Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2017	2017_418615_0017	016045-15, 016223-15, 018602-15, 020415-15, 013417-16, 017493-16, 017503-16, 018341-16, 018941-16, 021011-16, 021890-16, 028775-16, 029197-16, 029607-16, 029659-16, 029842-16, 030852-16, 031123-16, 031705-16, 033465-16, 035157-16, 000042-17, 002144-17, 002694-17, 005460-17, 006741-17, 008501-17, 008752-17	Critical Incident System

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF WATERLOO
150 Frederick Street KITCHENER ON N2A 4J3

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

SUNNYSIDE HOME
247 FRANKLIN STREET NORTH KITCHENER ON N2A 1Y5

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

HELENE DESABRAIS (615), DOROTHY GINTHER (568), SHARON PERRY (155), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 12, 13, 14, 15, 16 and 19, 2017.

The following Critical Incident System (CIS) report inspections were completed during this inspection:

Related to falls prevention:
CIS Log #018341-16 / M578-000035-16;
CIS Log #013417-16 / M578-000002-16;
CIS Log #018941-16 / M578-000010-16;
CIS Log #021011-16 / M578-000036-16;
CIS Log #029197-16 / M578-000056-16;
CIS Log #029659-16 / M578-000058-16;
CIS Log #031705-16 / M578-000066-16;
CIS Log #033465-16 / M578-000069-16;
CIS Log #035157-16 / M578-000077-16;
CIS Log #005460-17 / M578-000007-17.

Related to prevention of abuse and neglect, and responsive behaviours:
CIS Log #016045-15 / M578-000020-15;
CIS Log #016223-15 / Letter of complaint;
CIS Log #017493-16 / M578-000033-16;
CIS Log #017503-16 / M578-000034-16;
CIS Log #021890-16 / M578-000043-16;
CIS Log #028775-16 / M578-000055-16;
CIS Log #029607-16 / M578-000060-16;
CIS Log #029842-16 / M578-000061-16;
CIS Log #030852-16 / M578-000064-16;
CIS Log #031123-16 / M578-000062-16;
CIS Log #000042-17 / M578-000001-17;
CIS Log #002144-17 / M578-000006-17;
CIS Log #002694-17 / M578-000007-17;
CIS Log #006741-17 / M578-000019-17;

CIS Log #008501-17 / M578-000023-17;
CIS Log #008752-17 / M578-000024-17.

Related to medication management:
CIS Log #018602-15 / M578-000022-15;
CIS Log #020416-15 / M578-000024-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Care (MoC), the Resident Care Manager (RCM), two Resident Care Coordinators (RCC), one Education Lead (EL), two Physiotherapists, one unit Clerk, One Registered Nurse-Behavioural Support Ontario (RN-BSO), two Registered Nurses (RN), seven Registered Practical Nurses (RPN), one Resident Home Assistant (RHA), sixteen Personal Support Workers (PSW) and families and residents.

The Inspectors also observed resident care provision, resident/staff interactions, reviewed residents' clinical records, the home investigation reports, education/training records, policies and relevant documentations.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was protected from abuse by

anyone and not neglected by the licensee or staff in the home.

Section 2 (1) of the Long-Term Care Homes Act defined “abuse”, in relation to a resident, means physical, sexual, emotional, verbal or financial (2007, c. 8, s. 1.)

Section 2(1) of Ontario Regulation 79/10 defined verbal abuse as "any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self worth made by anyone other than a resident. Verbal abuse also includes any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences".

Section 2(1) (a) of Ontario Regulation 79/10 defined emotional abuse as " any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, related to alleged abuse of a resident by a staff member.

A review of the home's "resident abuse and neglect zero tolerance" policy #7-10 revised October 15, 2016 stated, "Sunnyside Home's expectation: abuse and/or neglect of residents is not tolerated at Sunnyside Home. However, if abuse does occur, any persons who witness or suspect it are required to intervene, stop the abuse and immediately report it" and, "If Sunnyside Home knows of or suspect abuse it will: report it to the Ministry of Health and Long Term Care as set out in the Critical Incident Reporting Policy 5-100, 5-110".

During an interview, a PSW stated that they remembered the incident involving the resident and the PSW. A PSW had covered another PSW for their break and when the PSW returned they told them that they had some issues while providing care for a resident as the resident had become upset with them stating they weren't providing care the way they wanted it and was crying. The resident said that the PSW called them a name. The PSW said they left the room and later told the oncoming shift that the resident had been upset.

During an interview, the resident stated they had one incident where a PSW was mean to

them during a shift. The resident said that the PSW would not do as they had asked, called them a name and it was very upsetting at the time and said they did not want to speak about it anymore, that they had finally put the incident behind them.

During an interview, the RCC stated that the PSW had been abusive and that the home's expectation was that residents should be protected from abuse by anyone. [s. 19. (1)]

2. A CIS report was submitted by the home to the MOHLTC on a specific date, related to alleged abuse of a resident by a staff member.

A review of the home's investigation notes of the incident included interviews with staff and residents. A resident stated that on a specific date, a resident was using a new device and was trying to get accustomed to it. The resident was going into a common area of the home, and tried to maneuver the device but got stuck and paused to think about how to get the device unstuck. They said that an RPN was verbally abusive causing the resident to be upset. The resident tried to back up and sustain an injury. The RPN never came to check on the resident.

The home's investigation also included an interview of a resident stating that all residents were gone to the common area during the incident and stated that the RPN came in and yelled at the resident.

A review of the home's investigation conclusion and discipline letter written by the RCC stated that the home believed that verbal and emotional abuse occurred, there was negative impact on the resident and had not reassured and provided the resident with emotional support. Other residents witnessed the incident and were upset by the way the RPN spoke abruptly and acted towards the resident. The RPN was required to complete modules on Resident Abuse and the Residents Bill of Rights prior to the next scheduled shift.

During an interview, the RCC said that the RPN had been abusive and that the home's expectation was that residents should be protected from abuse by anyone. [s. 19. (1)]

3. Section 2(1) of Ontario Regulation 79/10 defined physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain; administering or withholding a drug for an inappropriate purpose, or the use of physical force by a resident that causes physical injury to another resident".

Two CIS reports were submitted by the home to the MOHLTC on specific dates, related to alleged abuse of a resident by a resident.

A review of a resident's Behaviour Assessment, on a specific date, stated that a “PSW one-on-one” was required. The Behaviour Assessment on two different dates stated that the resident demonstrated behaviours and these behaviours had worsened since admission to the home. The Cohen-Mansfield Agitation Inventory for the resident on a specific date stated that several times per hour, on a shift, the resident demonstrated the behaviours and hurting self or others.

A record review of the plan of care for the resident stated that they were admitted to the home on a specific date with specific diagnosis.

A review of the resident's progress notes in PointClickCare (PCC) weeks before the physical aggression towards another resident, 17 different abusive incidents and behaviours from the resident to other residents and staff were documented.

During interviews, the RN-BSO and RCC, both stated that the resident was physically and verbally aggressive towards both residents and staff. That an assigned one-to-one PSW for the resident was not in place previous to the altercation.

A review of the residents progress notes in PCC, after the last incident and previous incident involving another resident, four different abusive incidents and behaviours from the resident to other residents and staff were documented.

Progress notes in PCC for the resident, documented seven different abusive incidents and behaviours to other residents and staff were documented. The One-to-one staffing was initiated 24/7 after the last incident. [s. 19. (1)]

4. A CIS report was submitted by the home to the MOHLTC on a specific date related to alleged abuse of resident by a resident.

A review of the CIS and the home's investigation stated that on a specific date, a resident had a physical altercation with another resident twice while walking through the home and the resident fell on the floor and sustained an injury.

A review of the resident progress notes documented 11 different abusive incidents and behaviours from the resident to other residents and staff. The resident was referred to

the BSO caseload as a result of a physically responsive episode on the last incident.

During an interview, the RCC and the RN-BSO, both said that this was abuse and that the resident was becoming more physically aggressive towards residents over time. The RN-BSO stated that the first time the resident was abusive to the other residents that it was the home's expectation that staff would refer the resident to BSO for an assessment and monitoring the resident closely.

The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The severity was determined to be a level 3 as there was actual harm or risk. The scope of this issue was determined to be widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on Oct 28, 2015 as a Written Notification (WN) on a Critical Incident Inspection # 2015_303563_0046 and on May 26, 2016, as a Voluntary Plan of Correction (VPC) on a Critical Incident Inspection # 2016_457630_0017. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair, excluding the residents' personal aids or equipment.

A CIS report was submitted by the home to the MOHLTC on a specific date for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

The CIS report stated that a resident was using a device when a PSW moved the device the resident fell and sustained an injury. The resident was sent to the hospital for further assessment.

During an interview, an RPN stated that they responded to the incident with the resident and shared that the PSW had reported that the device broke.The RPN stated that they did not see the device as once the paramedics left with the resident they left the area and the room was closed.

During an interview, the MoC stated that the device that was involved in the incident was no longer in the home as they have a contract with a company that picks up old, broken or unwanted equipment.

On a specific date, the Inspector asked the MoC to provide records that showed that procedures have been implemented to ensure that the specific device in the home were kept in good repair. The MoC provided the Environmental Services Manual that included Preventative Maintenance Program Procedure and they stated that there were no checks done on the specific device in the home to ensure that it was kept in good repair and that the device would only be looked at if the staff had put in a concern on a work order.

During an interview, the Administrator and the MoC, the MoC shared that the device involved in the incident was looked at by them and the RCC. The MoC stated that they turned the device over and there was no damage. At a later time that day, the MoC informed the Inspector that the device involved in the incident was in the basement of the home.

On a specific date, two Inspectors and the MoC observed the device in the basement involved in the incident. On the back of the device was a sign "Broken Do Not Use" with the area of the home where the incident occurred. One Inspector turned the device over and observe that the device was broken.

The licensee failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids, and positioning aids in the home were

kept in good repair.

The severity was determined to be a level 3 as there was actual harm or risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 90. (2) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

A CIS report was submitted by the home to the MOHLTC on a specific date for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

The CIS report stated, in part that, on a specific date, a PSW was moving a resident using a device in a common area of the home. The device suddenly broke due to a lip on the floor surface and the resident fell and sustained an injury. The resident was sent to the hospital, returned to the home.

During an interview, the PSW said that they brought up concerns about a lip on the surface of the floor at the unit meetings before the incident.

During an interview, a PSW said that prior to the incident, staff had reported concerns about the "lip" on the floor surface, that it was talked about at meetings and there had been work order forms filled out about it.

During an interview, a RPN said that concerns had been raised about the "lip" prior to the

incident in a specific area of the home.

During an interview, the RCC stated that prior to the incident, no concerns had been reported about the lip on the floor surface and no concerns had been raised at unit meetings.The Inspector requested copies of the unit meeting minutes and the RCC provided minutes from specific date and said that they would try to get more minutes which were never provided during the inspection.

A review of the unit meeting minutes stated "E-mail to RCC" on a specific date; unit meeting mentioned that the lip on the surface of the floor is difficult to push residents over.
During an interview, the MoC stated that they remembered seeing at least two work orders related to this area.

A review of the work orders regarding the common area stated " Work request code 512340; the date requested; the date to perform; date work completed was blank; work description-please check common area floor lip as staff are complaining of the lip as too high and causes devices to tip" and "Work request code 528170; the date requested; the date to perform; date work completed was blank; work description-URGENT- common area. There is a high lip on the surface of the floor that is difficult to push devices over when a resident in in them. There has been an injury as a result of this".

The lip on the floor surface in the common area was addressed after the incident in which the resident sustained an injury and was admitted to hospital.

The licensee failed to ensure that the home was a safe and secure environment for the resident.

The severity was determined to be a level 3 as there was actual harm or risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A CIS report submitted on a specific dated, identified that while a resident was in bed and being turned for care the resident slid onto the floor with the help of a PSW. The resident had some pain to touch on a part of their body so an order for a diagnostic test was obtained and confirmed an injury.

A record of the resident's MDS assessment on a specific date and the plan of care identified that the resident required extensive assistance of two people for bed mobility, transfers and toileting.

During an interview a PSW stated that they recalled the incident involving the resident where they sustained an injury. When asked if there was another staff present to assist with them with the resident's care the PSW said they were alone and that two people were required to assist the resident with care and transfers using the lift.

During an interview, RCC stated that staff are to follow the plan of care when providing assistance to residents with their activities of daily living. The RCC reviewed the plan of care of the resident which stated that they were extensive assistance of two persons for bed mobility, transfers and toileting. The RCC agreed that the resident should have had two people assisting with their care and turning the resident on the date of the incident, when they fell from their bed.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident.

The severity was determined to be a level 3 as there was actual harm or risk. The scope of this issue was determined to be isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on August 11, 2014 as a Voluntary Plan of Correction (VPC) on a Critical Incident Inspection # 2014_229213_0052, on June 9, 2015, as a Voluntary Plan of Correction (VPC) on a Critical Incident Inspection # 2015_303563_0020, on October 28, 2015 as a Voluntary Plan of Correction (VPC) on a Critical Incident Inspection # 2015_303563_0045, on Jun 9, 2016 as a Voluntary Plan of Correction (VPC) on a Critical Incident Inspection # 2016_259636_0007 and on Jan 19, 2017 as a Voluntary Plan of Correction (VPC) on a Critical Incident Inspection # 2017_263524_0004. [s. 6. (7)]

Additional Required Actions:

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

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A CIS report was submitted by the home to the MOHLTC on a specific date, related to an incident where a PSW was verbally abusive to a resident. The resident told their family about the incident.

The home's policy #7-12 titled "Reporting Resident Abuse and/or Neglect stated that it was a mandatory requirement of all staff members who observe or suspect resident abuse, in any form, to report the incident to a supervisor or manager immediately".

During an interview, a PSW recalled the incident identified in the CIS related to the resident. The PSW said that they had returned from break and when they went to see the resident they were visibly upset. The resident told the PSW that another PSW had provided them assistance while they were on break did not know what they were doing and was verbally abusive. The PSW was asked if they had reported the incident to anyone after they left the resident's room and they said it was near shift change at that time and they told the oncoming staff that the resident had been upset. When asked if

they had received education regarding the Prevention of Abuse and Neglect the staff member said they could not recall when they last had the training. When asked what their responsibility was if they witnessed or suspected abuse of a resident by staff they said they would tell a registered staff or manager. The PSW acknowledged that they had not reported the suspected verbal abuse towards the resident by a colleague.

A review of the home's education records related to Prevention of Abuse and Neglect identified that seven nursing staff had not received education in 2016 and the first six months of 2017. The records stated that the PSW had not had Prevention of Abuse Education since October 2015. As part of a disciplinary action the PSW had read and signed off on the home's Prevention of Abuse and Neglect policy.

The licensee failed to ensure that the home's policy that promotes zero tolerance of abuse and neglect for the resident was complied with. [s. 20. (1)]

2. A review of the home's policy 7-10 titled Reporting Resident Abuse and Neglect Zero Tolerance last revised October 15, 2016, that applies to all employees, stated that all persons who witness or suspect abuse must immediately report to a manager, manager on-call, Registered Nurse, Manager of Resident Care, Administrator, Director of Seniors Services and the MOHLTC during business hours or the Long Term Care Action Line if after hours.

A review of the home's policy 7-12 titled Reporting Resident Abuse/Or Neglect last revised October 15, 2016, that applies to all employees, stated that "all staff members who observe or suspect resident abuse" are to "report to a supervisor or manager immediately". This policy also directed staff to contact the MOHLTC "immediately" by telephone if after hours and then electronically using the Critical Incident Report.

A CIS report related to the alleged abuse of a resident was initiated by the RCC by calling the MOHLTC after-hours pager on a specific date.

A review of the CIS, the home's investigation notes and the progress notes in PCC for the resident stated that the alleged abuse of the resident occurred on a specific date and the PSW did not report the incident to the RN until the next day.

During interviews, a RHA, a RPN, a RN and the MoC, stated that staff were to report all alleged abuse immediately to the registered staff who would report to a Manager or RCC who would inform the MoC. The MoC stated that the home's expectation was for staff to

report alleged abuse and also stated that all alleged abuse was to be reported to the MOHLTC immediately.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on October 28, 2015 as a Written Notification (WN) on a Critical Incident Inspection # 2015_303563_0046, and on February 29, 2016, as a Voluntary Plan of Correction (VPC) on a Resident Quality Inspection (RQI) #2016_263524_0007. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CIS report was submitted by the home to the MOHLTC on specific date, alleged neglect of a resident. The CIS stated that the alleged neglect of resident occurred on a specific date and after the home's investigation, it was concluded that neglect had occurred.

A review of the home's complaint reporting form on a specific date by a RN, identified the alleged neglect of the resident.

A review of the home's "Reporting Resident Abuse and/or neglect" policy #7-12 dated October 15, 2016, stated "It is a mandatory requirement of all staff members who observed or suspect resident abuse, in any form to report the incident to a supervisor or manager immediately. The supervisor or Manager will: Report to the Ministry of Health as per the Critical Incident Policy 5-100 Master Manual; Contact the Ministry of Health and Long-Term Care immediately by telephone if after hours, and then electronically using the Critical Incident Report".

During an interview, the RCC stated an investigation was initiated on a specific date and that neglect of the resident was found. RCC said that the family reported the alleged neglect to a RN on a different date. The RN informed the alleged neglect to the team leader, evening supervisor and physiotherapist. The RCC said that no one reported the alleged neglect immediately to the MOHLTC and that it is the home's expectation to report to the immediately any allegations of abuse or neglect to the MOHLTC. [s. 24. (1)]

2. A CIS report was submitted by the home to the MOHLTC on a specific date for an incident that occurred on a different date related to alleged abuse of a resident by a staff member .

During an interview, the RCC stated that they were made aware of the incident of alleged verbal abuse of the resident by a PSW on a specific date and acknowledged that they did not report the suspected incident of staff to resident abuse to the MOHLTC immediately. [s. 24. (1)]

3. During the inspection of a CIS report related to alleged abuse of a resident, the following was discovered by the inspector:

A review of the home's Medication Incident/Near Miss Report on a specific date, stated the description of incident and follow-up actions of a medication given early to the resident. The resident asked the RPN at the time of the incident to give the medication at suppertime. Order states medication at meals. The resident suffered side effects.

During an interview, a RN, stated that the day after the incident the resident was interviewed and shared that they were upset about receiving the medication and suffered side effects. The RN stated that the resident was well aware of their condition and it was too early to receive it, they did not want it. The RN shared that the home's physician was very clear that they want the medication given at the time it is ordered. The RN shared that no notes were written of that conversation and that this was reported to the manager.

During an interview, the RCC, stated that the the RPN had provided improper or incompetent treatment that caused actual harm to the resident and that the home's expectation was that it should of been reported to the MOHLTCH immediately. [s. 24. (1)]

4. Three other CIS reports were submitted by the home to the MOHLTC on on a specific dates related to the alleged abuse of three residents.

The CIS, the home's investigation notes and the progress notes in PCC for each of the residents stated that the alleged abuse of the resident occurred on a specific date and was not reported to the MOHLTC until a later date.

During interviews, the MoC stated the home's expectation was that all alleged abuse be reported to the MOHLTC immediately.

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

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to a pattern during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 24. (1)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received

individualized personal care, including hygiene care and grooming, on a daily basis.

On a specific date the home received a letter of complaint from a resident's family member. The family member stated that the resident told them that on a specific date the resident was neglected by a staff member.

A review of the resident's current plan of care identified that the resident required extensive assistance of one staff for care. The resident's MDS assessment stated that the resident required extensive assistance of two staff for care; and extensive assistance of one staff for walking in the room.

During an interview, a PSW stated that they frequently provided care for the resident and that the resident was a one person assist with care. The PSW said that the resident would usually ring when they needed assistance for care. The PSW said that if the resident needed assistance they would definitely care for the resident.

The investigation notes related to the identified complaint provided interviews with two PSWs that had been involved in the resident's care on the day of the incident. The resident had rang the bell said they needed care. When asked if they had spoken rudely to the resident, the PSW denied making any rude or insensitive comments. The interview with the other PSW stated that they remembered helping the PSW with the resident's care. When asked specifically about this resident's care, PSW said they were just helping the other PSW and denied making any rude or insensitive comments.

During an interview, the RCC said that it was the home's practice to care for resident's that request it and using the appropriate level of assistance required. In the case of the resident on the day of the incident, there were two PSW's available to provide care. The RCC stated that the home's expectation was that the resident should have been cared for as per their request.

The licensee failed to ensure that the resident received individualized personal care on a daily basis.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be a pattern during the course of this inspection. There was a no compliance history of this legislation being issued in the home. [s. 32.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis, to be implemented voluntarily.

WN #8: 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. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

During the inspection of CIS report related to alleged abuse of a resident, the following incident was discovered by the inspector.

A review of the home's investigation of CIS report, it was noted that in another incident the resident received a medication earlier than prescribed. As a result of this, the resident suffered side effects. The home was concerned that the RPN provided the medication as prescribed and did not acknowledge the resident's concerns.

A review of the home's Medication Incident/Near Miss Report, on a specific date, stated "Description of incident and follow-up actions": medication given early and the resident had asked the RPN to give as prescribed. The resident suffered side effects.

A review of the physician's order for the resident stated that the medication be given at specific times.

During an interview, the RN stated that the day after the incident the resident was met and shared that they were upset about receiving the medication too early and that they suffered side effects as a result. The RN stated that the resident was well aware of their condition and it was too early to receive it, that they did not want it. The RN shared that the home's physician was very clear that they wanted the medication given at the time it was ordered.The RN shared that no notes were written of that conversation and was not reported to the manager.

During an interview, the RCC stated that the home's expectation was that registered staff will follow the physician orders as prescribed.

The licensee failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

The severity was determined to be a level 3 as there was actual harm or risk. The scope of this issue was determined to be isolated during the course of this inspection. There was a no compliance history of this legislation being issued in the home. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

A review of a resident's clinical record identified that on a specific date, the resident had a fall in the home. As a result of the fall the resident sustained injuries. The resident was transferred to hospital for further evaluation and treatment. The resident returned to the home with injuries.

A review of the resident's clinical records and paper chart had no documented evidence that the resident had been referred to the Registered Dietitian (RD) for an assessment related to the skin injuries sustained as a result of the fall.

During an interview, the RCC said that it was the home's expectation that residents identified as having altered skin integrity should had been referred to the RD. The RCC acknowledged that the resident had not been referred to the RD for an assessment related to the skin injuries sustained as a result of the fall.

The licensee failed to ensure that the resident who was exhibiting skin lacerations had been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

The severity was determined to be a level 2 as there was minimal harm or potential for actual Harm. The scope of this issue was determined to be isolated during the course of this inspection. There was a no compliance history of this legislation being issued in the home. [s. 50. (2) (b) (iii)]

Issued on this 3rd day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HELENE DESABRAIS (615), DOROTHY GINTHER (568), SHARON PERRY (155), SHERRI COOK (633)
Inspection No. / No de l'inspection :	2017_418615_0017
Log No. / No de registre :	016045-15, 016223-15, 018602-15, 020415-15, 013417-16, 017493-16, 017503-16, 018341-16, 018941-16, 021011-16, 021890-16, 028775-16, 029197-16, 029607-16, 029659-16, 029842-16, 030852-16, 031123-16, 031705-16, 033465-16, 035157-16, 000042-17, 002144-17, 002694-17, 005460-17, 006741-17, 008501-17, 008752-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 23, 2017
Licensee / Titulaire de permis :	REGIONAL MUNICIPALITY OF WATERLOO 150 Frederick Street, KITCHENER, ON, N2A-4J3
LTC Home / Foyer de SLD :	SUNNYSIDE HOME 247 FRANKLIN STREET NORTH, KITCHENER, ON, N2A-1Y5

Ontario

Ministry of Health and Long-Term Care

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

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Helen Eby

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To REGIONAL MUNICIPALITY OF WATERLOO, 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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

Specifically, the home will ensure that residents demonstrating challenging and/or disruptive behaviors will have a behavioral assessment, or reassessment, completed to identify factors of behaviours and implement strategies to manage challenging behaviours to minimize the risk of altercations, harmful interactions between residents to protect residents from abuse by anyone.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was protected from abuse by anyone and not neglected by the licensee or staff in the home.

Section 2 (1) of the Long-Term Care Homes Act defined "abuse", in relation to a resident, means physical, sexual, emotional, verbal or financial (2007, c. 8, s. 1.)

Section 2(1) of Ontario Regulation 79/10 defined verbal abuse as "any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self worth made by anyone other than a resident. Verbal abuse also includes any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences".

Section 2(1) (a) of Ontario Regulation 79/10 defined emotional abuse as " any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, related to alleged abuse of a resident by a staff member.

A review of the home's "resident abuse and neglect zero tolerance" policy #7-10 revised October 15, 2016 stated, "Sunnyside Home's expectation: abuse and/or neglect of residents is not tolerated at Sunnyside Home. However, if abuse does occur, any persons who witness or suspect it are required to intervene, stop the abuse and immediately report it" and, "If Sunnyside Home knows of or suspect abuse it will: report it to the Ministry of Health and Long Term Care as set out in the Critical Incident Reporting Policy 5-100, 5-110".

During an interview, a PSW stated that they remembered the incident involving the resident and the PSW. A PSW had covered another PSW for their break and when the PSW returned they told them that they had some issues while providing care for a resident as the resident had become upset with them stating they weren't providing care the way they wanted it and was crying. The resident said that the PSW called them a name. The PSW said they left the room and later told the oncoming shift that the resident had been upset.

During an interview, the resident stated they had one incident where a PSW was mean to them during a shift. The resident said that the PSW would not do as they had asked, called them a name and it was very upsetting at the time and said they did not want to speak about it anymore, that they had finally put the incident behind them.

During an interview, the RCC stated that the PSW had been abusive and that the home's expectation was that residents should be protected from abuse by anyone. [s. 19. (1)] (615)

2. Section 2(1) of Ontario Regulation 79/10 defined physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain; administering or withholding a drug for an inappropriate purpose, or the use of physical force by a resident that causes physical injury to another resident".

Two CIS reports were submitted by the home to the MOHLTC on specific dates, related to alleged abuse of a resident by a resident.

A review of a resident's Behaviour Assessment, on a specific date, stated that a "PSW one-on-one" was required. The Behaviour Assessment on two different dates stated that the resident demonstrated behaviours and these behaviours had worsened since admission to the home. The Cohen-Mansfield Agitation Inventory for the resident on a specific date stated that several times per hour, on a shift, the resident demonstrated the behaviours and hurting self or others.

A record review of the plan of care for the resident stated that they were admitted to the home on a specific date with specific diagnosis.

A review of the resident's progress notes in PointClickCare (PCC) weeks before the physical aggression towards another resident, 17 different abusive incidents and behaviours from the resident to other residents and staff were documented.

During interviews, the RN-BSO and RCC, both stated that the resident was physically and verbally aggressive towards both residents and staff. That an assigned one-to-one PSW for the resident was not in place previous to the altercation.

A review of the residents progress notes in PCC, after the last incident and previous incident involving another resident, four different abusive incidents and behaviours from the resident to other residents and staff were documented.

Progress notes in PCC for the resident, documented seven different abusive incidents and behaviours to other residents and staff were documented. The One-to-one staffing was initiated 24/7 after the last incident. [s. 19. (1)]

(633)

3. A CIS report was submitted by the home to the MOHLTC on a specific date related to alleged abuse of resident by a resident.

A review of the CIS and the home's investigation stated that on a specific date, a resident had a physical altercation with another resident twice while walking through the home and the resident fell on the floor and sustained an injury.

A review of the resident progress notes documented 11 different abusive incidents and behaviours from the resident to other residents and staff. The resident was referred to the BSO caseload as a result of a physically responsive episode on the last incident.

During an interview, the RCC and the RN-BSO, both said that this was abuse and that the resident was becoming more physically aggressive towards residents over time. The RN-BSO stated that the first time the resident was abusive to the other residents that it was the home's expectation that staff would refer the resident to BSO for an assessment and monitoring the resident closely.

(615)

4. A CIS report was submitted by the home to the MOHLTC on a specific date, related to alleged abuse of a resident by a staff member.

A review of the home's investigation notes of the incident included interviews with staff and residents. A resident stated that on a specific date, a resident was using a new device and was trying to get accustomed to it. The resident was going into a common area of the home, and tried to maneuver the device but got stuck and paused to think about how to get the device unstuck. They said that an RPN was verbally abusive causing the resident to be upset. The resident tried to back up and sustain an injury. The RPN never came to check on the resident.

The home's investigation also included an interview of a resident stating that all residents were gone to the common area during the incident and stated that the RPN came in and yelled at the resident.

A review of the home's investigation conclusion and discipline letter written by the RCC stated that the home believed that verbal and emotional abuse occurred, there was negative impact on the resident and had not reassured and provided the resident with emotional support. Other residents witnessed the incident and were upset by the way the RPN spoke abruptly and acted towards the resident. The RPN was required to complete modules on Resident Abuse and the Residents Bill of Rights prior to the next scheduled shift.

During an interview, the RCC said that the RPN had been abusive and that the home's expectation was that residents should be protected from abuse by

anyone. [s. 19. (1)]

The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The severity was determined to be a level 3 as there was actual harm or risk. The scope of this issue was determined to be widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on Oct 28, 2015 as a Written Notification (WN) on a Critical Incident Inspection # 2015_303563_0046 and on May 26, 2016, as a Voluntary Plan of Correction (VPC) on a Critical Incident Inspection # 2016_457630_0017. [s. 19. (1)]

(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 06, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

Specifically, the home will ensure that procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair, excluding the residents' personal aids or equipment.

A CIS report was submitted by the home to the MOHLTC on a specific date for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

The CIS report stated that a resident was using a device when a PSW moved the device the resident fell and sustained an injury. The resident was sent to the hospital for further assessment.

During an interview, an RPN stated that they responded to the incident with the resident and shared that the PSW had reported that the device broke.The RPN stated that they did not see the device as once the paramedics left with the resident they left the area and the room was closed.

During an interview, the MoC stated that the device that was involved in the incident was no longer in the home as they have a contract with a company that picks up old, broken or unwanted equipment.

On a specific date, the Inspector asked the MoC to provide records that showed that procedures have been implemented to ensure that the specific device in the home were kept in good repair. The MoC provided the Environmental Services Manual that included Preventative Maintenance Program Procedure and they stated that there were no checks done on the specific device in the home to ensure that it was kept in good repair and that the device would only be looked at if the staff had put in a concern on a work order.

During an interview, the Administrator and the MoC, the MoC shared that the device involved in the incident was looked at by them and the RCC. The MoC

stated that they turned the device over and there was no damage. At a later time that day, the MoC informed the Inspector that the device involved in the incident was in the basement of the home.

On a specific date, two Inspectors and the MoC observed the device in the basement involved in the incident. On the back of the device was a sign "Broken Do Not Use" with the area of the home where the incident occurred. One Inspector turned the device over and observe that the device was broken.

The licensee failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids, and positioning aids in the home were kept in good repair.

The severity was determined to be a level 3 as there was actual harm or risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 90. (2) (b)] (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 06, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 23rd day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

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

Name of Inspector / Nom de l'inspecteur : Helene Desabrais

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