically aggressive behaviours for quite a while and that the presence of these behaviours fluctuated and were unpredictable. When asked if any behavioural assessments had been completed for resident #002, the RN stated that resident #002 was being referred to an external Behavioural Response Team (BRT) and that behavioural assessments would be completed when the referral was made. The RN stated that after an incident where resident #002 had physically abused another resident, the time of resident #002's one to one staffing was changed from a specific time of day to another specific time of day because they felt this was when resident #002 needed it the most. They stated that when the timing of resident #002's one to one staffing had been changed resident #002 had been exhibiting physically aggressive behaviours outside of this new time frame and that altercations between resident #002 and other residents had occurred at all times of day. The RN stated that when one to one staffing was not in place for resident #002 staff were expected to keep an eye on resident #002 and that there had been altercations between resident #002 and other residents when one to one staffing was not in place.

The homes policy titled "Responsive Behaviours" last revised May 2016, stated the following:
- "The management of residents experiencing responsive behaviours will be met using an interdisciplinary approach to screening, assessment, reassessment, and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental, or other, and to determine the occurrence, frequency, and duration of responsive behaviour concerns".
- When a resident exhibits responsive behaviours registered staff will "Conduct and document an assessment of the resident experiencing responsive behaviours; the assessment may include: Evaluating the effectiveness of a planned intervention on the care plan addressing specific responsive behaviours".
- When a resident exhibits responsive behaviours the interdisciplinary care team will "Work together to identify possible triggers for responsive behaviours based on preliminary evidence-based assessments" and "Evaluate effectiveness of the plan of care and revise as needed".

A review of resident #002's electronic and physical medical record did not show documentation of any completed behavioural assessments. A review of resident #002's

clinical record in PCC showed that a Behavioural Supports Ontario (BSO) Team Assessment was initiated for resident #002 on the date of the last reported incident of abuse involving resident #002.

During an interview, the Executive Director (ED) reviewed resident #002's clinical record with Inspector #721. The ED told Inspector #721 that since the first reported incident of physical abuse involving resident #002, there were five other incidents in the three months following where resident #002 had been physically abusive towards other residents. They stated that after the third incident where resident #002 had been physically abusive towards another resident, the time of resident #002's one to one staffing was changed from a specific time of day to another specific time of day and that since this incident one to one staffing remained in place for resident #002 at the same time of day. The ED stated that one to one staffing was not in place when resident #002 had been physically abusive towards other residents on four of six identified dates. The ED stated they did not feel that the interventions in place to manage resident #002's responsive behaviours were effective in managing their behaviours. When asked if any behavioural assessments had been completed for resident #002, the ED reviewed resident #002's clinical record and stated that one behavioural assessment had been completed for resident #002 which was completed after the sixth identified incident of physical abuse towards other residents. The ED told Inspector #721 that it was their expectation that resident #002's behaviours should have been reassessed and that the interventions in place were re-evaluated based on the residents needs between the first and sixth identified incidents of physical abuse towards other residents when resident #002 was exhibiting physically aggressive behaviours.

The licensee failed to ensure that, for resident #002 who demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments and reassessments and that the resident's responses to interventions were documented. [s. 53. (4) (c)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident that occurred on a specific date, where resident #002 had become physically aggressive towards another resident.
A review of resident #002's progress notes in Point Click Care (PCC) following the reported incident of abuse, showed the following documentation:
- An Incident/Patient Safety Reporting System (PSRS) Note on a specific date and time stated that resident #002 slapped another resident on their cheek.
- An Incident/PSRS Note on a specific date and time stated that resident #002 hit another resident on their forehead.
- An Incident/PSRS Note on a specific date and time stated that resident #002 hit and punched another resident on the side of their face and eyes.
- An Incident/PSRS Note on a specific date and time stated that resident #002 slapped another resident on the side of their face.
- An Incident/PSRS Note on a specific date and time stated that resident #002 hit another resident on their face.

A review of the MOHLTC Critical Incident reporting system showed that no CIS reports were submitted related to four of the five incidents of physical abuse that occurred between resident #002 and other residents documented in resident #002's progress notes.

A review of the homes policy "Abuse and Neglect of Residents: Zero Tolerance" last revised September 27, 2016, and last reviewed November 8, 2016, stated that "Staff/affiliates must immediately report to the Ministry of Health for Long-Term Care (MOHLTC) every alleged, suspected or witnessed incidents of abuse of a resident by anyone".

During an interview, an Assistant Director of Care (ADOC) told Inspectors that they were aware of the five identified incidents which involved resident #002 physically abusing other residents. The ADOC stated that the home did not submit a CIS report related to four of the five identified incidents of physical abuse involving resident #002.

During an interview, the Executive Director (ED) stated that the first incident of physical abuse involving resident #002 was reported to management on the same day that the incident occurred. The ED told Inspector #721 that this incident was not reported to the MOHLTC until the following day and that it was their expectation that this should have been reported on the same day that the incident occurred. The ED stated that they were aware of the four subsequent incidents which involved resident #002 physically abusing other residents and that these incidents were not reported to the MOHLTC. The ED told Inspector #721 that it was their expectation that these incidents should have immediately been reported to the MOHLTC.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of residents by resident #002 that resulted in harm or a risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone, or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it is based to the Director,, to be implemented voluntarily.

Issued on this 8th day of April, 2019

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MEAGAN MCGREGOR (721), AMBERLY COWPERTHWAITE (435), HELENE DESABRAIS (615)
Inspection No. / No de l'inspection :	2019_788721_0009
Log No. / No de registre :	000105-19, 001088-19, 003348-19, 003531-19, 003805-19, 005187-19, 005549-19, 006124-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 1, 2019
Licensee / Titulaire de permis :	St. Joseph's Health Care, London 268 Grosvenor Street, P.O. Box 5777, LONDON, ON, N6A-4V2
LTC Home / Foyer de SLD :	Mount Hope Centre for Long Term Care 21 Grosvenor Street, P.O. Box 5777, LONDON, ON, N6A-1Y6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gary Butt

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

To St. Joseph's Health Care, London, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:
a) Ensure that when non-consensual touching or behaviour of a sexual nature is directed towards resident #014 and every other resident that actions are taken immediately to ensure the safety of that resident.
b) Develop and implement measures in the home to ensure that resident #014 and every other resident is protected from abuse by anyone.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

Ontario Regulation 79/10 s. 2 (1) defines sexual abuse as "(a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or
(b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member;

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident where resident #015 sexually abused resident #014.

The CIS report stated that a Personal Care Provider (PCP) had heard noises coming from resident #014's room and upon investigation, the PCP found

resident #015 sitting on the floor in resident #014's room with their clothing removed and resident #014 was found with their face at resident #015's groin area. The CIS report continued to state that there were three prior incidents occurring involving this behavior.

A review of resident #015's progress notes in Point Click Care (PCC) showed the following:
- A Behaviour Note on a specific date that documented an incident where resident #015 was found in resident #014's bedroom, was half naked and leaning towards resident #014. Resident #014 was trying to push resident #015 away.
- A Behaviour Note on a specific date that documented an incident where resident #015 was found taking resident #014 to the washroom, locking the door and when staff unlocked the door resident #015 was found with their clothing removed.
- A Behaviour Note on a specific date that documented an incident where resident #015 was found with their hands on resident #014's chest and stated that resident #014 was distressed by resident #015's actions.
- An Incident/Patient Safety Reporting System (PSRS) Note on a specific date that documented an incident where resident #015 was found naked in resident #014's room sitting on the floor with resident #014's face in resident #015's groin area.

During an interview with a PCP, when asked when resident #015's sexually inappropriate behaviours began towards resident #014, they stated they began when resident #014 was first moved to the floor. When asked if they considered the four identified incidents between resident #015 and resident #014 to be sexual abuse, the PCP stated yes. When asked what interventions were put in place after the first incident of sexual abuse occurred, the PCP stated that nothing was put in place.

During an interview with an Assistant Director of Care (ADOC), when asked what they considered to be sexual abuse, the ADOC stated they would consider non-consensual touching, distress of the resident, including pushing away, to be signs of sexual abuse. When asked when the first incident between resident #015 and #014 occurred related to inappropriate sexual behavior, the ADOC stated that the first incident occurred on a specific date, the second incident

occurred on the following day, and two incidents occurred on a third consecutive date. When asked when they first became aware of the incidents, the ADOC stated they first became aware of these incidents two days after the first incident occurred. When asked if they considered these incidents to be sexual abuse, the ADOC stated yes. When asked what interventions were put in place at the time that the identified incidents occurred, the ADOC stated that interventions were not put in place as they did not know about these incidents until two days after the first incident occurred, when one to one monitoring, behavioural support, assessments and safety monitoring of residents #015 and #014 were implemented. The ADOC stated it was their expectation that staff should have reported the first identified incident on the date that it occurred, and that if the incident had been reported, the three incidents of sexual abuse that followed would not have happened. The ADOC stated they were continuing their investigation into staff member's knowledge of these incidents and their reporting requirement.

The licensee had failed to ensure that resident #014 was protected from abuse by resident #015 when the first documented incident occurred on a specific date, and continued three more identified times in the two consecutive days following, when interventions were initiated. [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of five residents reviewed. The home had a level 4 compliance history as despite MOHLTC action, non-compliance continues with original area of non-compliance that included:
- Written Notification (WN) and Director's Referral (DR) issued October 3, 2016 (2016_226192_0022);
- WN and Compliance Order (CO) issued October 20, 2016 (2016_217137_0014);
- WN, CO and DR issued May 29, 2017 (2016_457630_0045);
- WN and CO issued November 16, 2017 (2017_536537_0035). This CO was complied January 2, 2018; and
- WN and Voluntary Plan of Correction (VPC) issued November 16, 2018 (2018_263524_0017). (435)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

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

Specifically, the licensee must:
a) Ensure that the policy to promote zero tolerance of abuse and neglect of residents is complied with, specific to but not limited to the immediate reporting of the allegation of abuse or neglect to the Ministry of Health and Long-Term Care (MOHLTC).
b) Re-education and training shall be provided to all staff on the home's policy to promote zero tolerance of abuse, specific but not limited to the immediate reporting of the allegation of abuse or neglect to the MOHLTC. The home must keep a documented record of the education provided.

Grounds / Motifs :

1. The licensee has failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident that occurred on a specific date, where resident #015 sexually abused resident #014. The CIS report stated that a Personal Care Provider (PCP) had heard noises coming from resident #014's room and upon investigation, the PCP found resident #015 sitting on the floor in resident #014's room with their clothing removed and resident #014 was found with their face at resident #015's groin area. The CIS report continued to state that there were three prior incidents that had occurred

which involved the same behaviours.

A review of resident #015's progress notes in Point Click Care (PCC) showed the following:
- A Behaviour Note on a specific date that documented an incident where resident #015 was found in resident #014's bedroom, was half naked and leaning towards resident #014. Resident #014 was trying to push resident #015 away.
- A Behaviour Note on a specific date that documented an incident where resident #015 was found taking resident #014 to the washroom, locking the door and when staff unlocked the door resident #015 was found with their clothing removed.
- A Behaviour Note on a specific date that documented an incident where resident #015 was found with their hands on resident #014's chest and stated that resident #014 was distressed by resident #015's actions.
- An Incident/Patient Safety Reporting System (PSRS) Note on a specific date that documented an incident where resident #015 was found naked in resident #014's room sitting on the floor with resident #014's face in resident #015's groin area.

During an interview with a PCP, when asked what they would do if they had witnessed or suspected abuse of a resident, the PCP stated they would go directly to the charge nurse to report the incident and they would contact the Associate Director of Care (ADOC) to inform them of an incident.

During an interview with a Registered Practical Nurse (RPN), when asked what they would do if they had witnessed or suspected abuse of a resident or abuse was reported to them by staff, the RPN stated that they would report the incident to their boss and receive direction from there.

During an interview another RPN, when asked what they considered to be sexual abuse, the RPN stated that it would be non-consensual touching. When asked what process they were to follow if a resident is sexually inappropriate with another resident, the RPN stated that they would create a progress note, report to the Registered Nurse (RN) and then the RN would contact family members, the Ministry and leadership of the home. When asked if they were present during the incidents outlined in resident #115's progress notes on four

identified occurrences, the RPN they stated that they witnessed the two incidents which occurred on the third consecutive day, and that is when it was reported. When asked about resident #015's behaviour towards resident #014 which was noted in their progress notes on PCC, the RPN stated that they considered their behaviour to be sexual abuse.

During an interview with an ADOC, when asked what they considered to be sexual abuse, they stated they would consider non-consensual touching, distress of the resident including pushing away to be signs of sexual abuse. When asked what process staff were expected to follow if a resident was sexually inappropriate with another resident, the ADOC stated that staff were expected to report this to the RN and consult the on-call manager to initiate an immediate investigation. When asked when the first incident between resident #015 and #014 occurred related to inappropriate sexual behavior, the ADOC stated that the first incident occurred on a specific date, the second incident occurred on the day following, and two incidents occurred on a third consecutive date. When asked when they first became aware of the incidents, the ADOC stated they first became aware of these incidents two days after the first incident occurred. When asked if they considered these incidents to be sexual abuse, the ADOC stated yes. When asked if the MOHLTC was made aware of the incidents that occurred on the first and second consecutive dates, the ADOC stated that the MOHLTC was made aware of the incidents on the third consecutive date, when they were first notified. The ADOC stated that it was upon the initiation of their investigation into resident #015's clinical records that they became aware of the incidents which occurred on the first and second consecutive dates. The ADOC told Inspector #435 that if staff had reported the incident to management on the date which the first incident occurred, the three subsequent incidents would not have happened.

A review of the homes policy "Abuse and Neglect of Residents: Zero Tolerance" last revised September 27, 2016, and last reviewed November 8, 2016, stated the following:
1.1 "Staff/affiliates will ensure that they take appropriate actions in response to any alleged, suspected or witnessed incident of abuse or neglect of a resident as outlined in the procedure.
1.2 staff/affiliates must immediately report to the Ministry of Health and Long-Term Care (MOHLTC) every alleged, suspected or witnessed incidents of:

1.2.1 Abuse of a resident by anyone; and/or
1.2.2 Neglect of a resident by the licensee, a staff/affiliate of Mount Hope"

The licensee has failed to ensure that the home's Abuse and Neglect of Residents Policy was complied with when staff failed to immediately report to the Ministry of Health and Long-Term Care the incidents of sexual abuse of resident #014 by resident #015 on two consecutive dates. [s. 20. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of five residents reviewed. The home had a level 4 compliance history as despite MOHLTC action, non-compliance continues with original area of non-compliance that included:
- Written Notification (WN), Compliance Order (CO) and Director's Referral (DR) issued October 3, 2016 (2016_226192_0022);
- WN and Voluntary Plan of Correction (VPC) issued October 20, 2016 (2016_217137_0014);
- WN, CO and DR issued May 29, 2017 (2016_457630_0045);
- WN and CO issued November 16, 2017 (2017_536537_0035). This CO was complied January 2, 2018;
- WN issued November 16, 2017 (2017_536537_0037);
- WN issued November 16, 2018 (2018_263524_0017); and
- WN and VPC issued January 30, 2019 (2019_508137_0003). (435)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 27, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s.53(4)(c).

Specifically, the licensee must:
a) Ensure there is a process developed and implemented for residents #002 and any other resident demonstrating responsive behaviours, to take action and respond to the needs of the resident, including documented assessments and reassessments, and that strategies are developed and implemented based on these assessments and the resident's needs.
c) Ensure there is a process developed and implemented for resident #002 and any other resident demonstrating responsive behaviours, to ensure resident's responses to interventions are documented and that the effectiveness of the interventions are evaluated based on the resident's needs.

Grounds / Motifs :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments and reassessments, and that the resident's responses to interventions were documented.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident that occurred on a specific date, where resident #002 had physically abused another resident. The

CIS report stated that at the time of the incident resident #002 had one to one staffing in place to monitor and prevent altercations. Prior to the incident with the other resident, resident #002 had been showing aggression towards their one to one staff member.

A CIS report was also submitted to the MOHLTC related to an incident that occurred on a specific date, where resident #002 had physically abused another resident. The CIS report stated that a Personal Care Provider (PCP) witnessed resident #002 punch another resident in the face.

A review of resident #002's Minimum Data Set (MDS) Quarterly review assessment completed prior to the first reported incident of physical abuse involving resident #002, under the Resident Assessment Protocols (RAPs), stated that resident #002's mood state and behaviours tend to fluctuate and that their behaviours had declined. The RAPs also stated that resident #002 exhibited changes in mood at a specific time of day and that if not monitored by staff they may exhibit physically responsive behaviours towards other residents.

The care plan in Point Click Care (PCC) for resident #002 was reviewed for the period prior to the first reported incident of physical abuse, which showed that they had one to one monitoring in place at a specific time of day to monitor and redirect the resident related to resident #002 exhibiting verbally and physically aggressive behaviours.

The Documentation Survey Report v2 for resident #002's behaviour was reviewed for the three month period following the first reported incident of physical abuse involving resident #002, which showed that resident #002 predominantly exhibited verbally and physically aggressive behaviours at a time of day when they did not have one to one staffing in place.

The progress notes in PCC for resident #002 were reviewed for the three month period prior to and following the first reported incident of physical abuse, which showed that during the specific time of day when one to one staffing was not in place, they had exhibited verbally or physically aggressive behaviours towards staff on 13 occurrences, had exhibited verbally or physically aggressive behaviours towards other residents on 14 occurrences and had wandered the home unattended entering other residents rooms on five occurrences.

The care plan in Point Click Care (PCC) for resident #002 was reviewed for the period following the last reported incident of physical abuse, which showed that resident #002 had one to one monitoring in place at a specific time of day to monitor and redirect the resident related to resident #002 exhibiting verbally and physically aggressive behaviours. The one to one monitoring that was in place at this time was for a shorter duration of time than the one to one monitoring that was in place prior to the first reported incident of physical abuse involving resident #002.

During an interview, a PCP told Inspector #721 that resident #002 had aggressive behaviours and that these behaviours were getting worse. The PCP stated that resident #002 had one to one staffing in place at a specific time of day to monitor their behaviours. They also stated that resident #002 had exhibited aggressive behaviours when one to one staffing was not in place and that they felt one to one staffing should always be in place for this resident.

During an interview, another PCP stated that resident #002 had one to one staffing in place at a specific time of day and that they felt when one to one staffing was in place this was effective in managing this residents behaviours. They stated that during the time when one to one staffing was not in place resident #002 did not have any increased supervision in place to monitor their behaviours.

During an interview, a Registered Nurse (RN) told Inspector #721 that resident #002 had been exhibiting physically aggressive behaviours for quite a while and that the presence of these behaviours fluctuated and were unpredictable. When asked if any behavioural assessments had been completed for resident #002, the RN stated that resident #002 was being referred to an external Behavioural Response Team (BRT) and that behavioural assessments would be completed when the referral was made. The RN stated that after an incident where resident #002 had physically abused another resident, the time of resident #002's one to one staffing was changed from a specific time of day to another specific time of day because they felt this was when resident #002 needed it the most. They stated that when the timing of resident #002's one to one staffing had been changed resident #002 had been exhibiting physically aggressive behaviours outside of this new time frame and that altercations between resident #002 and

other residents had occurred at all times of day. The RN stated that when one to one staffing was not in place for resident #002 staff were expected to keep an eye on resident #002 and that there had been altercations between resident #002 and other residents when one to one staffing was not in place.

The homes policy titled "Responsive Behaviours" last revised May 2016, stated the following:
- "The management of residents experiencing responsive behaviours will be met using an interdisciplinary approach to screening, assessment, reassessment, and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental, or other, and to determine the occurrence, frequency, and duration of responsive behaviour concerns".
- When a resident exhibits responsive behaviours registered staff will "Conduct and document an assessment of the resident experiencing responsive behaviours; the assessment may include: Evaluating the effectiveness of a planned intervention on the care plan addressing specific responsive behaviours".
- When a resident exhibits responsive behaviours the interdisciplinary care team will "Work together to identify possible triggers for responsive behaviours based on preliminary evidence-based assessments" and "Evaluate effectiveness of the plan of care and revise as needed".

A review of resident #002's electronic and physical medical record did not show documentation of any completed behavioural assessments. A review of resident #002's clinical record in PCC showed that a Behavioural Supports Ontario (BSO) Team Assessment was initiated for resident #002 on the date of the last reported incident of abuse involving resident #002.

During an interview, the Executive Director (ED) reviewed resident #002's clinical record with Inspector #721. The ED told Inspector #721 that since the first reported incident of physical abuse involving resident #002, there were five other incidents in the three months following where resident #002 had been physically abusive towards other residents. They stated that after the third incident where resident #002 had been physically abusive towards another resident, the time of resident #002's one to one staffing was changed from a specific time of day to another specific time of day and that since this incident

one to one staffing remained in place for resident #002 at the same time of day. The ED stated that one to one staffing was not in place when resident #002 had been physically abusive towards other residents on four of six identified dates. The ED stated they did not feel that the interventions in place to manage resident #002's responsive behaviours were effective in managing their behaviours. When asked if any behavioural assessments had been completed for resident #002, the ED reviewed resident #002's clinical record and stated that one behavioural assessment had been completed for resident #002 which was completed after the sixth identified incident of physical abuse towards other residents. The ED told Inspector #721 that it was their expectation that resident #002's behaviours should have been reassessed and that the interventions in place were re-evaluated based on the residents needs between the first and sixth identified incidents of physical abuse towards other residents when resident #002 was exhibiting physically aggressive behaviours.

The licensee failed to ensure that, for resident #002 who demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments and reassessments and that the resident's responses to interventions were documented. [s. 53. (4) (c)]

The severity of this issue was determined to be a level 3 as there was actual risk to other residents. The scope of the issue was a level 1 as it related to one of four residents reviewed. The home had a level 4 compliance history as despite MOHLTC action, non-compliance continues with original area of non-compliance that included:
- Written Notification (WN) and Compliance Order (CO) issued October 3, 2016 (2016_262523_0025). This CO was complied April 6, 2017;
- WN and CO issued May 29, 2017 (2016_457630_0045). This CO was complied October 26, 2017;
- WN issued November 16, 2017 (2017_536537_0037); and
- WN and Voluntary Plan of Correction (VPC) issued January 22, 2018 (2017_566669_0035). (721)

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

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

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 1st day of April, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Meagan McGregor

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