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

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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
Aug 29, 2019	2019_633577_0018	005567-19	Critical Incident System

Licensee/Titulaire de permis

Nipigon District Memorial Hospital
125 Hogan Road NIPIGON ON P0T 2J0

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

Nipigon District Memorial Hospital
125 Hogan Road P.O. Box 37 NIPIGON ON P0T 2J0

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

DEBBIE WARPULA (577)

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): July 22-26, 2019.

The following intake was inspected upon during this Critical Incident System (CIS) inspection:
- One intake related to staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Long-Term Care (LTC) Lead, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Planning and Project Coordinator, and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed an employee file and investigation records, reviewed staff training records, reviewed relevant health care records, and reviewed licensee policy procedures and programs.

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

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

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

neglect by the licensee or staff.

A Critical Incident System (CIS) report was received by the Director on an identified date, which outlined allegations of abuse and neglect by RPN #101 toward resident's #001, #002, #004 and #005. The report identified allegations were made that RPN #101 had administered a specific medication to residents, when they were not assigned the role of medication nurse; administered medication to a resident in a form that the resident had specifically requested them not to; removed residents call bells from their reach; used a specific apparatus to transfer residents without assistance; yelled specific statements to residents; fed resident #005 unsafely and inappropriately; applied incontinence products inappropriately with residents; transferred residents to specific areas of the home at inappropriate times; and routinely completed care activities with residents at inappropriate times.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

O. Reg. 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

O. Reg. 79/10 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A review of the home's policy, "Zero Tolerance of Abuse and Neglect– ADM 10", revised October 2017, indicated that all residents had the right to live in a home that treated them with dignity, respect and was free from any form of abuse or neglect at all times, and in all circumstances. The home was committed to zero tolerance of abuse or neglect of its residents.

A review of the investigation file concerning RPN #101, included the following documentation:

a) Notes from staff, which included the following:

-a note stamped as ‘received’ on an identified date, signed by RPN #103, which had indicated that on an identified date, they had been working a specific shift with RPN #101. Further, the note identified that during the shift, resident #001's bed alarm had been alarming and RPN #101 stated that if the resident pulled on their call bell, and if the resident continued to activate their bed alarm, they would take a specific action. The note reported that RPN #101 then proceeded to get the resident up and located to a specific area of the home, where they remained.

-a note dated on an identified date, and signed by RPN #103. The note indicated that they had observed many incidents where RPN #101 had completed a certain care activity with resident #005, when the resident was capable of completing the activity themselves;

-a note dated on an identified date, and signed by RPN #104 and resident #002. The note indicated that RPN #101 provided resident #002's their medication in a form that the resident had specifically requested them not to.

b) A review of documented staff interviews conducted by the Administrator on an identified date, identified that:

-PSW #105 consistently witnessed RPN #101 feed resident #005 unsafely and inappropriately; applied incontinence products inappropriately with residents; removed all the residents call bells on a specific shift; witnessed residents who had become agitated by interactions with RPN #101; observed RPN #101 swear at day staff if they had not had residents in bed by a specific time; and that staff felt afraid to report RPN #101;

-PSW #106 witnessed RPN #101 independently change resident's diets without assessment;

-PSW #107 witnessed RPN #101 feed resident #005 unsafely and inappropriately; consistently observed resident #001's call bell out of reach and on the floor on a specific shift when RPN #101 was working; demanded residents be in their beds when RPN #101 arrived for their shift at a specific time; witnessed RPN #101's use of a specific apparatus to transfer residents without assistance; and that staff felt afraid to report RPN #101;

-RPN #103 reported that RPN #101 requested medication keys from the medication nurse and administered specific medication to residents if the medication nurse had not yet administered the medication; provided resident #002 their medication in a form that the resident had specifically requested them not to; instructed staff to remove resident #001's and #004's call bells from their reach; witnessed RPN #101 put residents to bed at a specific time; used a specific apparatus to transfer residents without assistance; witnessed the RPN remove residents mobility aids from their rooms during the night, so that they could not get out of bed; witnessed them to have completed care activities with residents at inappropriate times; witnessed them raise resident #001's bed high in the air, so that they could not get into their bed; witnessed them feed resident #005 unsafely and inappropriately; and witnessed them accost staff if they had not put residents to bed at a specific time. RPN #103 reported that staff had previously reported RPN #101 to the previous Administrator #102, but nothing had been done;

-RPN #108 witnessed RPN #101 provide resident #001 with their snacks in a particular way; witnessed residents call bells out of reach and on the floor; witnessed RPN #101 tell staff to "mind their own business and not report them"; witnessed them change residents diet consistencies without consultation; witnessed them feed resident #005 unsafely and inappropriately; witnessed them question and threaten staff when residents weren’t in their beds by a specific time; witnessed them instruct staff to complete care activities with residents at inappropriate times; witnessed them force residents to bed against the their wishes; witnessed them threaten staff; witnessed them use a derogatory name to refer to resident #007; and reported that everyone was afraid of “the wrath of RPN #101”;

-RPN #109 witnessed RPN #101 to have provided resident #002 their medication in a form that the resident had specifically requested them not to; and reported they had became upset when residents were not in bed at a specific time; and

-RPN #104 witnessed RPN #101 to have provided resident #002 their medication in a form that the resident had specifically requested them not to; was aware of an incident where they had transferred resident #001 to a specific area of the home at an inappropriate time because their bed alarm and call bell had been activated; witnessed them yell at staff for not putting residents to at a specific time; was aware of RPN #101 feeding resident #005 unsafely and inappropriately; that they had informed Nurse Manager #110 at that time and was told that it needed to be reported as a CIS report and Nurse Manager #110 told them to put it in writing.

c) A review of the Administrator's investigation notes concerning RPN #101 identified the following:
-conducted interviews with eight staff on an identified date;
-RPN #101 had suggested to the medication nurse to administer a specific medication to residents, and would administer the medication themselves if the medication nurse was not in agreement;
-administered medication to resident #002 in a form that the resident had specifically requested them not to;
-that staff confirmed RPN #101 removed call bells from residents if they had rung them “too much”, and had advised staff to remove residents call bells if they activated them;
-shook their finger in residents faces, yelled specific statements to residents;
-transferred residents with a specific apparatus without assistance;
-transferred residents to bed at a specific time;
-applied incontinence products inappropriately with residents;
-washed and partially dressed residents into their clothes during the night;
-routinely provided care activities with residents at inappropriate times;
-removed resident's mobility aids from their rooms during a specific shift, so that the resident could not get up, and raised the bed level so they could not get into their bed on their own;
-that staff witnessed RPN #101 feed resident #005 unsafely and inappropriately; and
-that staff were afraid of RPN #101, and described them as confrontational and threatening.

A review of the home’s policy, "Zero Tolerance of Abuse and Neglect– ADM 10", revised October 2017, indicated that staff were to ensure that the resident whom had been harmed by abuse or neglect was not left in the responsibility of the person alleged to have caused the abuse or neglect.

A review of the home’s policy, “Safeguards for residents – LTC 03”, revised April 2019, indicated that resident call bells must be secured to the bed within reach of the resident at all times; and staff were to keep beds at their lowest level to facilitate ease in getting in and out of bed.

A review of the home’s policy, “Electrical Mechanical Lifts – NUR 46” revised November 2013, indicated that all resident transfers completed with a mechanical lift must be done by two caregivers.

During an interview with RPN #111, they reported to Inspector #577 that RPN #101 had

been abusive and neglectful towards residents for years and that staff had been afraid to report due to fear of retaliation. They reported that they had witnessed RPN #101 feeding residents unsafely and inappropriately; and witnessed them remove residents call bells on a specific shift.

During an interview with RPN #108, they reported to Inspector #577 that RPN #101 had been abusive and neglectful toward residents for many years and reported to have witnessed the following conduct of RPN #101, as follows; a long history of completing care activities with residents at inappropriate times; witnessed them feed resident #005 unsafely and inappropriately; reported they had reported this to the previous Administrator #102 one year ago; witnessed RPN #101 to have put residents to bed at a specific time for years; witnessed residents' call bells on the floor after RPN #101's shift; witnessed them using a specific apparatus without assistance. RPN #108 reported that they had previously reported their concerns to the previous Administrator #102 and had been told that "they dealt with the individual already".

During an interview with RPN #103, they reported to Inspector #577 that they had previously reported their concerns of abuse and neglect by RPN #101 to the previous Administrator on an identified date. They reported they had witnessed the following conduct of RPN #101, as follows; witnessed them remove residents' mobility aids from out of their rooms at a specific time, so that they couldn't get out of bed; put residents' call bells on the floor and instructed other staff to move their call bells; witnessed RPN #101 get resident #001 up and located them to a specific area of the home, where they remained; witnessed RPN #101 feed resident #005 unsafely and inappropriately. RPN #103 identified that when they had reported this to the previous Administrator #102, they were told, "I would have to witness it myself for it to be true, it would be your word against their word".

During an interview with RPN #104, they reported to Inspector #577 that they had witnessed physical and verbal abuse of RPN #101 towards residents and they had reported previous incidents to Nurse Manager #110.

During an interview resident #004, they reported to Inspector #577 that RPN #101 had routinely completed care activities with them at inappropriate times and that it had occurred for years; and when the resident told them 'no', RPN #101 told them that it was none of their business.

During an interview with the Administrator, they reported to Inspector #577 that staff had

begun initiating concerns to them in an identified month, and the following month, they had begun an investigation. They reported that their investigation had confirmed abuse and neglect by RPN #101 to residents and they had concluded their investigation on an identified date. They reported that RPN #101 continued to work during the investigation until an identified date; and that there were no safeguards in place over a specified time period, when RPN #101 had continued to provide care. They further reported that staff had previously reported allegations of abuse and neglect to the previous Administrator #102, and there was no documentation of any investigations or incident reports within RPN #101’s employee file.

The licensee failed to protect residents from abuse and neglect by RPN #101. The licensee and staff were aware of RPN #101 removing call bells and mobility aids from residents' reach, feeding resident #005 unsafely and inappropriately, transferred resident #001 to a specific area of the home at an inappropriate time, applied incontinence products inappropriately with residents, transferred residents to bed at a specific time, used a specific apparatus to transfer residents without assistance, and routinely completed care activities with residents at inappropriate times. Staff interviews had confirmed that RPN #101 had been abusive to residents for years, allegations had been previously reported to the previous Administrator #102, and it had not been investigated or reported to the Director. [s. 19. (1)]

Additional Required Actions:

***CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.
DR # 001 – The above written notification is also being referred to the Director for further action by the Director.***

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident by the licensee or staff, that the licensee knew of, or that was reported to the licensee, was immediately investigated.

A Critical Incident System (CIS) report was received by the Director on an identified date, which outlined allegations of abuse and neglect by RPN #101 toward resident’s #001, #002, #004 and #005.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

A review of the investigation file included a handwritten note dated on an identified date, signed by RPN #103, which had indicated that they had observed many incidents where RPN #101 had fed resident #005 unsafely and inappropriately;

During an interview with RPN #108, they reported to Inspector #577 that RPN #101 had been abusive and neglectful toward residents for many years, and that they had previously reported their concerns to the previous Administrator #102, and had been told that "they dealt with the individual already".

During an interview with RPN #103, they reported to Inspector #577 that they had previously reported their concerns of abuse and neglect to the previous Administrator #102, on a specified date, and had been told, "I would have to witness it myself for it to be true; it would be your word against their word".

During an interview with RPN #104, they reported to Inspector #577 that they had witnessed physical and verbal abuse of RPN #101 towards residents and they had reported the previous incidents to Nurse Manager #110.

During an interview with the Administrator, they reported that staff had begun initiating concerns to them in an identified month, and on an identified date, when RPN #103 submitted a letter to them related to RPN #101’s conduct towards residents, they initiated an informal investigation. They reported that their investigation confirmed abuse and neglect by RPN #101 to residents and had concluded their investigation on an identified date. They further reported that staff had reported that they had reported allegations of abuse and neglect to the previous Administrator #102 and there was no documentation of any investigation or incident reports in RPN #101’s employee file. [s. 23. (1) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.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 a person who had 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 was based to the Director: 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 residents.

A Critical Incident System (CIS) report was received by the Director on an identified date, which outlined allegations of abuse and neglect by RPN #101 toward resident’s #001, #002, #004 and #005. The report indicated allegations were made of them having administered a specific medication to residents, when they were not assigned the role of medication nurse; administering medication to a resident in a form that the resident had specifically requested them not to; removing residents' call bells from their reach; using a specific apparatus to transfer residents without assistance; yelling specific statements to residents; applied incontinence products inappropriately with residents; transferring residents to bed at a specific time; and routinely completed care activities with residents at inappropriate times.

See WN #1 for further details.

A review of the home’s policy, "Zero Tolerance of Abuse and Neglect– ADM 10", revised October 2017, indicated that when a manager/designate or other received an internal

report from an employee on a suspected or alleged, or actual incident of abuse or neglect, they would immediately report to the Ministry of Health and Long Term Care by using the Critical Incident System.

During an interview with the Administrator, they reported to Inspector #577 that staff had begun initiating concerns to them in an identified month, related to RPN #101 allegedly removing call bells from residents. They further reported that on an identified date, RPN #103 submitted a letter to them related to RPN #101’s conduct towards residents, and at that time they initiated an informal investigation, which included interviews with staff.

A review of the investigation file included documentation from staff interviews conducted by the Administrator on an identified date:

-PSW #105 consistently witnessed RPN #101 to have completed a certain care activity with resident #005, when the resident was capable of completing the activity themselves, and stated, “Not when I’m here”; had applied incontinence products inappropriately with residents; would remove all the residents' call bells on a specific shift; witnessed residents who had become agitated by RPN #101; would swear at day staff if they had not put residents in bed by a specific time; felt afraid to report RPN #101;

-PSW #106 witnessed RPN #101 to have changed resident’s diets without assessment;

-PSW #107 witnessed RPN #101 to have fed resident #005 unsafely and inappropriately; consistently found resident #001's call bell out of reach and on the floor at a specific time, after RPN #101's shift; demanded that residents be in their beds when RPN #101 would have arrived for their shift at a specific time; witnessed them using a specific apparatus to transfer residents without assistance; felt afraid to report RPN #101;

-RPN #103 reported that RPN #101 requested medication keys from the medication nurse and administered specific medication to residents if the medication nurse had not administered the medication; provided resident #002's medication in a form that the resident had specifically requested them not to; instructed staff to remove resident #001's and #004's call bells; witnessed RPN #101 put residents to bed at a specific time; used a specific apparatus to transfer residents without assistance; witnessed them remove resident's mobility aids from their rooms during the night so that they could not get out of bed; witnessed them to have completed certain care activities with residents at inappropriate times; witnessed them to have raised resident #001's bed high in the air so that they could not get into their bed; witnessed them feed resident #005 unsafely and

inappropriately; witnessed them to have accosted staff if they had not put residents to bed before they came on shift at a specific time; reported that staff had previously reported RPN #101 to the previous Administrator #102, but felt that nothing had been done and staff had been told to put it in writing;

-RPN #108 witnessed RPN #101 to have provided resident #001 with their snacks in a particular way; witnessed residents' call bells out of reach and on the their floor; RPN #101 had told staff to mind their own business and not report them; witnessed them to have changed residents' diet consistencies; witnessed them to have fed resident #005 unsafely and inappropriately; witnessed them to have questioned and threatened staff when residents weren’t in their beds by a specific time; witnessed them to have instructed staff to complete care activities with residents at inappropriate times; witnessed them to have forced residents to bed at inappropriate times; witnessed them to have threatened staff; used a derogatory name to refer to resident #007; reported that everyone was afraid of “the wrath of RPN #101”;

-RPN #109 witnessed RPN #101 to have provided resident #002 their medication in a form that the resident had specifically requested them not to; reported they had become upset when residents were not in bed at a specific time; and

-RPN #104 witnessed RPN #101 to have provided resident #002 their medication in a form that the resident had specifically requested them not to; aware of an incident where RPN #101 had proceeded to get resident #001 up and located to a specific area of the home at an inappropriate time; witnessed them to have yelled at staff for not putting residents to bed at a specific time; aware of them feeding resident #005 unsafely and inappropriately; they had informed Nurse Manager #110 at that time and had told them that it needed to be reported as a CIS report and Nurse Manager #110 told them to put it in writing.

During an interview with RPN #108, they reported to Inspector #577 that RPN #101 had been abusive and neglectful toward residents for many years and they had previously reported their concerns to the previous Administrator #102 and had been told that "they dealt with the individual already".

During an interview with RPN #103, they reported to Inspector #577 that they had previously reported their concerns of abuse and neglect to the previous Administrator #102, on an identified date, and had been told, "I would have to witness it myself for it to be true; it would be your word against their word".

During an interview with RPN #104, they reported to Inspector #577 that they had witnessed physical and verbal abuse of RPN #101 towards residents and they had reported previous incidents to Nurse Manager #110.

During an interview with the Administrator, they reported that they were unaware that any suspicion of abuse and/or neglect needed to be reported immediately, and had submitted the CIS report on an identified date, following their investigation. They further reported that staff had reported to them that they had reported allegations of abuse and neglect to the previous Administrator #102, and there was no documentation in RPN #101's employee file. [s. 24. (1)]

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. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received training in the home's policy to promote Zero Tolerance of Abuse and Neglect of residents before performing their responsibilities.

Inspector #577 conducted a record review of the home's policy titled, "Zero Tolerance of Abuse and Neglect – ADM 10", revised October 2017, which indicated that they had adopted "AdvantAge's Zero Tolerance of Abuse and Neglect", sample policy and procedures, revised November 29, 2012. The policy indicated that the "Residents' Bill of Rights" and the policy on "Zero Tolerance of Abuse and Neglect" would be reviewed with each new employee during orientation and annually thereafter.

During an interview with the Administrator, they reported to Inspector #577 that they had been hired as interim Administrator in October 2018, and their role became permanent in January 2019. They further reported that Nurse Manager #110 was hired into their position on August 20, 2018.

Inspector #577 conducted a record review of abuse training for all staff, which also included a review for Nurse Manager #110 and the Administrator. During a review, the Inspector could not find abuse training records for the Administrator or the Nurse Manager.

During an interview with the Administrator, they confirmed that they, and Nurse Manager #110 had not been trained on the home's policy for Zero Tolerance of Abuse. [s. 76. (2) 3.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,
(a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration; O. Reg. 79/10, s. 212 (4).
(b) has at least three years working experience,
(i) in a managerial or supervisory capacity in the health or social services sector, or
(ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d); O. Reg. 79/10, s. 212 (4).
(c) has demonstrated leadership and communications skills; and O. Reg. 79/10, s. 212 (4).
(d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time. O. Reg. 79/10, s. 212 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that everyone hired as an Administrator after coming into force of this section, successfully completed or, subject to subsection (6), was enrolled in a program in long-term home administration or management that was a minimum of 100 hours in duration of instruction time.

During an interview with the Administrator, they reported to Inspector #577 that they had been hired as interim Administrator in October 2018, and their role became permanent in January 2019. They further reported that they had enrolled into the June 2019, Administrator course, but would not be taking the course until June 2020. They further reported that the previous Administrator #102 had never enrolled or completed the Administrator's course. [s. 212. (4) (d)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may have constituted a criminal offence.

A Critical Incident System (CIS) report was received by the Director on an identified date, which outlined allegations of abuse and neglect by RPN #101 toward resident’s #001, #002, #004 and #005. The report identified allegations were made that RPN #101 had administered specific medication to residents, when they were not assigned the role of medication nurse; administering medication to a resident in a form that the resident had specifically requested them not to; and fed resident #005 unsafely and inappropriately.

During a review of the CIS report, there had been no documentation that the police had been notified. A review of the home’s investigation records had not included a record of the police being notified.

A review of the home’s policy, "Zero Tolerance of Abuse and Neglect– ADM 10", revised October 2017, indicated that staff must report to the police if the alleged, suspected or witnessed incident of abuse or neglect constituted a criminal offence under the Criminal Code (staff were to refer to the MOHLTC Licensee Reporting Decision Trees). The police would determine if there were ‘reasonable grounds’ for charges.

During an interview with the Administrator, they reported to Inspector #577 that their investigation had confirmed abuse and neglect by RPN #101 to residents, and they had not notified the police. [s. 98.]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee’s policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents.

A Critical Incident System (CIS) report was received by the Director, which outlined allegations of abuse and neglect by RPN #101 toward resident's #001, #002, #004 and #005.

Inspector #577 conducted a record review of the home's policy titled, "Zero Tolerance of Abuse and Neglect – ADM 10", revised October 2017, which indicated that they had adopted "AdvantAge's Zero Tolerance of Abuse and Neglect", sample policy and procedures, revised November 29, 2012. The policy indicated that management staff would evaluate the effectiveness of the policy for prevention of abuse and neglect at least once per year to identify what changes and improvements were required to prevent further occurrences. In addition, the policy would have been evaluated when an incident was suspected, alleged or had occurred, to determine what improvements were necessary to prevent further occurrences.

During an interview with the Administrator, they stated that the home's policy for "Zero Tolerance for Abuse and Neglect", had not been evaluated annually and had not been evaluated after the substantiated allegations of abuse concerning RPN #101. The Administrator acknowledged that the last revision of the policy was in October 2017. [s. 99. (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 at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident’s substitute decision-maker, if any, and any other person specified by the resident, were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A Critical Incident System (CIS) report was received by the Director on an identified date, concerning allegations of staff to resident abuse and neglect.

A review of the CIS report indicated that there were no amendments documented and the family and/or substitute decision maker were not contacted, and that the investigation had just concluded and they would be notified today or tomorrow.

A review of the home's policy, "Zero Tolerance of Abuse and Neglect- ADM 10", revised October 2017, indicated that the home would notify the resident's SDM, if any and any other person the resident had specified, immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in physical injury or pain to the resident, or distress to the resident that had potential to be detrimental to the resident's health and well-being; and within 12 hours of becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. Staff must notify the resident and the resident's SDM, if any, and any other person requested by the resident of the results of the investigation immediately upon the completion of the investigation.

Inspector #577 reviewed a copy of letters sent to all family members from the Administrator which indicated that the home was writing to inform them that they had reason to believe that their loved one may have been treated in a way that was not consistent with the expectations of Nipigon District Memorial’s Code of Conduct, in keeping with the Resident’s Bill of Rights or compliant with the Long Term Care Act. Further, they take these matters very seriously and were taking the necessary steps to ensure that it never happened again.

During an interview with the Administrator, they reported to Inspector #577 that on an identified date, they had sent letters to resident’s families and capable residents, and had only notified residents #001's and #005's families after the investigation was completed. [s. 97. (1) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. In making a report to the Director under subsection 23(2) of the Act, the licensee failed to have included the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: A description of the individuals involved in the incident, including names of staff members or other persons who were present at or discovered the incident.

A Critical Incident System (CIS) report was received by the Director on an identified date, concerning allegations of staff to resident abuse and neglect. The report had not indicated the full name or designation of the staff member.

During an interview with the Administrator, they had acknowledged that they had documented the staff members first name on the CIS report, and had not included their last name or designation. [s. 104. (1) 2. ii.]

2. In making a report to the Director under subsection 23 (2) of the Act, the licensee failed to have included the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: Actions taken in response to the incident, including, whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons.

A Critical Incident System (CIS) report was received by the Director on an identified date, concerning allegations of staff to resident abuse and neglect.

A review of the CIS report indicated that there were no amendments documented and family and/or substitute decision maker was not contacted, and that the investigation had just concluded and they would be notified today or tomorrow.

A review of the home's policy, "Zero Tolerance of Abuse and Neglect- ADM 10", revised October 2017, indicated that the home would notify the resident's SDM, if any and any other person the resident had specified, immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in physical injury or pain to the resident, or distress to the resident that had potential to be detrimental to the resident's health and well-being; and within 12 hours of becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. Staff must notify the resident and the resident's SDM, if any, and any other

person requested by the resident of the results of the investigation immediately upon the completion of the investigation.

Inspector #577 reviewed a copy of letters sent to all family members from the Administrator which indicated that the home was writing to inform them that they had reason to believe that their loved one may have been treated in a way that was not consistent with the expectations of Nipigon District Memorial's Code of Conduct, in keeping with the Resident's Bill of Rights or compliant with the Long Term Care Act. Further, they take these matters very seriously and were taking the necessary steps to ensure that it never happened again.

During an interview with the Administrator, they reported to Inspector #577 that on an identified date, they had sent letters to resident's families and capable residents, and had notified residents #001's and #005's families after the investigation was completed. They further reported that they had not amended the CIS report to include this information. [s. 104. (1) 3. iv.]

3. In making a report to the Director under subsection 23(2) of the Act, the Licensee failed to have included the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect by the licensee or staff that led to the report: Analysis and follow-up action, including the long-term actions planned to correct the situation and prevent recurrence.

A Critical Incident System (CIS) report was received by the Director on an identified date, which outlined allegations of abuse and neglect by RPN #101 toward resident's #001, #002, #004 and #005.

A review of the CIS report indicated that there were no amendments documented after the home's investigation; the CIS report indicated "further investigation and reprimand to staff that work with the employee as they have known about this for some time", documented under the long-term actions planned to correct this situation and prevent recurrence.

A review of the home's policy, "Zero Tolerance of Abuse and Neglect– ADM 10", revised October 2017, indicated that the management staff would report to the MOHLTC Director the results of every investigation the home conducts under this policy, and any action the home has taken in response to any incident of resident abuse or neglect.

During an interview with the Administrator, they reported to Inspector #577 that on an identified date, they had concluded their investigation and had not amended the CIS report to include any further information. [s. 104. (1) 4. ii.]

Issued on this 17th day of September, 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

Ordre(s) de l'inspecteur

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : DEBBIE WARPULA (577)

Inspection No. / No de l'inspection : 2019_633577_0018

Log No. / No de registre : 005567-19

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Aug 29, 2019

Licensee / Titulaire de permis : Nipigon District Memorial Hospital
125 Hogan Road, NIPIGON, ON, P0T-2J0

LTC Home / Foyer de SLD : Nipigon District Memorial Hospital
125 Hogan Road, P.O. Box 37, NIPIGON, ON, P0T-2J0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Cathy Covino

To Nipigon District Memorial Hospital, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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 in compliance with s. 19. (1) of O. Reg. 79/10.
Specifically the licensee must:

a) Ensure all residents are protected from abuse and neglect.

b) Review and revise all policies related to resident abuse and neglect to ensure that they are in compliance with the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

c) Train all staff working on, or having responsibility for, the long-term care unit on the revised abuse and neglect policies, specifically related to abuse prevention, recognition, response, and reporting requirements as identified in the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

d) Maintain records of training.

e) Immediately report to the Director all incidents of alleged, suspected or witnessed abuse.

f) Develop and implement a system to monitor compliance with the home's abuse and neglect policies.

g) Notify the resident's SDM immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and notify the SDM within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse and neglect by the licensee or staff.

A Critical Incident System (CIS) report was received by the Director on an identified date, which outlined allegations of abuse and neglect by RPN #101 toward resident's #001, #002, #004 and #005. The report identified allegations

were made that RPN #101 had administered a specific medication to residents, when they were not assigned the role of medication nurse; administered medication to a resident in a form that the resident had specifically requested them not to; removed residents call bells from their reach; used a specific apparatus to transfer residents without assistance; yelled specific statements to residents; fed resident #005 unsafely and inappropriately; applied incontinence products inappropriately with residents; transferred residents to specific areas of the home at inappropriate times; and routinely completed care activities with residents at inappropriate times.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

O. Reg. 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

O. Reg. 79/10 defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A review of the home's policy, "Zero Tolerance of Abuse and Neglect– ADM 10", revised October 2017, indicated that all residents had the right to live in a home that treated them with dignity, respect and was free from any form of abuse or neglect at all times, and in all circumstances. The home was committed to zero tolerance of abuse or neglect of its residents.

A review of the investigation file concerning RPN #101, included the following documentation:

a) Notes from staff, which included the following:

-a note stamped as 'received' on an identified date, signed by RPN #103, which

had indicated that on an identified date, they had been working a specific shift with RPN #101. Further, the note identified that during the shift, resident #001's bed alarm had been alarming and RPN #101 stated that if the resident pulled on their call bell, and if the resident continued to activate their bed alarm, they would take a specific action. The note reported that RPN #101 then proceeded to get the resident up and located to a specific area of the home, where they remained.

-a note dated on an identified date, and signed by RPN #103. The note indicated that they had observed many incidents where RPN #101 had completed a certain care activity with resident #005, when the resident was capable of completing the activity themselves;

-a note dated on an identified date, and signed by RPN #104 and resident #002. The note indicated that RPN #101 provided resident #002's their medication in a form that the resident had specifically requested them not to.

b) A review of documented staff interviews conducted by the Administrator on an identified date, identified that:

-PSW #105 consistently witnessed RPN #101 feed resident #005 unsafely and inappropriately; applied incontinence products inappropriately with residents; removed all the residents call bells on a specific shift; witnessed residents who had become agitated by interactions with RPN #101; observed RPN #101 swear at day staff if they had not had residents in bed by a specific time; and that staff felt afraid to report RPN #101;

-PSW #106 witnessed RPN #101 independently change resident's diets without assessment;

-PSW #107 witnessed RPN #101 feed resident #005 unsafely and inappropriately; consistently observed resident #001's call bell out of reach and on the floor on a specific shift when RPN #101 was working; demanded residents be in their beds when RPN #101 arrived for their shift at a specific time; witnessed RPN #101's use of a specific apparatus to transfer residents without assistance; and that staff felt afraid to report RPN #101;

-RPN #103 reported that RPN #101 requested medication keys from the medication nurse and administered specific medication to residents if the medication nurse had not yet administered the medication; provided resident #002 their medication in a form that the resident had specifically requested them not to; instructed staff to remove resident #001's and #004's call bells from their reach; witnessed RPN #101 put residents to bed at a specific time; used a specific apparatus to transfer residents without assistance; witnessed the RPN remove residents mobility aids from their rooms during the night, so that they could not get out of bed; witnessed them to have completed care activities with residents at inappropriate times; witnessed them raise resident #001's bed high in the air, so that they could not get into their bed; witnessed them feed resident #005 unsafely and inappropriately; and witnessed them accost staff if they had not put residents to bed at a specific time. RPN #103 reported that staff had previously reported RPN #101 to the previous Administrator #102, but nothing had been done;

-RPN #108 witnessed RPN #101 provide resident #001 with their snacks in a particular way; witnessed residents call bells out of reach and on the floor; witnessed RPN #101 tell staff to "mind their own business and not report them"; witnessed them change residents diet consistencies without consultation; witnessed them feed resident #005 unsafely and inappropriately; witnessed them question and threaten staff when residents weren't in their beds by a specific time; witnessed them instruct staff to complete care activities with residents at inappropriate times; witnessed them force residents to bed against the their wishes; witnessed them threaten staff; witnessed them use a derogatory name to refer to resident #007; and reported that everyone was afraid of “the wrath of RPN #101”;

-RPN #109 witnessed RPN #101 to have provided resident #002 their medication in a form that the resident had specifically requested them not to; and reported they had became upset when residents were not in bed at a specific time; and

-RPN #104 witnessed RPN #101 to have provided resident #002 their medication in a form that the resident had specifically requested them not to; was aware of an incident where they had transferred resident #001 to a specific area of the home at an inappropriate time because their bed alarm and call bell

had been activated; witnessed them yell at staff for not putting residents to at a specific time; was aware of RPN #101 feeding resident #005 unsafely and inappropriately; that they had informed Nurse Manager #110 at that time and was told that it needed to be reported as a CIS report and Nurse Manager #110 told them to put it in writing.

c) A review of the Administrator's investigation notes concerning RPN #101 identified the following:
-conducted interviews with eight staff on an identified date;
-RPN #101 had suggested to the medication nurse to administer a specific medication to residents, and would administer the medication themselves if the medication nurse was not in agreement;
-administered medication to resident #002 in a form that the resident had specifically requested them not to;
-that staff confirmed RPN #101 removed call bells from residents if they had rung them “too much”, and had advised staff to remove residents call bells if they activated them;
-shook their finger in residents faces, yelled specific statements to residents;
-transferred residents with a specific apparatus without assistance;
-transferred residents to bed at a specific time;
-applied incontinence products inappropriately with residents;
-washed and partially dressed residents into their clothes during the night;
-routinely provided care activities with residents at inappropriate times;
-removed resident's mobility aids from their rooms during a specific shift, so that the resident could not get up, and raised the bed level so they could not get into their bed on their own;
-that staff witnessed RPN #101 feed resident #005 unsafely and inappropriately; and
-that staff were afraid of RPN #101, and described them as confrontational and threatening.

A review of the home's policy, "Zero Tolerance of Abuse and Neglect– ADM 10", revised October 2017, indicated that staff were to ensure that the resident whom had been harmed by abuse or neglect was not left in the responsibility of the person alleged to have caused the abuse or neglect.

A review of the home's policy, “Safeguards for residents – LTC 03”, revised April

2019, indicated that resident call bells must be secured to the bed within reach of the resident at all times; and staff were to keep beds at their lowest level to facilitate ease in getting in and out of bed.

A review of the home's policy, "Electrical Mechanical Lifts – NUR 46" revised November 2013, indicated that all resident transfers completed with a mechanical lift must be done by two caregivers.

During an interview with RPN #111, they reported to Inspector #577 that RPN #101 had been abusive and neglectful towards residents for years and that staff had been afraid to report due to fear of retaliation. They reported that they had witnessed RPN #101 feeding residents unsafely and inappropriately; and witnessed them remove residents call bells on a specific shift.

During an interview with RPN #108, they reported to Inspector #577 that RPN #101 had been abusive and neglectful toward residents for many years and reported to have witnessed the following conduct of RPN #101, as follows; a long history of completing care activities with residents at inappropriate times; witnessed them feed resident #005 unsafely and inappropriately; reported they had reported this to the previous Administrator #102 one year ago; witnessed RPN #101 to have put residents to bed at a specific time for years; witnessed residents' call bells on the floor after RPN #101's shift; witnessed them using a specific apparatus without assistance. RPN #108 reported that they had previously reported their concerns to the previous Administrator #102 and had been told that "they dealt with the individual already".

During an interview with RPN #103, they reported to Inspector #577 that they had previously reported their concerns of abuse and neglect by RPN #101 to the previous Administrator on an identified date. They reported they had witnessed the following conduct of RPN #101, as follows; witnessed them remove residents' mobility aids from out of their rooms at a specific time, so that they couldn't get out of bed; put residents' call bells on the floor and instructed other staff to move their call bells; witnessed RPN #101 get resident #001 up and located them to a specific area of the home, where they remained; witnessed RPN #101 feed resident #005 unsafely and inappropriately. RPN #103 identified that when they had reported this to the previous Administrator #102, they were told, "I would have to witness it myself for it to be true, it would be your word

against their word".

During an interview with RPN #104, they reported to Inspector #577 that they had witnessed physical and verbal abuse of RPN #101 towards residents and they had reported previous incidents to Nurse Manager #110.

During an interview resident #004, they reported to Inspector #577 that RPN #101 had routinely completed care activities with them at inappropriate times and that it had occurred for years; and when the resident told them 'no', RPN #101 told them that it was none of their business.

During an interview with the Administrator, they reported to Inspector #577 that staff had begun initiating concerns to them in an identified month, and the following month, they had begun an investigation. They reported that their investigation had confirmed abuse and neglect by RPN #101 to residents and they had concluded their investigation on an identified date. They reported that RPN #101 continued to work during the investigation until an identified date; and that there were no safeguards in place over a specified time period, when RPN #101 had continued to provide care. They further reported that staff had previously reported allegations of abuse and neglect to the previous Administrator #102, and there was no documentation of any investigations or incident reports within RPN #101's employee file.

The licensee failed to protect residents from abuse and neglect by RPN #101. The licensee and staff were aware of RPN #101 removing call bells and mobility aids from residents' reach, feeding resident #005 unsafely and inappropriately, transferred resident #001 to a specific area of the home at an inappropriate time, applied incontinence products inappropriately with residents, transferred residents to bed at a specific time, used a specific apparatus to transfer residents without assistance, and routinely completed care activities with residents at inappropriate times. Staff interviews had confirmed that RPN #101 had been abusive to residents for years, allegations had been previously reported to the previous Administrator #102, and it had not been investigated or reported to the Director. [s. 19. (1)]

The decision to issue this Compliance Order (CO) was based on the scope which was widespread, the severity which was actual harm. In addition, the

home's compliance history identified a history of previous on-going unrelated non compliance.
(577)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 26, 2019

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

Order / Ordre :

The licensee must be in compliance with s. 23. (1) of O. Reg. 79/10. Specifically the licensee must:

Ensure that every alleged, suspected or witnessed incident of abuse and neglect of a resident is immediately investigated, and appropriate action is taken in response to every such incident.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident by the licensee or staff, that the licensee knew of, or that was reported to the licensee, was immediately investigated.

A Critical Incident System (CIS) report was received by the Director on an identified date, which outlined allegations of abuse and neglect by RPN #101 toward resident's #001, #002, #004 and #005.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being,

and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

A review of the investigation file included a handwritten note dated on an identified date, signed by RPN #103, which had indicated that they had observed many incidents where RPN #101 had fed resident #005 unsafely and inappropriately;

During an interview with RPN #108, they reported to Inspector #577 that RPN #101 had been abusive and neglectful toward residents for many years, and that they had previously reported their concerns to the previous Administrator #102, and had been told that "they dealt with the individual already".

During an interview with RPN #103, they reported to Inspector #577 that they had previously reported their concerns of abuse and neglect to the previous Administrator #102, on a specified date, and had been told, "I would have to witness it myself for it to be true; it would be your word against their word".

During an interview with RPN #104, they reported to Inspector #577 that they had witnessed physical and verbal abuse of RPN #101 towards residents and they had reported the previous incidents to Nurse Manager #110.

During an interview with the Administrator, they reported that staff had begun initiating concerns to them in an identified month, and on an identified date, when RPN #103 submitted a letter to them related to RPN #101’s conduct towards residents, they initiated an informal investigation. They reported that their investigation confirmed abuse and neglect by RPN #101 to residents and had concluded their investigation on an identified date. They further reported that staff had reported that they had reported allegations of abuse and neglect to the previous Administrator #102 and there was no documentation of any investigation or incident reports in RPN #101’s employee file. [s. 23. (1) (a)]

The decision to issue this Compliance Order (CO) was based on the scope which was widespread, the severity which was actual harm. In addition, the home's compliance history identified a history of previous on-going related non-compliance specific to this area of the legislation, as follows:
- a Voluntary Plan of Correction (VPC) was issued from a Resident Quality

Inspection (RQI) #2016_463616_0019, on October 4, 2016.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 26, 2019

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be in compliance with s. 24. (1) of O. Reg. 79/10. Specifically the licensee must:

a) Ensure all staff are trained to identify and report all alleged, suspected and witnessed incidents of abuse and neglect are immediately to the Director.

b) Ensure staff are familiar with and understand how to use the Licensee Reporting of Emotional Abuse Decision Tree, the Licensee Reporting of Financial Abuse Decision Tree, the Licensee Reporting of Physical Abuse Decision Tree, the Licensee Reporting of Sexual Abuse Decision Tree, the Licensee Reporting of Verbal Abuse Decision Tree and the Licensee Reporting of Neglect Decision Tree.

d) Maintain records of the training provided.

e) Develop and implement a monitoring system to ensure that abuse and neglect is reported as required by this section.

Grounds / Motifs :

1. The licensee failed to ensure that a person who had 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 was based to the Director: 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 residents.

A Critical Incident System (CIS) report was received by the Director on an identified date, which outlined allegations of abuse and neglect by RPN #101 toward resident’s #001, #002, #004 and #005. The report indicated allegations were made of them having administered a specific medication to residents, when they were not assigned the role of medication nurse; administering medication to a resident in a form that the resident had specifically requested them not to; removing residents' call bells from their reach; using a specific apparatus to transfer residents without assistance; yelling specific statements to residents; applied incontinence products inappropriately with residents; transferring residents to bed at a specific time; and routinely completed care activities with residents at inappropriate times.

See WN #1 for further details.

A review of the home’s policy, "Zero Tolerance of Abuse and Neglect– ADM 10", revised October 2017, indicated that when a manager/designate or other received an internal report from an employee on a suspected or alleged, or actual incident of abuse or neglect, they would immediately report to the Ministry of Health and Long Term Care by using the Critical Incident System.

During an interview with the Administrator, they reported to Inspector #577 that staff had begun initiating concerns to them in an identified month, related to RPN #101 allegedly removing call bells from residents. They further reported that on an identified date, RPN #103 submitted a letter to them related to RPN #101’s conduct towards residents, and at that time they initiated an informal investigation, which included interviews with staff.

A review of the investigation file included documentation from staff interviews conducted by the Administrator on an identified date:

-PSW #105 consistently witnessed RPN #101 to have completed a certain care activity with resident #005, when the resident was capable of completing the

activity themselves, and stated, "Not when I'm here"; had applied incontinence products inappropriately with residents; would remove all the residents' call bells on a specific shift; witnessed residents who had become agitated by RPN #101; would swear at day staff if they had not put residents in bed by a specific time; felt afraid to report RPN #101;

-PSW #106 witnessed RPN #101 to have changed resident's diets without assessment;

-PSW #107 witnessed RPN #101 to have fed resident #005 unsafely and inappropriately; consistently found resident #001's call bell out of reach and on the floor at a specific time, after RPN #101's shift; demanded that residents be in their beds when RPN #101 would have arrived for their shift at a specific time; witnessed them using a specific apparatus to transfer residents without assistance; felt afraid to report RPN #101;

-RPN #103 reported that RPN #101 requested medication keys from the medication nurse and administered specific medication to residents if the medication nurse had not administered the medication; provided resident #002's medication in a form that the resident had specifically requested them not to; instructed staff to remove resident #001's and #004's call bells; witnessed RPN #101 put residents to bed at a specific time; used a specific apparatus to transfer residents without assistance; witnessed them remove resident's mobility aids from their rooms during the night so that they could not get out of bed; witnessed them to have completed certain care activities with residents at inappropriate times; witnessed them to have raised resident #001's bed high in the air so that they could not get into their bed; witnessed them feed resident #005 unsafely and inappropriately; witnessed them to have accosted staff if they had not put residents to bed before they came on shift at a specific time; reported that staff had previously reported RPN #101 to the previous Administrator #102, but felt that nothing had been done and staff had been told to put it in writing;

-RPN #108 witnessed RPN #101 to have provided resident #001 with their snacks in a particular way; witnessed residents' call bells out of reach and on the their floor; RPN #101 had told staff to mind their own business and not report them; witnessed them to have changed residents' diet consistencies; witnessed them to have fed resident #005 unsafely and inappropriately; witnessed them to

have questioned and threatened staff when residents weren't in their beds by a specific time; witnessed them to have instructed staff to complete care activities with residents at inappropriate times; witnessed them to have forced residents to bed at inappropriate times; witnessed them to have threatened staff; used a derogatory name to refer to resident #007; reported that everyone was afraid of "the wrath of RPN #101";

-RPN #109 witnessed RPN #101 to have provided resident #002 their medication in a form that the resident had specifically requested them not to; reported they had become upset when residents were not in bed at a specific time; and

-RPN #104 witnessed RPN #101 to have provided resident #002 their medication in a form that the resident had specifically requested them not to; aware of an incident where RPN #101 had proceeded to get resident #001 up and located to a specific area of the home at an inappropriate time; witnessed them to have yelled at staff for not putting residents to bed at a specific time; aware of them feeding resident #005 unsafely and inappropriately; they had informed Nurse Manager #110 at that time and had told them that it needed to be reported as a CIS report and Nurse Manager #110 told them to put it in writing.

During an interview with RPN #108, they reported to Inspector #577 that RPN #101 had been abusive and neglectful toward residents for many years and they had previously reported their concerns to the previous Administrator #102 and had been told that "they dealt with the individual already".

During an interview with RPN #103, they reported to Inspector #577 that they had previously reported their concerns of abuse and neglect to the previous Administrator #102, on an identified date, and had been told, "I would have to witness it myself for it to be true; it would be your word against their word".

During an interview with RPN #104, they reported to Inspector #577 that they had witnessed physical and verbal abuse of RPN #101 towards residents and they had reported previous incidents to Nurse Manager #110.

During an interview with the Administrator, they reported that they were unaware

that any suspicion of abuse and/or neglect needed to be reported immediately, and had submitted the CIS report on an identified date, following their investigation. They further reported that staff had reported to them that they had reported allegations of abuse and neglect to the previous Administrator #102, and there was no documentation in RPN #101’s employee file. [s. 24. (1)]

The decision to issue this Compliance Order (CO) was based on the scope which was widespread, the severity which was actual harm. In addition, the home's compliance history identified a history of previous on-going related non-compliance specific to this area of the legislation, as follows:
- a Voluntary Plan of Correction (VPC) was issued from a Complaint Inspection #2017_633577_0013, on August 14, 2017.
(577)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Sep 26, 2019

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee must be in compliance with s. 76. (2) of O. Reg. 79/10.
Specifically the licensee must:

a) Ensure that the home's management and the Administrator receive training in the areas of the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the whistle-blowing protections afforded by section 26.

d) Maintain records of the training provided.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff have received training in the home's policy to promote Zero Tolerance of Abuse and Neglect of residents before performing their responsibilities.

Inspector #577 conducted a record review of the home's policy titled, "Zero Tolerance of Abuse and Neglect – ADM 10", revised October 2017, which indicated that they had adopted “AdvantAge's Zero Tolerance of Abuse and Neglect”, sample policy and procedures, revised November 29, 2012. The policy indicated that the “Residents' Bill of Rights” and the policy on “Zero Tolerance of Abuse and Neglect” would be reviewed with each new employee during orientation and annually thereafter.

During an interview with the Administrator, they reported to Inspector #577 that they had been hired as interim Administrator in October 2018, and their role became permanent in January 2019. They further reported that Nurse Manager #110 was hired into their position on August 20, 2018.

Inspector #577 conducted a record review of abuse training for all staff, which also included a review for Nurse Manager #110 and the Administrator. During a review, the Inspector could not find abuse training records for the Administrator or the Nurse Manager.

During an interview with the Administrator, they confirmed that they, and Nurse Manager #110 had not been trained on the home's policy for Zero Tolerance of Abuse. [s. 76. (2) 3.]

The decision to issue this Compliance Order (CO) was based on the scope which was a pattern, the severity which was actual harm. In addition, the home's compliance history identified a history of previous on-going unrelated non compliance. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 26, 2019

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 212. (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,
(a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration;
(b) has at least three years working experience,
(i) in a managerial or supervisory capacity in the health or social services sector, or
(ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d);
(c) has demonstrated leadership and communications skills; and
(d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time. O. Reg. 79/10, s. 212 (4).

Order / Ordre :

The licensee must be in compliance with r. 212. (4) of O. Reg. 79/10.
Specifically the licensee must:

Ensure that the Administrator successfully completes a long-term home administration program.

Grounds / Motifs :

1. The licensee has failed to ensure that everyone hired as an Administrator after coming into force of this section, successfully completed or, subject to subsection (6), was enrolled in a program in long-term home administration or management that was a minimum of 100 hours in duration of instruction time.

During an interview with the Administrator, they reported to Inspector #577 that they had been hired as interim Administrator in October 2018, and their role became permanent in January 2019. They further reported that they had enrolled into the June 2019, Administrator course, but would not be taking the course until June 2020. They further reported that the previous Administrator #102 had never enrolled or completed the Administrator's course. [s. 212. (4) (d)]

The decision to issue this Compliance Order (CO) was based on the scope which was widespread, the severity which was actual harm. In addition, the home's compliance history identified a history of previous on-going unrelated non compliance. (577)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 26, 2019

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Order / Ordre :

The licensee must be in compliance with r. 98 of O. Reg. 79/10.
Specifically the licensee must:

Immediately notify the appropriate police force of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Grounds / Motifs :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may have constituted a criminal offence.

A Critical Incident System (CIS) report was received by the Director on an identified date, which outlined allegations of abuse and neglect by RPN #101 toward resident's #001, #002, #004 and #005. The report identified allegations were made that RPN #101 had administered specific medication to residents, when they were not assigned the role of medication nurse; administering medication to a resident in a form that the resident had specifically requested them not to; and fed resident #005 unsafely and inappropriately.

During a review of the CIS report, there had been no documentation that the police had been notified. A review of the home's investigation records had not included a record of the police being notified.

A review of the home's policy, "Zero Tolerance of Abuse and Neglect– ADM 10", revised October 2017, indicated that staff must report to the police if the alleged, suspected or witnessed incident of abuse or neglect constituted a criminal offence under the Criminal Code (staff were to refer to the MOHLTC Licensee Reporting Decision Trees). The police would determine if there were 'reasonable grounds' for charges.

During an interview with the Administrator, they reported to Inspector #577 that their investigation had confirmed abuse and neglect by RPN #101 to residents, and they had not notified the police. [s. 98.]

The decision to issue this Compliance Order (CO) was based on the scope which was widespread, the severity which was actual harm. In addition, the home's compliance history identified a history of previous on-going unrelated non compliance.
(577)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 26, 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 29th day of August, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Debbie Warpula

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