Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 1, 2014	2014_293554_0028	O-000403-14	Follow up

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South WHITBY ON L1N 9W2

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

STRATHAVEN LIFECARE CENTRE
264 King Street East Bowmanville ON L1C 1P9

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

KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 7-11 and July 14-16, 2014

During this inspection the following intakes were completed, Follow Up Inspection Logs: #O-000282-14 and #O-000403-14; concurrent with Logs #O-000381-14, O-000408-14, O-000419-14, O-000593-14, and O-000644-14

During the course of the inspection, the inspector(s) spoke with Interim Administrator, Director of Care(DOC), Assistant Director of Care(ADOC), Regional Nurse Consultant, Registered Nurses(RN), Registered Practical Nurses(RPN), MDS-RAI Coordinator, Personal Support Workers(PSW), Residents, and Family

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 101. (1)	CO #001	2014_220111_0007	554

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	Legendé 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. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

1. Related to Log #O-000408-14, for Resident #008:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring the care set out in the plan of care is provided to the resident as specified in the plan.

Staff reported finding Resident #008 sitting on the toilet, unattended. Staff who reported the incident began their tour approximately hour and a half earlier.

According to the Assistant Director of Care, Staff #120, left Resident #008 on the toilet to assist another resident; staff indicated forgetting to return to Resident #008. ADOC indicated that Staff #120 had further communicated transferring Resident #008 onto the toilet without the assistant of a second staff.

The written care plan indicated the following care requirements specific to the needs of Resident #008:
- 2 staff required to transfer onto and off of toilet for safety
- do not leave resident unattended on the toilet
- falls risk [s. 6. (7)]

2. Related Log #O-000419-14, for Resident #003:

The licensee failed to comply with LTCHA, 2007, s. 6 (9)1, by ensuring the provision of the care set out in the plan of care is documented.

The home submitted a Critical Incident Report, specific to Resident #003, the report indicated resident exhibited responsive behaviours which resulted in injuries to another resident.

The Critical Incident Report, written by and submitted by the Assistant Director of Care (ADOC), as well as the progress notes written by registered staff indicated Resident #003 was being observed due to safety risk. According to the ADOC staff are to document the safety observations, during a specific time period, using a monitoring tool; staff are to document the following on the form: date, time, resident's location and observation made.

The Assistant Director of Care indicated that the safety observations/checks were being completed and signed for by nursing staff following the incident. ADOC indicated that the observations specific to Resident #003 were to be completed for a period of 72 hours, then every half-hour for seven days.

The home's monitoring tool was reviewed for a specific time period; the monitoring tool specific to Resident #003 indicated the following:
- the observations were not initiated on the date indicated
- the documented entries on the form were not consistent with the required observation periods

Staff # 112, who supervises the unit, indicated the missing entries were most likely due to staff being too busy to complete the form.

The Assistant Director of Care indicated direction was given to staff on a specific date to initiate the safety observations for Resident #003; ADOC was unsure why the monitoring tool was not initiated as directed.

Assistant Director of Care indicated it was the responsibility of the Registered Practical Nurse to ensure the monitoring form was completed as assigned and it was the responsibility of the RN Supervisor to ensure direction is followed with respect to care, specifically heightened monitoring due to safety risk. [s. 6. (9)]

3. Related to Log #O-000644-14, for Resident #002:

The licensee failed to comply with LTCHA, 2007, s. 6 (10) (b), by ensuring the resident reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

Resident #002 exited the home on a identified date. Resident was located and taken by ambulance to the hospital; resident was assessed and treated for injuries sustained.

Resident was discharged from hospital and returned to the long term care home the same day.

Staff #107 indicated being assigned to care for resident during a three day period (post hospitalization) but was unaware that resident was at risk due to responsive behaviours exhibited; Staff #107 indicated no awareness of the incident which had occurred, indicating being told by co-workers that Resident #002 had fallen and had been injured.

Staff #107 indicated Resident #002's care needs had changed significantly since the fall incident.

According to Staff #107, resident required the following assistance with care following the incident:
- requires extensive transferring; with the aide of one to two staff
- uses wheelchair to and from all areas of the home
- extensive assistance by one staff for dressing, undressing, and application and removal of a specific treatment measure
- spends the majority of day in bed resting due to discomfort; resident is only up for meals

The plan of care, in place at the time of the inspection was not reflective of the care needs of Resident #002.

The written care plan in place at the time of the inspection had not been updated to reflect Resident #002’s care needs specific to, dressing, transferring, mobility/use of mobility aides and sleep/wake patterns following resident's incident, nor had the written care plan been updated to reflect new strategies to mitigate risk specific to responsive behaviours recently exhibited.

The RAI Coordinator indicated during an interview that all registered staff are responsible for updating the care plan. RAI Coordinator indicated that written care plan should have been reviewed and updated based on resident care needs.

Assistant Director of Care indicated directing registered nursing staff to update the plan of care following resident's return from hospital.

The Assistant Director of Care indicated that the written care plan should at all times reflect resident care needs, especially when a resident has had a significant change and or high risk of responsive behaviours; any changes in the care should be communicated to direct care staff (e.g. nursing).

A Compliance Order, specific to, LTCHA, 2007, s. 6 (10) (b) was previously issued. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 s. 19, by failing to protect resident(s) from abuse and or neglect.

Definitions:

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means, (a) any threatening, insulting, intimidating or

humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of “abuse” in subsection 2 (1) of the Act, “physical abuse” is defined as (c) the use of physical force by a resident that causes physical injury to another resident.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of “abuse” in subsection 2 (1) of the Act, “verbal abuse” means, (a) 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 another other than a resident.

Under O. Reg. 79/10, s. 5., for the purpose of the definition “neglect” in subsection 5, of the Act and this regulation, “neglect” means, 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.

Summary of the facts:

Related to Resident #002:

Resident #002, exited the home on a specific date. Resident was located, noted to have injuries and was taken to hospital; resident was treated and discharged back to the home, the same day.

The Assistant Director of Care indicated that MOHLTC was not notified using the after-hours contact number. A Critical Incident Report was not submitted by the home until the following day.

To further note, the written care plan, for this resident failed to demonstrate any revisions to the plan had been made following the incident; nor during the week post incident/hospitalization.

Staff #107, indicated being assigned to care for Resident #002 and having care for Resident #002 during a three day period post incident. Staff 107, indicated no awareness

of resident being at safety risk nor was staff aware of the incident which occurred earlier that week.

Staff #108, who was working on the unit where Resident #002 resides, indicated no awareness of Resident #002 being at safety risk due to responsive behaviours.

The licensee failed to comply with:
- O. Reg. 79/10, s. 107 (1), by ensuring that the Director is immediately informed of the following incidents: 4. Any missing resident who returns to the home with injury or any adverse change in condition regardless of the length of time the resident was missing. (WN #12)
- O. Reg. 79/10, s. 55 (b), by ensuring that direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident. (WN #9)

Related to Resident #003:

On a specific date, Resident #003 exhibited responsive behaviours and injured Resident #004; Resident #004 required medical assessment following the incident.

According to the progress notes, registered nursing staff were instructed by the Administrator to contact the police as to the incident; police attended the home.

The home submitted a Critical Incident Report, specific to Resident to Resident Abuse, but the submission was a day later.

Registered Staff #111, #112 and #121 indicated that staff do not contact MOHLTC as to incidents of abuse, as that is the role of the management team.

The Assistant Director of Care, who is responsible for submitting Critical Incident Reports, indicated working the day of the incident, but was unsure why the report was delayed. ADOC indicated C.I.A.T.T. was not notified by telephone of the incident.

To further note, progress notes reviewed indicated this was not the first incident of responsive behaviours exhibited by Resident #003 and directed towards other residents and staff.

Progress notes reviewed, for a seven month period, documented numerous incidents of responsive behaviours exhibited by Resident #003 where registered staff failed to document the action taken and or the resident's response to the intervention.

Staff interviewed indicated that the interventions listed in the written care plan were rarely effective in reducing or eliminating Resident #003's responsive behaviours.

Assistant Director of Care indicated resident's responsive behaviours remain challenging for the home and places other resident's at risk of harm.

There is no indication in Resident #003's plan of care that an external psychogeriatric support service has been accessed in the current year to mitigate risk of harm to the resident and or others.

On a specific date, Staff #114 was assigned to specifically care for Resident #003; Staff #114 indicated no awareness of the care needs, nor responsive behaviours which resident may exhibit despite being assigned to the shift, and the shift beginning approximately three and a half hours earlier.

Staff #114 was unable to provide details of behavioural triggers, strategies to reduce responsive behaviours or how to intervene should Resident #003 demonstrate responsive behaviours. Staff #114 further indicated no report had been provided at the beginning of the shift assignment which began at earlier that day.

Staff #112, who supervises the unit, indicated no awareness of the staffing assignment for Resident #003 at the beginning of the shift on the date identified, staff indicated that once aware of the assignment, that report had not been given to Staff #114, as there had been not been time available.

The licensee failed to comply with:
- LTCHA, 2007, s. 24 (1), by ensuring that a person who has reasonable ground to suspect that any of the following has occurred shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. (WN #7)
- LTCHA, 2007, s. 53 (4) (c), by ensuring that actions are taken to meet the needs of residents with responsive behaviours, include, reassessment, interventions and

documentation of the resident's response to the interventions. (WN #3)
- O. Reg. 79/10, s. 55 (b), by ensuring that all direct care staff are advised at the beginning of every shift of each resident whose behaviour, including responsive behaviours, required heightened monitoring because those behaviours pose a potential risk to the resident or others. (WN #9)

Related to Resident #005:

Resident #005 and #006 were involved with an altercation (resident to resident abuse); both residents sustained injuries as a result of the incident.

Progress notes, indicated the RN Supervisor (Charge Nurse), working the day of the altercation, was made aware of the incident of Resident to Resident Abuse, by staff working.

The Assistant Director of Care indicated working the day of the incident,but could not recall why the incident of Resident to Resident Abuse was not immediately reported to MOHLTC.

The Critical Incident Report specific to this incident was not submitted until two days later.

According to Staff #111 the incident of Resident to Resident Abuse was not reported to the police.

To further note, Progress notes reviewed, during a four month period, indicated Resident #005 as exhibiting several responsive behaviours.

The written care plan for the period indicated above failed to identify strategies or interventions specific to responsive behaviours nor were there interventions implemented as identified (e.g. referral to BSO Team).

During this same period, progress notes indicated Resident #005 hit another resident on more than one occasion.

There are numerous documented entries in the progress notes, where registered nursing staff have identified Resident #005 as exhibiting a responsive behaviour, but there is no

indication as to the action taken nor the response of the resident to the intervention if implemented.

There is no indication that an external psychogeriatric supports has been accessed in the current year to mitigate the risk of harm to the resident and or others.

Staff indicated responsive behaviours exhibited by Resident #005 place other residents at risk of harm.

The licensee failed to comply with:
- LTCHA, 2007, s. 24 (1), by ensuring that a person who has reasonable ground to suspect that any of the following has occurred shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. (WN #7)
- O. Reg. 79/10, s. 98, by ensuring that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse. (WN #10)
- LTCHA, 2007, s. 53 (4) (b), by ensuring strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours. (WN #3)
- LTCHA, 2007, s. 53 (4) (c), by ensuring that actions are taken to meet the needs of residents with responsive behaviours, include, reassessment, interventions and documentation of the resident's response to the interventions. (WN #3)

Related to Resident #007:

An allegation of emotional/verbal abuse was reported, by Resident #007, to the Assistant Director of Care on an identified date.

Resident #007 indicated needing to use the washroom and rang the call bell for assistance. Resident reported Staff #119 responded to the call bell and spoke to the resident sarcastically; resident commented that Staff #119 was 'not nice' during the interaction. Resident indicated being upset by the interaction.

Staff #119 worked subsequent shifts following the allegation of verbal/emotional abuse and was not interviewed by the management team until days later.

The home submitted the Critical Incident Report a day following the reported incident.

The incident was not immediately reported to MOHLTC, despite the incident being directly reported to the Assistant Director of Care.

The licensee failed to comply with:
- LTCHA, 2007, s. 23 (1) (a), by ensuring that every alleged, suspected or witnessed incident of abuse and or neglect of a resident, that the licensee knows of is immediately investigated.
(WN #6)
- LTCHA, 2007, s. 24 (1), by ensuring that a person a person who has reasonable ground to suspect that any of the following has occurred shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. (WN #7)

Related to Resident #008:

Resident #008 was left on the toilet. According to the Assistant Director of Care, Staff #120 indicated leaving the resident unattended while assisting another resident, staff did not return and indicated forgetting Resident #008 was on the toilet. Staff #120 reported transferring Resident #008 onto the toilet without the assistance of a second staff.

The plan of care indicated Resident #008 was at high risk for falls, was not to be left unattended on the toilet and was to be transferred at all times with the assistance of two staff.

Personal Support Workers who discovered the incident reported the care concern to both the Registered Practical Nurse and the RN Supervisor who was in charge at the time of the incident.

The Critical Incident Report specific to neglect of care was reported, to MOHLTC, but not until a day later.

The licensee failed to comply with:
- LTCHA, 2007, s. 6 (7), by ensuring the care set out in the plan of care is provided. (WN #1)
- LTCHA, 2007, s. 24 (1), by ensuring that a person who has reasonable grounds to suspect that any of the following has occurred shall immediately report the suspicion and

the information upon which it is based to the Director: 2 Abuse or Neglect of a resident by the licensee or staff that resulted in harm or risk of harm. (WN #7)

Related to Resident #009:

An allegation of neglect was reported by Resident #009 to a Personal Support Worker, the incident was reported during care (the shift after the incident occurring).

Resident #009 indicated ringing the call bell as needed to use the washroom. Resident indicated an unidentified staff entered the room and turned off the call bell, and exited the room without toileting or assisting the resident; resident was incontinent as a result.

Staff who received the care concern, from Resident #009, reported the incident to the Registered Practical Nurse who reported the concern to the RN Supervisor (#121) who was in charge of the home at the time.

RN Supervisor (#121) indicated contacting the Assistant Director of Care (ADOC), but could not recall if spoke directly to the Assistant Director of Care or if a phone message was left.

Assistant Director of Care recalls receiving a phone message from the RN Supervisor #121, but indicated when the call was returned Staff #121 had left for the day; ADOC indicated that the RN Supervisor on the evening shift was not aware of the incident.

Staff working the night of the incident, were not interviewed as to the neglect allegation until three days later, despite working shifts following the incident.

The Assistant Director of Care was unsure as to why there was a delay in investigating Resident #009's care concern.

The Assistant Director of Care indicated that MOHLTC was not contacted, nor was a Critical Incident Report submitted, as the home had dealt with the matter as a complaint not an incident of abuse.

The home has since reported this occurrence as a Critical Incident.

The licensee failed to comply with:

- LTCHA, 2007, s. 23 (1) (a), by ensuring that every alleged, suspected or witnessed incident of abuse and or neglect of a resident, that the licensee knows of is immediately investigated.
(WN #6)
- LTCHA, 2007, s. 24 (1), by ensuring that a person who has reasonable ground to suspect that any of the following has occurred shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. (WN #7)

Additionally:

The licensee failed to comply with LTCHA, 2007, s. 20 (1), by ensuring the home's policy to promote zero tolerance of abuse is complied with. (WN #5)

The home's policy, Abuse and Neglect of a Resident-Actual or Suspected (VII-G-10.00) directs that the Administrator or designate will notify the MOHLTC Director immediately according to protocols established for reporting of abuse and critical incidents.

The policy further directs that implicated staff (or volunteers) will be informed about any allegation as quickly as possible.

As detailed in this report, under Written Notification (WN) #6 and #7, there were several situations involving alleged, suspected or witnessed abuse or neglect of residents which were not reported as per requirements under Section 24 nor immediately investigated as per requirements under Section 23.

Registered Staff #111, #112 and #121 all indicated awareness of reporting requirements relating to abuse and neglect and indicated having access to the after-hours contact number for MOHLTC; staff indicated that contacting MOHLTC was the role of the managerial team.

The Assistant Director of Care did indicate awareness of the reporting requirements under Section 24, but could not recall why there were time delays in immediately reporting and or investigating allegations, suspected or witnessed incidents of abuse and or neglect.

The licensee failed to comply with LTCHA, 2007, s. 20 (2) (d), by ensuring at minimum,

the policy to promote zero tolerance of abuse and neglect of residents, shall contain an explanation of the duty under Section 24 to make mandatory reports. (WN #5)

The home's policy Abuse and Neglect of a Resident – Actual or Suspected (VII-G-10.00) does not provide:
- An explanation of the duty to make mandatory reports under s. 24 in its policy to promote zero tolerance of abuse and neglect.
- A clear explanation to Personal Support Workers, Registered Nursing Staff, Support Staff or others, on their individual obligation for reporting to the Director, under s. 24 (1) of the LTCHA, irrespective of the licensee's duty to report.

Conclusion:

The home's compliance history was reviewed for the past three years. The home was issued a Written Notification (WN) and a Voluntary Plan of Correction (VPC) for failing to comply with the LTCHA, 2007, s. 24 (failure to immediately report instances of alleged, suspected or witnessed abuse to the Director).

The home was issued a WN relating to O. Reg. 79/10, s. 53 (4), specific to failing to identify behavioural triggers and ensuring strategies are developed and implemented to respond to the resident demonstrating responsive behaviours. During this same inspection, the home was issued a WN and a VPC for failing to notify immediately notify the police regarding Resident to Resident Abuse.

Two years previously, the home was issued a WN and VPC, for failing to provide clear direction relating to the management of a resident exhibiting responsive behaviours. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Related to Log #O-000593-14, for Resident #005:

The licensee failed to comply with O. Reg. 79/10, s. 53 (4) (a), by ensuring behavioural triggers are identified for resident’s demonstrating responsive behaviours.

Progress notes reviewed, for Resident #005, during a four month period indicated numerous responsive behaviours exhibited by the resident.

The resident care flow sheets, completed by Personal Support Workers, for the period indicated detail Resident #005 as exhibiting specific responsive behaviours almost daily during all shifts.

A review of the care plan identifies resident as having numerous responsive behaviours, but does not identify triggers to all behaviours.

The written care plan for Resident #005 does not include all behaviours being exhibited by Resident #005 nor does the plan identify triggers for specific behaviours identified in the progress notes and or care flow sheet records. [s. 53. (4) (a)]

2. Related to Log # O-000593-14, for Resident #005:

The licensee failed to comply with O. Reg. 79/10, s. 53 (4)(b), by ensuring strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours.

The written care plan for Resident #005 identifies numerous responsive behaviours and some associated interventions.

Progress notes, for a three month period, indicate Resident #005 as exhibiting responsive behaviours on numerous occasions.

The written care plan for this resident failed to identify strategies or intervention specific to, all indicated responsive behaviours.

Despite ongoing challenges with responsive behaviours exhibited by Resident #005, there is no evidence to indicate that all planned interventions had been initiated, despite interventions being listed in the resident's care plan. [s. 53. (4) (b)]

3. Related to Log # O-000419-14, for Resident #003:

The licensee failed to comply with O. Reg. 79/10, s. 53 (4)(c), by ensuring that actions taken to meet the needs of the resident with responsive behaviours include, reassessment, interventions and documentation of the resident's responses to the interventions.

Resident #003 was admitted to the home with a known history of responsive behaviours.

The home submitted a Critical Incident, indicating that an altercation between Resident #003 and a co-resident occurred on a specific date; details of the incident are as follows:

Resident #003 exhibited responsive behaviours which resulted in the injury of Resident #004.

Progress notes indicate Resident #003 on several occasions, exhibited responsive behaviours towards staff and other residents; notes indicate responsive behaviours escalating and subsequently required the home's staff to contact police for assistance.

Progress notes reviewed, during a seven month period, detail Resident #003 as exhibiting numerous responsive behaviours.

There were thirty-two progress notes, written by registered nursing staff, during a seven

month period, that indicate Resident #003 as exhibiting responsive behaviour(s), the notes failed to identify actions taken by staff or response by the resident of any intervention taken.

Staff #113 could offer no explanation as to why there was no updated Crisis Care Plan / Behavioural Assessment Tool completed for this resident, nor could the staff comment as to why a referral hadn't been requested to reassess Resident #003, noting continued challenges and incidents of responsive behaviours directed towards others.

Staff #115 indicated, resident continues to exhibit responsive behaviors directed towards others. Staff commented that the only thing that works to reduce Resident #003's behaviour is to give resident what resident wants and even then, the behaviour may not change.

Assistant Director of Care indicated that Resident #003's responsive behaviours remain challenging and interventions in place are rarely effective; ADOC was uncertain as to why a referral for reassessment had not been initiated.

The responsive behaviours exhibited by Resident #003 continue to place the resident at risk of harm to self and others. [s. 53. (4) (c)]

4. Related to Log #O-000593-14, for Resident #005:

The licensee failed to comply with O. Reg. 79/10, s. 53 (4)(c), by ensuring that actions are taken to meet the needs of the resident with responsive behaviours include, reassessment, interventions and documentation of the resident's response s to the interventions.

Progress notes reviewed, for a four month period, indicate Resident #005 as exhibiting several responsive behaviours. Progress notes document occasions where other residents were hit by Resident #005.

There are numerous progress notes, written by registered staff, during the time period indicated above, which indicate Resident #005 as exhibiting responsive behaviour(s), but fail to identify the action taken by the staff or the response of the resident to any intervention taken.

Staff #126 and #111 both indicated resident's responsive behaviour(s) remain a

challenge. Staff #126 stated that interventions indicated in the written care plan are rarely effective.

The responsive behaviours exhibited by Resident #005 continue to place the resident at risk of harm to self and other residents. [s. 53. (4) (c)]

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 there is a process in place to monitor that behavioural triggers are identified for resident's demonstrating responsive behaviours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 3 (1)11, by ensuring that the resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act has been fully respected and promoted specifically:

During the inspection, a home form labelled Unit Two was observed lying on top of a medication cart; during the observation the medication cart was unattended and in the hallway.

The form identified the unit residents and their assigned room numbers, the form indicated the following additional information:

Resident #004 – information written on the form included, identified resident exhibiting responsive behaviours

Resident #010 – information written on the form included, identified resident as having had a fall

Resident #011 – information written on the form included, identified resident as requiring increased observation due to responsive behaviours

Resident #003 – information written on the form included, identified resident as exhibiting responsive behaviours and requiring increased observation

Resident #012– information written on the form included, identified resident as being monitored using specific assessment tools due to responsive behaviours

During the above observation, two residents walked past the medication cart. The medication cart was observed to be in the hallway approximately thirty minutes with the form containing resident information visible.

The Director of Care indicated that resident health and personal information is not to be visible to or shared with individuals other than Health Care Workers. [s. 3. (1) 11. iv.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 20 (1), by ensuring the home’s policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home’s policy, Abuse and Neglect of a Resident-Actual or Suspected (VII-G-10.00) directs that the Administrator or designate will notify the MOHLTC Director immediately according to protocols established for reporting of abuse and critical incidents.

The policy further directs that implicated staff (or volunteers) will be informed about any allegation as quickly as possible.

As detailed in this report, under Written Notification (WN) #6 and #7, there were several situations involving alleged, suspected or witnessed abuse or neglect of residents which were not reported as per requirements under Section 24 nor immediately investigated as per requirements under Section 23.

In all instances, the Assistant Director of Care could not recall why there were delays in reporting and or investigating such allegations. [s. 20. (1)]

2. The licensee failed to comply with LTCHA, 2007, s. 20 (2) (d), by ensuring at minimum, the policy to promote zero tolerance of abuse and neglect of residents, shall contain an explanation of the duty under Section 24 to make mandatory reports.

The home’s policy Abuse and Neglect of a Resident – Actual or Suspected (VII-G-10.00) does not provide:

- An explanation of the duty to make mandatory reports under s. 24 in its policy to promote zero tolerance of abuse and neglect.

- A clear explanation to Personal Support Workers, Registered Nursing Staff, Support Staff or others, on their individual obligation for reporting to the Director, under s. 24 (1) of the LTCHA, irrespective of the licensee’s duty to report.

There is a high risk posed to the safety of residents if alleged, suspected or witnessed incidents of abuse and or neglect are not reported as required by legislation. [s. 20. (2) (d)]

WN #6: 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. Related to Log #O-000381-14, for Resident #007:

The licensee failed to comply with LTCHA, 2007, s. 23 (1) (a), by ensuring that every alleged, suspected or witnessed incident of abuse or neglect that the licensee knows of, or that is reported is immediately investigated.

An allegation of Verbal/Emotional Abuse (staff to resident) was reported by Resident #007 to the Assistant Director of Care (ADOC). Resident indicated the incident occurred when resident rang the call bell needing to use the washroom.

Resident #007 indicated to the Assistant Director of Care that Staff #119 was sarcastic with comments during the interaction, and indicated Staff #119 as ‘not being nice’. ADOC asked Resident #007 how the interaction made resident feel, resident indicated being upset by the interaction. Resident indicated if Staff #119 was working again, that resident would not ring the call bell to use the washroom.

A review of the home’s Internal Incident Report indicated Staff #119 was permitted to work on another resident home area following incident and prior to being interviewed as to the allegation.

The Assistant Director of Care indicated in a letter to Resident #007, that the management team had not yet met with Staff #119 relating to the incident, but did convey staff had been reassigned.

The Assistant Director of Care, during an interview, indicated that Staff #119 was not interviewed as to the abuse allegations until approximately a week later.

Assistant Director of Care could not recall why there was a delay in meeting with the identified staff; ADOC indicated the usual practice is to investigate any allegation of abuse and neglect immediately. [s. 23. (1) (a)]

2. For Resident #009:

During a review of the home’s complaint log an incident involving neglect of care was noted, The documented entry in the log details the following:
- Resident #009 reported ringing the call bell, resident indicated needing to use the washroom. Resident #009 indicated a nursing staff, working the shift, entered the room, turned off the call bell, and exited the room without toileting the resident. Resident was incontinent as a result.

As noted in the home's Complaint Log, Resident #009 communicated the incident to an oncoming shift staff, who intern communicated the details to the unit Registered Practical Nurse who then communicated the care concern to the RN Supervisor (#121) working the same day.

RN Supervisor (#121) who worked the day of the report, indicated receiving details of the care concern and contacting the Assistant Director of Care to report the incident. Staff was not sure if communicated directly to ADOC or if a phone message was left.

The Assistant Director of Care recalled receiving a phone message as to the incident, but indicated when called back RN #121's shift had ended. ADOC indicated speaking to another registered staff who was unaware of the incident.

The Assistant Director of Care indicated that two of the staff alleged to have been involved with the incident worked subsequent shifts the following day.

According to the entry in the Complaint Log staff who had worked the identified shift,

were not interviewed until four days later.

The Director of Care (new to the home) could not comment as to why there was a delay in the investigation, and indicated the Assistant Director of Care would need to speak to such.

The Assistant Director of Care could not recall why there was a delay in investigating Resident #009's concern.

Assistant Director of Care indicated staff involved with allegations of abuse or neglect are usually interviewed immediately. [s. 23. (1) (a)]

WN #7: 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. Log #O-000419-14, for Resident #003 and #004:

The licensee failed to comply with LTCHA, 2007, s. 24 (1), by ensuring that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to

the Director,
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

A Critical Incident Report(CIR) was received by MOHLTC specific to Resident to Resident Abuse, the incident according to the CIR occurred a day prior to the report being submitted. The CIR indicated that Resident #003 exhibited responsive behaviours which resulted in injury to a Resident #004.

Resident #004 sustained injuries which required increased monitoring. Following the incident Resident #004 complained of discomfort and required medication to be administered.

Progress notes, written by a Registered Practical Nurse, the day of the incident, indicate the Administrator directed staff to contact the police regarding the altercation.

Critical Incident Report, written by the Assistant Director of Care, indicates the home submitted the report the day following the incident. [s. 24. (1)]

2. Related to Log #O-000593-14, for Resident #005 and #006:

The home's Risk Management Incident Reports and progress notes indicated Residents #005 and #006 were involved with an altercation (resident to resident abuse). Both residents sustained injuries as a result of the altercation, and required first aid.

Notes indicate RN Supervisor, who was in charge and working the shift when the incident occurred was notified of the altercation.

The Critical Incident Report (CI) was submitted by the Assistant Director of Care two days later. (1)]

3. Related to Log #O-000381-14, for Resident #007:

An allegation of Verbal/Emotional Abuse (staff to resident) was reported by the resident to the Assistant Director of Care (ADOC) on a specific date, the allegation was brought forward by Resident #007. Resident indicated the incident occurred earlier that day when resident rang the call bell, needing to use the washroom.

During an interview with the ADOC, Resident #007 indicated Staff #119 as being sarcastic with comments, and further indicated staff as 'not being nice'. ADOC asked Resident #007 how the interaction made resident feel, resident indicated being upset by the interaction; resident further indicated if Staff #119 was working again, that resident would not ring to use the washroom.

The Critical Incident Report was submitted, by the Assistant Director of Care, approximately two days later.

The Assistant Director of Care was unable to recall why there was a delay in reporting an allegation of verbal/emotional abuse (staff to resident), despite the resident reporting the incident directly to ADOC.
[s. 24. (1)]

4. Related to Log #O-000408-14, for Resident #008:

Personal Support Workers, reported finding Resident #008 sitting on the toilet; staff reported resident was left on the toilet by staff from the previous shift, which ended approximately an hour and a half earlier.

Assistant Director of Care reported that Resident #008 was placed on the toilet by Staff #120 (exact time unknown), and left to attend to another resident; staff conveyed forgetting to return to Resident #008 and intern left the home at the end of the assigned shift.

The care plan indicates Resident #008 as being at high risk for falls. The care plan indicated resident was not to be left unattended during toileting.

The incident was reported to both the Registered Practical Nurse and the RN Supervisor (Charge Nurse) working the same shift as the date in which incident occurred. According to the Incident Report, there was no visible injury to Resident #008 as a result of the incident.

A Critical Incident Report, indicating neglect of care, was submitted by the Assistant Director of Care a day later. [s. 24. (1)]

5. For Resident #009:

During a review of the home's complaint log the following was noted:
- Resident #009 reported ringing the call bell, resident indicated needing to use the washroom. Resident #009 indicated a nursing staff, working the shift, entered the room, turned off the call bell, and left the room without toileting the resident. Resident was incontinent as a result.

Staff #122 indicated reporting the care concerns of Resident #009 to the oncoming shift Registered Practical Nurse, who later reported the incident to the Nursing Supervisor on shift.

Staff #121, who was the RN Supervisor in the home the day of the report, indicated receiving the care concern and contacting the Assistant Director of Care at home (by phone) to report the incident as reported by Resident #009.

The Assistant Director of Care recalled receiving a phone message regarding the incident but indicated when she called back RN #121 had completed the assigned shift and had gone home; ADOC indicated speaking to another registered staff who was unaware of the incident.

RN Supervisor, and who was in charge of the home on date of the report, indicated that MOHLTC was not immediately notified of incident.

Assistant Director of Care indicated that the home had not submitted a Critical Incident Report specific to this incident, as had dealt with matter as a resident complaint.

The home has since reported this occurrence as a Critical Incident.

Staff #111, #112 and #121 all indicated awareness of the reporting requirements under Section 24 and having access to the after-hours contact number for MOHLTC, but indicated registered staff do not contact MOHLTC as that is a managerial role; staff indicated that it's up to Administrator or Assistant Director of Care to submit reports to the MOHLTC.

Assistant Director indicated all registered nursing staff have had education specific to reporting of incident of abuse and or neglect and should be reporting as incidents occur.

The Assistant Director of Care indicated awareness of the reporting requirements under Section 24, but could offer no explanation as to why the incidents of abuse and or

neglect were not immediately reported by registered nursing staff nor herself. [s. 24. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. Related to Log # O-000593-14, for Resident #005:

The licensee failed to comply with O. Reg. 79/10, s. 43, by ensuring strategies are developed and implemented to meet the needs of those residents with compromised communication and verbalization skills, residents with cognitive impairment and residents who cannot communicate in the languages used in the home.

The written care plan, for Resident #005, indicated resident as having a language barrier and will exhibit responsive behaviours when not understood by staff or co- residents. The care plan does direct staff to contact family to assist as able.

Staff #111, during an interview, indicated it was difficult to reach Resident #005's family and often the responsive behaviour(s), exhibited by this resident, have escalated beyond frustration, resulting in increased responsive behaviours directed towards staff and other residents.

Staff #111 indicated the home currently has no access to translators; staff indicated the home does not have or use communication boards for residents presenting with language barriers. Staff #111 indicated the resident's inability to effectively communicate with others may be a contributing factor to responsive behaviours exhibited by Resident #005.

Staff #126 indicated that it was difficult to communicate with Resident #005 due to resident's inability to effectively communicate. [s. 43.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. Related to Log #O-000644-14, for Resident #002:

The licensee failed to comply with O. Reg. 79/10, s.55 (b), by ensuring that direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident.

Resident #002, has a history of responsive behaviours, specific to safety risk, dating back to the previous year.

Resident #002 exited the building without staff being aware; resident was later located and was taken to the hospital, treated for injuries sustained and was later transferred back to the home, the same day as the incident occurred.

The written care plan, for this resident failed to demonstrate any revisions to the plan following the incident nor within the week following the incident.

Staff #107, indicated being assigned to care for Resident #002 and having had worked during a three day period post incident. Staff 107, indicated no awareness of resident being at safety risk nor was staff aware of the incident occurring earlier that week.

Staff #108, working the day of the inspection, on the unit where Resident #002 resides, indicated no awareness of Resident #002 having responsive behaviours placing resident at risk for safety. [s. 55. (b)]

2. Related to Log #O-000419-14, for Resident #003:

Resident #003 has a long standing history of responsive behaviours.

Progress Notes, written by registered nursing staff, indicate Resident #003 exhibited specific responsive behaviours on an identified date, and hit Resident #004; police were contacted to intervene. Notes indicate, increased staffing was initiated as a result of this incident.

Staff #114 indicated no awareness of Resident #003's care needs, nor responsive behaviours exhibited by this resident, including behavioural triggers, care strategies or how to intervene is resident was to demonstrate behaviours. Staff #114 indicated that no report had been provided despite the assigned shift beginning three and a half hours earlier.

Staff #114 indicated being contacted and given the staffing assignment with Resident #003 for a specific date. Staff 114's normal work assignment is in another department.

Staff #112, who supervises the unit where Resident #003 resides, indicated not being informed of the staffing assignment by off-going registered staff. Staff #112 indicated becoming aware of the staffing assignment for Resident #003 around breakfast time, but had not had time to provide Staff #114 with a report as to the care needs of the resident.

The home's policy Shift to Shift Communication for Registered and PSW Staff (VII-B-50.00) directs that at shift report the registered staff will ensure that report is delivered efficiently, communicating key issues associated with resident care, and incidents. Communication will address changes in resident health status, behavioural issues incidents, and other issues which the oncoming staff should be aware of (e.g. staffing). The policy further communicates that following report the oncoming registered staff will complete a visual check of all the residents on the home area.

During an interview, Assistant Director of Care indicated that registered nursing staff should be communicating to Personal Support Workers any 'high risk' responsive behaviours so that such is monitored accordingly.

The Director of Care indicated that staff assigned to care for residents should be aware of the care needs of each individual resident. [s. 55. (b)]

WN #10: 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. Related to Log #O-000593-14, for Resident #005 and #006:

The licensee failed to comply with O. Reg. 79/10, s. 98, by ensuring that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse.

An incident of Resident to Resident Abuse which occurred on a specific date was not reported to the police. The incident involved Resident #005 and #006, both residents sustained injury in the altercation.

Staff #112 indicated the incident was not reported to police due to medical conditions of both residents.

Assistant Director of Care indicated that all incidents of Resident to Resident Abuse are to be reported to the police. [s. 98.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. Related to Log #O-00403-14:

The licensee failed to comply with O. Reg. 79/10, s. 101 (3)(a), by failing to ensure that complaints received are reviewed and analyzed for trends, at least quarterly.

The Interim Administrator indicated that the home has not conducted a quarterly review or analysis of trends with regards to complaints received during the current year. Interim Administrator was unable to verify if such was completed the previous year.

The Interim Administrator indicated that the plan is to begin a review, when the interdisciplinary team next meets for the Continuous Quality Improvement meeting. [s. 101. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. Related to Log #O-000644-14, for Resident #002:

The licensee failed to comply with O. Reg. 79/10, s. 107(1) 4, by ensuring that the Director is immediately informed, of any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.

The home was notified by a community agency that one of the home's resident's had been located outside of the home. Resident had sustained injuries and had been taken to hospital for assessment and treatment. Resident #002 was treated and released from hospital later that day.

The Critical Incident Report, submitted indicated staff, working the shift during the date of the incident, were not aware of Resident #002 having had left the home.

The Assistant Director of Care (ADOC) indicated Resident #002 as having a history of similar responsive behaviours during the previous year.

The Critical Incident Report relating to incident was not submitted by the Assistant Director of Care until a day later.

Assistant Director of Care indicated awareness of time lines for reporting, and was unable to comment for the delay in reporting the incident. [s. 107. (1) 4.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. Log #O-000419-14, for Resident #003:

The licensee failed to comply with O. Reg. 79/10, s. 131 (2), by ensuring that drugs are administered to the resident in accordance with the directions for use specified by the prescriber.

Progress Notes and Medication Administration Records reviewed for a two month period indicated Resident #003 was administered medications on specific dates during the daytime due to responsive behaviours resident was exhibiting.

Physician's Quarterly Review, for the above period indicated the following order for this medication:
- the medication staff were administering was only to be administered at bed time as needed

Resident #003 did have an alternative order for another medication to be administered twice daily, as needed, for responsive behaviours; this order was not administered on either of the above dates.

The Assistant Director of Care and Director of Care was not aware of the medication incidents. [s. 131. (2)]

Issued on this 12th day of December, 2014

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY BURNS (554)
Inspection No. / No de l'inspection :	2014_293554_0028
Log No. / Registre no:	O-000403-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 1, 2014
Licensee / Titulaire de permis :	Glen Hill Terrace Christian Homes Inc. 200 Glen Hill Drive South, WHITBY, ON, L1N-9W2
LTC Home / Foyer de SLD :	STRATHAVEN LIFECARE CENTRE 264 King Street East, Bowmanville, ON, L1C-1P9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michelle Stroud

To Glen Hill Terrace Christian Homes Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_220111_0006, CO #005;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to achieve compliance with LTCHA, 2007, s. 6 (10) (b), to ensure the following:
- the written care plan for Resident #002 is to be updated to reflect the actual care needs, specifically as it relates to dressing, transferring, mobility, sleep/rest patterns, responsive behaviour(s) and related risk factors
- that the home has a process in place to monitor that residents are reassessed and that the individualized written care plan is updated when resident care needs change or the care set out in the plan is no longer necessary

The plan shall be submitted in writing and emailed to Inspector, Kelly Burns at kelly.burns@ontario.ca on or before October 08, 2014. The plan shall identify who will be responsible for each of the corrective actions listed.

Grounds / Motifs :

1. Related to Log #O-000644-14, for Resident #002:

The licensee failed to comply with LTCHA, 2007, s. 6 (10) (b), by ensuring the resident reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

Resident #002 exited the home on a identified date. Resident was located and taken by ambulance to the hospital; resident was assessed and treated for injuries sustained.

Resident was discharged from hospital and returned to the long term care home the same day.

Staff #107 indicated being assigned to care for resident during a three day period (post hospitalization) but was unaware that resident was at risk due to responsive behaviours exhibited; Staff #107 indicated no awareness of the incident which had occurred, indicating being told by co-workers that Resident #002 had fallen and had been injured.

Staff #107 indicated Resident #002's care needs had changed significantly since the fall incident.

According to Staff #107, resident required the following assistance with care following the incident:
- requires extensive transferring; with the aide of one to two staff
- uses wheelchair to and from all areas of the home
- extensive assistance by one staff for dressing, undressing, and application and removal of a specific treatment measure
- spends the majority of day in bed resting due to discomfort; resident is only up for meals

The plan of care, in place at the time of the inspection was not reflective of the care needs of Resident #002.

The written care plan in place at the time of the inspection had not been updated to reflect Resident #002's care needs specific to, dressing, transferring, mobility/use of mobility aides and sleep/wake patterns following resident's incident, nor had the written care plan been updated to reflect new strategies to mitigate risk specific to responsive behaviours recently exhibited.

The RAI Coordinator indicated during an interview that all registered staff are responsible for updating the care plan. RAI Coordinator indicated that written care plan should have been reviewed and updated based on resident care needs.

Assistant Director of Care indicated directing registered nursing staff to update the plan of care following resident's return from hospital.

The Assistant Director of Care indicated that the written care plan should at all times reflect resident care needs, especially when a resident has had a significant change and or high risk of responsive behaviours; any changes in the care should be communicated to direct care staff (e.g. nursing).

A Compliance Order, specific to, LTCHA, 2007, s. 6 (10) (b) was previously issued. [s. 6. (10) (b)] (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 24, 2014

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to include the following:

All staff are to complete a mandatory, comprehensive and interactive education session offered in various formats to meet the learning needs of adult learners specific,

1) Abuse and or Neglect:
The education should include, but not limited to:
- how to identify the different types of abuse as defined by O. Reg. 79/10, s. 2
- the mandatory reporting obligations as outlined in Section 24
- the use of the Abuse Decision Tree Algorthims (as a guide)
- individuals who are to be notified in incidences of alleged, suspected or witnessed incidents of abuse and or neglect

2) Management of residents exhibiting responsive behaviours.
The education should include, but not limited to:
- identification of behavioural triggers
- identification of strategies to reduce or eliminate the responsive behaviour
- individualized care planning relating to Responsive Behaviours
- use of assessment tools
- documentation relating to action taken and resident response to interventions
- identification and communication of high risk residents specific to responsive behaviours, especially aggression and or elopement risk
- the role to the home's Behavioural Response Team
- the process for referral to community resources when a resident's responsive behaviours remain a challenge or when in home strategies prove to be

unsuccessful

3) The home will ensure there is a process in place to monitor the effectiveness of the education and a process to ensure sustained compliance relating to a) reporting requirements, b) notification of required individuals in incidence of alleged, suspected or witnessed abuse and or neglect, and c) management of resident responsive behaviours.

4) Licensee is to conduct a comprehensive review of your zero tolerance of abuse and neglect policy, called Abuse and Neglect of a Resident - Actual or Suspected, and revise the policy and procedures to reflect in the policy an explanation of the duty to make mandatory reports under Section 24, including but not limited to clarification of the following:
- that 'a person' which includes a staff member, has the duty to report under s. 24, irrespective of the Licensee's duty
- that staff members must report any incident or suspected incident of abuse or neglect of a resident to the Director
- that the duty to report is immediate

The plan shall be submitted in writing and emailed to Inspector, Kelly Burns at kelly.burns@ontario.ca on or before October 08, 2014. The plan shall identify who will be responsible for each of the corrective actions listed.

Grounds / Motifs :

1. 1. The licensee failed to comply with LTCHA, 2007 s. 19, by failing to protect resident(s) from abuse and or neglect.

Definitions:

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of “abuse” in subsection 2 (1) of the Act, “emotional abuse” means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of “abuse” in subsection 2 (1) of the Act, “physical abuse” is defined as (c) the use of physical force by a resident that causes physical injury to another resident.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a) 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 another other than a resident.

Under O. Reg. 79/10, s. 5., for the purpose of the definition "neglect" in subsection 5, of the Act and this regulation, "neglect" means, 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.

Summary of the facts:

Related to Resident #002:

Resident #002, exited the home on a specific date. Resident was located, noted to have injuries and was taken to hospital; resident was treated and discharged back to the home, the same day.

The Assistant Director of Care indicated that MOHLTC was not notified using the after-hours contact number. A Critical Incident Report was not submitted by the home until the following day.

To further note, the written care plan, for this resident failed to demonstrate any revisions to the plan had been made following the incident; nor during the week post incident/hospitalization.

Staff #107, indicated being assigned to care for Resident #002 and having care for Resident #002 during a three day period post incident. Staff 107, indicated no awareness of resident being at safety risk nor was staff aware of the incident which occurred earlier that week.

Staff #108, who was working on the unit where Resident #002 resides, indicated no awareness of Resident #002 being at safety risk due to responsive behaviours.

The licensee failed to comply with:

- O. Reg. 79/10, s. 107 (1), by ensuring that the Director is immediately informed of the following incidents: 4. Any missing resident who returns to the home with injury or any adverse change in condition regardless of the length of time the resident was missing. (WN #12)
- O. Reg. 79/10, s. 55 (b), by ensuring that direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident. (WN #9)

Related to Resident #003:

On a specific date, Resident #003 exhibited responsive behaviours and injured Resident #004; Resident #004 required medical assessment following the incident.

According to the progress notes, registered nursing staff were instructed by the Administrator to contact the police as to the incident; police attended the home.

The home submitted a Critical Incident Report, specific to Resident to Resident Abuse, but the submission was a day later.

Registered Staff #111, #112 and #121 indicated that staff do not contact MOHLTC as to incidents of abuse, as that is the role of the management team.

The Assistant Director of Care, who is responsible for submitting Critical Incident Reports, indicated working the day of the incident, but was unsure why the report was delayed. ADOC indicated C.I.A.T.T. was not notified by telephone of the incident.

To further note, progress notes reviewed indicated this was not the first incident of responsive behaviours exhibited by Resident #003 and directed towards other residents and staff.

Progress notes reviewed, for a seven month period, documented numerous incidents of responsive behaviours exhibited by Resident #003 where registered staff failed to document the action taken and or the resident's response to the intervention.

Staff interviewed indicated that the interventions listed in the written care plan

were rarely effective in reducing or eliminating Resident #003's responsive behaviours.

Assistant Director of Care indicated resident's responsive behaviours remain challenging for the home and places other resident's at risk of harm.

There is no indication in Resident #003's plan of care that an external psychogeriatric support service has been accessed in the current year to mitigate risk of harm to the resident and or others.

On a specific date, Staff #114 was assigned to specifically care for Resident #003; Staff #114 indicated no awareness of the care needs, nor responsive behaviours which resident may exhibit despite being assigned to the shift, and the shift beginning approximately three and a half hours earlier.

Staff #114 was unable to provide details of behavioural triggers, strategies to reduce responsive behaviours or how to intervene should Resident #003 demonstrate responsive behaviours. Staff #114 further indicated no report had been provided at the beginning of the shift assignment which began at earlier that day.

Staff #112, who supervises the unit, indicated no awareness of the staffing assignment for Resident #003 at the beginning of the shift on the date identified, staff indicated that once aware of the assignment, that report had not been given to Staff #114, as there had been not been time available.

The licensee failed to comply with:
- LTCHA, 2007, s. 24 (1), by ensuring that a person who has reasonable ground to suspect that any of the following has occurred shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. (WN #7)
- LTCHA, 2007, s. 53 (4) (c), by ensuring that actions are taken to meet the needs of residents with responsive behaviours, include, reassessment, interventions and documentation of the resident's response to the interventions. (WN #3)
- O. Reg. 79/10, s. 55 (b), by ensuring that all direct care staff are advised at the beginning of every shift of each resident whose behaviour, including responsive behaviours, required heightened monitoring because those behaviours pose a

potential risk to the resident or others. (WN #9)

Related to Resident #005:

Resident #005 and #006 were involved with an altercation (resident to resident abuse); both residents sustained injuries as a result of the incident.

Progress notes, indicated the RN Supervisor (Charge Nurse), working the day of the altercation, was made aware of the incident of Resident to Resident Abuse, by staff working.

The Assistant Director of Care indicated working the day of the incident,but could not recall why the incident of Resident to Resident Abuse was not immediately reported to MOHLTC.

The Critical Incident Report specific to this incident was not submitted until two days later.

According to Staff #111 the incident of Resident to Resident Abuse was not reported to the police.

To further note, Progress notes reviewed, during a four month period, indicated Resident #005 as exhibiting several responsive behaviours.

The written care plan for the period indicated above failed to identify strategies or interventions specific to responsive behaviours nor were there interventions implemented as identified (e.g. referral to BSO Team).

During this same period, progress notes indicated Resident #005 hit another resident on more than one occasion.

There are numerous documented entries in the progress notes, where registered nursing staff have identified Resident #005 as exhibiting a responsive behaviour, but there is no indication as to the action taken nor the response of the resident to the intervention if implemented.

There is no indication that an external psychogeriatric supports has been accessed in the current year to mitigate the risk of harm to the resident and or others.

Staff indicated responsive behaviours exhibited by Resident #005 place other residents at risk of harm.

The licensee failed to comply with:
- LTCHA, 2007, s. 24 (1), by ensuring that a person who has reasonable ground to suspect that any of the following has occurred shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. (WN #7)
- O. Reg. 79/10, s. 98, by ensuring that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse. (WN #10)
- LTCHA, 2007, s. 53 (4) (b), by ensuring strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours. (WN #3)
- LTCHA, 2007, s. 53 (4) (c), by ensuring that actions are taken to meet the needs of residents with responsive behaviours, include, reassessment, interventions and documentation of the resident's response to the interventions. (WN #3)

Related to Resident #007:

An allegation of emotional/verbal abuse was reported, by Resident #007, to the Assistant Director of Care on an identified date.

Resident #007 indicated needing to use the washroom and rang the call bell for assistance. Resident reported Staff #119 responded to the call bell and spoke to the resident sarcastically; resident commented that Staff #119 was 'not nice' during the interaction. Resident indicated being upset by the interaction.

Staff #119 worked subsequent shifts following the allegation of verbal/emotional abuse and was not interviewed by the management team until days later.

The home submitted the Critical Incident Report a day following the reported incident. The incident was not immediately reported to MOHLTC, despite the incident being directly reported to the Assistant Director of Care.

The licensee failed to comply with:

- LTCHA, 2007, s. 23 (1) (a), by ensuring that every alleged, suspected or witnessed incident of abuse and or neglect of a resident, that the licensee knows of is immediately investigated.
(WN #6)
- LTCHA, 2007, s. 24 (1), by ensuring that a person a person who has reasonable ground to suspect that any of the following has occurred shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. (WN #7)

Related to Resident #008:

Resident #008 was left on the toilet. According to the Assistant Director of Care, Staff #120 indicated leaving the resident unattended while assisting another resident, staff did not return and indicated forgetting Resident #008 was on the toilet. Staff #120 reported transferring Resident #008 onto the toilet without the assistance of a second staff.

The plan of care indicated Resident #008 was at high risk for falls, was not to be left unattended on the toilet and was to be transferred at all times with the assistance of two staff.

Personal Support Workers who discovered the incident reported the care concern to both the Registered Practical Nurse and the RN Supervisor who was in charge at the time of the incident.

The Critical Incident Report specific to neglect of care was reported, to MOHLTC, but not until a day later.

The licensee failed to comply with:
- LTCHA, 2007, s. 6 (7), by ensuring the care set out in the plan of care is provided. (WN #1)
- LTCHA, 2007, s. 24 (1), by ensuring that a person who has reasonable grounds to suspect that any of the following has occurred shall immediately report the suspicion and the information upon which it is based to the Director: 2 Abuse or Neglect of a resident by the licensee or staff that resulted in harm or risk of harm. (WN #7)

Related to Resident #009:

An allegation of neglect was reported by Resident #009 to a Personal Support Worker, the incident was reported during care (the shift after the incident occurring).

Resident #009 indicated ringing the call bell as needed to use the washroom. Resident indicated an unidentified staff entered the room and turned off the call bell, and exited the room without toileting or assisting the resident; resident was incontinent as a result.

Staff who received the care concern, from Resident #009, reported the incident to the Registered Practical Nurse who reported the concern to the RN Supervisor (#121) who was in charge of the home at the time.

RN Supervisor (#121) indicated contacting the Assistant Director of Care (ADOC), but could not recall if spoke directly to the Assistant Director of Care or if a phone message was left.

Assistant Director of Care recalls receiving a phone message from the RN Supervisor #121, but indicated when the call was returned Staff #121 had left for the day; ADOC indicated that the RN Supervisor on the evening shift was not aware of the incident.

Staff working the night of the incident, were not interviewed as to the neglect allegation until three days later, despite working shifts following the incident.

The Assistant Director of Care was unsure as to why there was a delay in investigating Resident #009's care concern.

The Assistant Director of Care indicated that MOHLTC was not contacted, nor was a Critical Incident Report submitted, as the home had dealt with the matter as a complaint not an incident of abuse.

The home has since reported this occurrence as a Critical Incident.

The licensee failed to comply with:
- LTCHA, 2007, s. 23 (1) (a), by ensuring that every alleged, suspected or witnessed incident of abuse and or neglect of a resident, that the licensee knows of is immediately investigated.

(WN #6)
- LTCHA, 2007, s. 24 (1), by ensuring that a person who has reasonable ground to suspect that any of the following has occurred shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. (WN #7)

Additionally:

The licensee failed to comply with LTCHA, 2007, s. 20 (1), by ensuring the home's policy to promote zero tolerance of abuse is complied with. (WN #5)

The home's policy, Abuse and Neglect of a Resident-Actual or Suspected (VII-G-10.00) directs that the Administrator or designate will notify the MOHLTC Director immediately according to protocols established for reporting of abuse and critical incidents.

The policy further directs that implicated staff (or volunteers) will be informed about any allegation as quickly as possible.

As detailed in this report, under Written Notification (WN) #6 and #7, there were several situations involving alleged, suspected or witnessed abuse or neglect of residents which were not reported as per requirements under Section 24 nor immediately investigated as per requirements under Section 23.

Registered Staff #111, #112 and #121 all indicated awareness of reporting requirements relating to abuse and neglect and indicated having access to the after-hours contact number for MOHLTC; staff indicated that contacting MOHLTC was the role of the managerial team.

The Assistant Director of Care did indicate awareness of the reporting requirements under Section 24, but could not recall why there were time delays in immediately reporting and or investigating allegations, suspected or witnessed incidents of abuse and or neglect.

The licensee failed to comply with LTCHA, 2007, s. 20 (2) (d), by ensuring at minimum, the policy to promote zero tolerance of abuse and neglect of residents, shall contain an explanation of the duty under Section 24 to make mandatory reports. (WN #5)

The home's policy Abuse and Neglect of a Resident – Actual or Suspected (VII-G-10.00) does not provide:
- An explanation of the duty to make mandatory reports under s. 24 in its policy to promote zero tolerance of abuse and neglect.
- A clear explanation to Personal Support Workers, Registered Nursing Staff, Support Staff or others, on their individual obligation for reporting to the Director, under s. 24 (1) of the LTCHA, irrespective of the licensee's duty to report.

Conclusion:

The home's compliance history was reviewed for the past three years. The home was issued a Written Notification (WN) and a Voluntary Plan of Correction (VPC) for failing to comply with the LTCHA, 2007, s. 24 (failure to immediately report instances of alleged, suspected or witnessed abuse to the Director).

The home was issued a WN relating to O. Reg. 79/10, s. 53 (4), specific to failing to identify behavioural triggers and ensuring strategies are developed and implemented to respond to the resident demonstrating responsive behaviours. During this same inspection, the home was issued a WN and a VPC for failing to notify immediately notify the police regarding Resident to Resident Abuse.

Two years previously, the home was issued a WN and VPC, for failing to provide clear direction relating to the management of a resident exhibiting responsive behaviours. [s. 19. (1)] (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 28, 2014

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire Commission d'appel et de révision des services de santé 151, rue Bloor Ouest, 9e étage Toronto (Ontario) M5S 2T5	Directeur a/s Coordinateur des appels Direction de l'amélioration de la performance et de la conformité Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Ontario, ON M5S-2B1 Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 1st day of October, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Kelly Burns

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