Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 9, 2019	2019_643111_0022	017280-19, 017379-19, 018096-19, 018100-19, 019756-19, 020207-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the City of Kawartha Lakes
26 Francis Streeet P.O. Box 9000 LINDSAY ON K9V 5R8

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

Victoria Manor Home for the Aged
220 Angeline Street South LINDSAY ON K9V 4R2

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

LYNDA BROWN (111)

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): October 29, 30, 31 and November 5, 6, 7, 2019.

The following critical incident reports (CIR) were inspected concurrently during this inspection:
-Log #018100-19, Log #018096-19 and Log #017379-19 related to alleged staff to resident abuse.
-Log #021381-19, Log # 019756-19 and Log #017280-19 related to a fall that resulted in transfer to hospital.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and the Physiotherapist (PT).

During the course of the inspection, the inspector: reviewed resident health care records, observed residents and resident rooms, reviewed post fall assessments, reviewed the home's investigations, reviewed staff training records and reviewed the following home's policies-prevention of abuse and neglect and falls prevention and management.

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that residents were protected from abuse by anyone,

by the licensee or staff in the home.

A critical incident report was submitted to the Director on a specified date, for alleged staff to resident abuse incidents that occurred on a specified date. The CIR indicated the incidents of abuse involved PSW #110 towards resident #003 and #004. The allegations were received by the ADOC by RN #105 a week after the incidents had occurred.

A review of the home's investigation indicated there were five staff (RN #105, RN #111, PSW #112, #113 and #114) who either alleged, suspected or witnessed, staff to resident abuse or improper care PSW #110 towards six residents (#003, #004, #005, #006, #007 and #010) and occurred on specified dates, during a specified shift. The alleged abuse was reported by email to the ADOC a week after the last incident had occurred but was not received by the ADOC until the following day.
-PSW #114 reported they witnessed PSW #110 being abusive towards with resident #006 and the resident complained of pain during care due to improper care and occurred a week earlier.
-PSW #112 reported hearing PSW #110 being abusive to resident #006 while provide care approximately a week earlier and the incident was also witnessed by PSW #114.
-PSW #113 reported that they witnessed PSW #110 being abusive towards resident #003 and the incident was witnessed by RN #111. PSW #113 also indicated resident #007 would refuse care by PSW #110 as they thought the PSW was abusive towards them.
-RN #111 reported that approximately two months earlier, at a specified time, they witnessed PSW #110 being abusive towards resident #003 and also witnessed PSW #110 being abusive towards another residents when they were asking for assistance with toileting and the toileting assistance was not provided.
-Resident #006 and #007 were deceased by the time the allegations were reported.

Review of the progress notes for resident #003, #004, #005, #006, #007 and #010 for a specified period, indicated there was no documentation regarding the incidents or to indicate any of the residents were assessed for injury or emotional response as a result of the incidents, or to indicate what emotional support was provided to the residents regarding the allegations, as per the home's prevention of abuse and neglect policy.

Resident #003, #004, #005 and #010 were interviewed by the Inspector on a specified date and none of the residents were able to recall the allegations. Resident #006 and #007 were no longer in the home.

During an interview with RN #111 by the Inspector, they indicated that for any alleged, suspected or witnessed incidents of staff to resident abuse, they would initiate the investigation by speaking to all the staff involved or aware regarding the allegations and including the residents involved (where possible) and then immediately report to their manager on call. The RN indicated they would document the incident and the assessment of the resident in the progress notes. The RN indicated during a specified shift on a specified date and time, they overheard resident #003 yelling and when they went to check on the resident, they witnessed PSW #110 being abusive towards the resident. The RN indicated on the same date, but later in the shift, they were notified by PSW #113 that they had witnessed PSW #110 being abusive towards resident #010. The RN confirmed that they did not intervene, the did not assess the residents, did not document the incidents and assessments or notify the manager on call, as per the home's prevention of abuse policy. The RN confirmed they did not inform the SDMs of resident #003 or #010 of the incidents, or notify the police and the Ministry of Long Term Care (MLTC) after hours.

During an interview with RN #105, they indicated on a specified date and time, PSW #112 and #113 had reported that they had been witnessing ongoing abuse by PSW #110 towards residents and they were concerned that no actions were being taken. The RN indicated that both PSWs confirmed they had been reporting their concerns to RN #111. The RN indicated that PSW #113 reported witnessing PSW #110 being abusive towards resident #003 and witnessing PSW #110 being abusive and providing improper care towards resident #004 resulting in pain to the resident. The RN indicated they sent the ADOC and DOC an email regarding the allegations. The RN confirmed they did not assess the residents at that time, did not document the incidents in the residents health record, they did not immediately report the allegations to the manager on call, did not inform the SDMs of either resident or notify the police and MLTC, regarding the allegations.

During an interview with ADOC #102, they indicated they received an email on a specified date, from RN #105 reporting allegations of PSW #110 being abusive towards residents on a specified unit. The ADOC indicated the email did not provide specific dates regarding when the incidents occurred but indicated that RN #111 was also aware of abusive incidents that occurred approximately two months prior, involving PSW #110. The ADOC indicated the email stated that the previous week, PSW #114 witnessed PSW #110 being abusive towards resident #003 and #004. The ADOC confirmed they did not document an assessment of resident #003, #004 or #010 in their health records related to the allegations but reported the allegations to the DOC, the SDMs, the police and the

MLTC at that time. The ADOC indicated during their investigation, they discovered that there were additional allegations of abuse and improper care by PSW #110 towards resident #005, #006 and #007 that were either witness or suspected by other staff who did not immediately intervene, assess the residents involved or immediately reported the incidents.

During an interview with the DOC, they indicated the investigation into the alleged staff to resident abuse incidents was concluded and confirmed that RN #105, RN #111, PSW #112, PSW #113 and PSW #114 all had either witnessed, suspected or received allegations of either staff to resident abuse or improper care by PSW #110 towards a number of residents. The DOC confirmed that both RNs failed to follow the home's prevention of abuse and neglect policy, as they did not immediately assess the residents involved for any injury or emotional distress, did not document the incidents in the resident's health records when they occurred or when they became aware. The DOC indicated both RNs also did not immediately report the allegations to their on call manager as per the home's policy. The DOC confirmed the RNs did not inform any of the resident's SDMs of the alleged incidents, did not immediately notify the police or the MLTC of the allegations, as per their policy. The DOC indicated resident #006 and #007 were no longer in the home and confirmed that none of the remaining residents involved, were capable of recalling the incidents. The DOC indicated they instructed the registered staff the day after the allegations was received and a week to two months after the incidents had occurred, to monitor and document on resident #003, #004 and #005 for any injuries or emotional responses related to the allegations.

The licensee failed to protect six residents (#003, #004, #005, #006, #007 and #010) from abuse by PSW #110 as follows:
-When the home's policy on prevention of abuse and neglect was not complied with, as three PSWs (#112, #113 and #114) either suspected or witnessed staff to resident abuse and/or improper care of six residents (#003, #004, #005, #006, #007 and #010) by PSW #110 and did not immediately intervene or report the allegations to their charge nurse. RN #111 and #105 were either notified, suspected or witnessed, incidents of staff to resident verbal/emotional abuse by PSW #110 and did not assess the residents or document the incidents as per the home's policy as identified under LTCHA, 2007, s.20 (1) under WN #3.
- When the Director was not immediately notified of alleged, suspected or witnessed incidents of staff to resident abuse and/or improper care by PSW #110 towards six residents (#003, #004, #005, #006, #007 and #010) as the Director was not made of the incidents that had occurred on specified dates, until approximately two months later, as

identified under LTCHA, 2007, s.24(1) under WN #4.
-When the SDMs of resident #003, #004, #005, #006, #007 and #010 were not notified within 12 hours of becoming aware of alleged or witnessed incidents of staff to resident abuse and/or improper care by PSW #110. The SDM of resident #006 and #007 were not notified of the allegations as identified under O.Reg. 79/10, s.97(1)(b) under WN #5.
-When the police were not immediately notified of alleged, suspected or witnessed incidents of staff to resident abuse and/or improper care by PSW #110 towards residents, until the ADOC and DOC were made aware of the incidents, approximately two months after the incidents occurred, as identified under O.Reg. 79/10, s.98 under WN #6.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the plan of care, set out clear directions to staff and others who provide direct care to the resident related to falls.

A critical incident report was submitted to the Director on a specified date for a fall incident that resulted in an injury, for which resident #012 was sent to hospital and resulted in a significant change in condition. The CIR indicated on a specified date and time, the resident was witnessed sustaining a fall, by RPN #118 and PSW #119. The following day, the resident was complaining of pain to a specified area. The resident was transferred to hospital and diagnosed with an injury to a specified area.

Review of the progress notes for resident #012 over a three month period related to falls, indicated the resident had sustained a number of falls on specified dates. Prior to the last fall, the resident was independently mobile with the use of a mobility aid. On a specified date, the resident was found on the floor, complaining of pain to a specified area with a change in mobility and was transferred to hospital for an assessment. The resident returned from the hospital two days later with a specified injury to a specified area, required the use of a mobility aid and the use of an alarming device for falls prevention. The following day, the resident sustained a fall from their mobility aid and the alarming device did not activate.

Observation of resident #012 on a specified date and time, indicated the resident was sitting in a mobility aid in an identified area. The resident had a specified alarming device in place, and other specified falls prevention interventions in place. The resident was not interviewable. Observation of the residents room indicated a fall symbol was noted above the resident's bed and the bed was placed in lowest position. There was no specified fall prevention intervention in place at the bedside.

During an interview with RPN #102, they indicated prior to resident #012 sustaining a specified injury to a specified area, from a previous fall, the resident was independently mobile. The RPN indicated the resident would demonstrate specified responsive behaviours that would increase their risk for falls. The RPN indicated the resident had a walker but would never use the walker. The RPN indicated on a specified date and time, the resident had sustained a fall that was witnessed but no injuries or complaints of pain were noted until the following day. The RPN confirmed the PSWs reported the resident was having difficulty with weight bearing and that they had given the resident analgesic for pain. The RPN indicated no awareness that prior to the resident's injury that the resident was a high risk for falls and had sustained a number of falls. The RPN indicated the resident was currently using a mobility aid and an alarming device for falls prevention.

During an interview with PSW #124, they indicated resident #012 used to be independently mobile prior to the fall that resulted in an injury to a specified area. The PSW indicated the resident was at risk for falls but unsure which level of risk. The PSW indicated all residents deemed at high risk for falls would have a fall symbol above their bed. The PSW indicated the resident now required two staff assistance with activities of daily living and used a specified mobility aid. The PSW identified specified falls prevention interventions. The PSW was aware the resident had sustained another fall

earlier in the day when they fell out of the mobility aid while sitting in a specified area. The PSW indicated the resident did not sustain an injury and they were not on the floor at the time of the fall.

During an interview with the Physiotherapist (PT), they indicated resident #012 was at risk for falls and recently sustained an injury to a specified area. The PT indicated the resident was currently using a mobility aid independently. The PT indicated the resident currently has an alarming device and other specified falls prevention interventions.

During an interview with RPN #125 (falls prevention lead), they indicated resident #012 had just returned from hospital after sustaining an injury to a specified area post fall. The RPN indicated the resident was at risk for falls and used to be independent with mobility prior to the injury. The RPN indicated the resident required the use of a specified mobility aid, an alarming device and other specified falls prevention interventions. The RPN confirmed awareness that the resident had recently sustained another fall in a specified area, while the alarming device was in place but the alarming device did not activate. The RPN indicated the home had other types of alarming devices that would be more effective in falls prevention and confirmed this intervention was not considered.

Review of the written plan of care for resident #012 (for a specified date) indicated the resident was at a specified risk for falls related to specified responsive behaviours, poor decision making, medications and a specified diagnosis with specified interventions. The plan of care did not include all the falls prevention interventions that were being used or to be used, when they were to be in use.

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 plan of care, sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: 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 :

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

Review of the home's policy "Prevention of Abuse & Neglect of a Resident", (VII-G-10.00) revised April 2019, indicated under procedure:
-if any team member or volunteer witnesses an incident, or has any knowledge of an incident, that constitutes resident abuse or neglect, all team members are responsible to immediately take these steps: stop the abusive situation and intervene immediately, remove the resident from the abuser, immediately inform the Executive Director and/or Nurse in charge.
-the Nurse will: check the resident's condition to assess his/her safety and emotional and physical well being. Document the current resident status on the resident's health record.
Under the Investigation:
-the Executive Director or designate initiates the investigation by requesting that anyone aware of or involved in the situation write, sign and date a statement accurately describing the event. The written statements are to be obtained as close to the time of the event as possible.
-all team members must report the incident to either the ED or the DOC if the nurse in charge/supervisor does not take action in accordance with this procedure.
-the resident/family/representative are offered emotional support and provided with a list of internal resources, including the social worker, pastoral care and external local resources as available.

Related to resident #001:

A critical incident report was submitted to the Director on a specified date, for a staff to resident abuse incident that occurred at a specified time. The CIR indicated PSW #100 witnessed improper care by PSW #101 towards resident #001. PSW #100 reported the incident to RPN #102 and the RPN immediately reported the incident to the DOC.

Observation of resident #001 on a specified date and time, by the Inspector, indicated the resident was confined to a mobility aid, was observed frequently demonstrating a responsive behaviour and required frequent reassurances from staff, which were effective.

A review of the progress note for resident #001 indicated on a specified date, there was no documentation related to the incident indicated in the CIR, to indicate the resident was assessed for their safety, emotional and physical well being, or to indicate the resident/family/representative were offered emotional support as per the home's policy.

During interview with PSW #100, they confirmed witnessing on a specified date and time, resident #001 sitting at a specified area, demonstrating a responsive behaviour and PSW #101 improperly handled and was abusive towards resident #001. The PSW confirmed they did not intervene and proceeded to provide care to resident #002. The PSW indicated PSW #101 then entered resident #002's room, after they had rang for assistance with a transfer, when they witnessed PSW #101 then improperly handle and be abusive towards resident #002. The PSW indicated they reported both incidences to the RPN at that time.

During an interview with ADOC #102, they indicated they were notified by PSW #100 of the staff to resident abuse incident involving PSW #101 towards resident #001 and #002 on the same day the incidents had occurred. The ADOC confirmed they did not document an assessment of the resident or to indicate what support was provided to the resident and SDM as per the home's policy.

The licensee had failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with as the staff member (PSW #100) failed to intervene or report to the charge nurse of a witnessed incident of staff to resident abuse and improper care, until after a second incident of staff to resident abuse occurred. There was also no documented evidence of the incident with resident #001 (until the next day), to indicate the staff assessed the resident for their safety, emotional and physical well being. There was also no documented evidence to indicate the resident/family/representative's were offered emotional support as per the home's policy.

2. Related to resident #002:

A critical incident report was submitted to the Director on a specified date, for a staff to

resident abuse incident that occurred at a specified time. The CIR indicated PSW #100 reported to ADOC #103 that they witnessed PSW #101 providing improper care and abuse towards resident #002 in the residents room, while they were assisting with care.

Observation of resident #002 on a specified date and time, by the Inspector, indicated the resident was in bed awake and did not respond to any questions asked.

A review of the progress notes for resident #002 indicated on a specified date,there was no documented evidence of the incident indicated in the CIR to indicate the resident was assessed for any injury or emotional distress at the time of the incident. The following day, the progress notes indicated to monitor the resident for any injuries, responsive behaviours or emotional distress on each shift for the next three days. The following day, the SDM was contacted about relocating the resident to another unit but there was not documented evidence the resident or the SDM were offered emotional support related to the witnessed staff to resident abuse incident.

During interview with PSW #100, they confirmed witnessing on a specified date and time, resident #001 sitting at a specified area, demonstrating a responsive behaviour and PSW #101 improperly handled and was abusive towards resident #001. The PSW confirmed they did not intervene and proceeded to provide care to resident #002. The PSW indicated PSW #101 entered resident #002's room, after they had rang for assistance with a transfer and witnessed PSW #101 improperly handle and being abusive towards resident #002. The PSW indicated they reported both incidences to the RPN at that time.

During an interview with ADOC #102, they indicated they were notified by PSW #100 of the staff to resident abuse incident involving PSW #101 towards resident #001 and #002 on the same day the incidents had occurred. The ADOC confirmed they did not document an assessment of the resident or to indicate what support was provided to the resident and SDM as per the home's policy.

During an interview with the DOC, they confirmed that PSW #100 had initially witnessed a staff to resident abuse incident by PSW #101 towards resident #001 and then witnessed a second incident of staff to resident improper care and abuse by PSW #101 towards resident #002. The DOC confirmed PSW #100 reported both incidents to RPN #102 after the second incident occurred. The DOC confirmed that staff did not intervene until after the second witnessed incident had occurred.

The licensee had failed to ensure that the written policy that promotes zero tolerance of

abuse and neglect of residents was complied with as there was no documented evidence of the incident until the next day, to indicate what had occurred and there was no documented evidence the resident/family/representative's were offered emotional support, as per the home's policy.

3. A critical incident report was submitted to the Director on a specified date, for alleged staff to resident abuse incidents that occurred on a specified date and time (approximately one week earlier). The CIR indicated the incidents of abuse involved PSW #110 towards resident #003 and #004 and the allegations were reported by RN #105.

A review of the home's investigation indicated there were five staff (RN #105, RN #111, PSW #112, #113 and #114) who either alleged, suspected or witnessed, staff to resident abuse and/or improper care by PSW #110 towards six residents (#003, #004, #005, #006, #007 and #010) and occurred on separate dates of approximately two months earlier and one week earlier. Resident #006 and #007 were deceased by the time the allegations were reported. Resident #003, #004 and #005 were unable to recall the incidents.

Review of the progress notes for resident #003, #004, #005, #006, #007 and #010 during the period the incidents alleged occurred, indicated there was no documentation regarding the incidents, an assessment of the residents or any emotional response as a result of the allegations.

During an interview with RN #111, they indicated they confirmed that approximately two months before the allegations were reported, during a specified shift, at a specified time, they witnessed PSW #110 being abusive towards resident #003. The RN indicated the same shift, they were later notified by PSW #113 that they had witnessed PSW #110 being abusive towards resident #010. The RN confirmed that both incidents were considered abuse and that they did not intervene, did not assess the residents involved, document the incidents or assessments or notify the manager on call, as per the home’s prevention of abuse and neglect policy.

During an interview with RN #105, they indicated on a specified date and time, PSW #112 and #113 had reported that they had been witnessing ongoing abusive behaviour by PSW #110 towards residents and were concerned that the behaviour was continuing. The PSWs had also indicated that they had reported their concerns to RN #111. The RN confirmed that PSW #113 reported witnessing PSW #110 being abusive and providing

improper care towards resident #003 and #004. The RN confirmed they did not assess the residents at that time, did not document the incidents or immediately notify the manager on call, as per the home's policy.

During an interview with ADOC #102, they indicated they received an email on a specified date from RN #105 reporting allegations of PSW #110 being abusive towards residents on a specified unit. The ADOC indicated the email also indicated RN #111 was also aware of alleged staff to resident abuse incidents involving PSW #110 that had occurred approximately two months earlier. The ADOC indicated the email indicated that RN #105 was notified the day before, of alleged, staff to resident abuse incidents that involved PSW #110, that the incidents had occurred the previous week and were reported by PSW #112 and #113. The ADOC indicated the incidents were also witnessed by a new staff member (PSW #114) and the alleged staff to resident abuse incidents occurred towards resident #003 and resident #004. The ADOC confirmed they did not document an assessment of the residents in their health records related to the allegations.

During an interview with the DOC, they indicated the investigation was concluded and they confirmed that RN #105, RN #111, PSW #112, PSW#113 and PSW #114 all had either suspected, received allegations or witnessed staff to resident verbal and/or emotional abuse by PSW #110 and both RNs had failed to follow the home's prevention of abuse and neglect policy as they did not immediately report, immediately assess the residents involved for any injury or emotional distress and document the incidents in the resident's health records. The DOC indicated they instructed the registered staff on September 5, 2019 to monitor resident #003, #004 and #005 for three days, on each shift and document any injuries or emotional responses related to the allegations.

The licensee had failed to ensure the home's policy on prevention of abuse and neglect was complied with, as three PSWs (#112, #113 and #114) either suspected or witnessed staff to resident abuse or improper care towards six residents (#003, #004, #005, #006, #007 and #010) by PSW #110 and did not immediately report the allegations to their charge nurse. RN #111 and #105 were either notified, suspected or witnessed, incidents of staff to resident abuse by PSW #100 and did not immediately assess the residents, provide emotional support, or document the incidents as per the home's policy.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident, that resulted in harm or a risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A critical incident report was submitted to the Director on a specified date, for an alleged staff to resident abuse incident. The CIR indicated on a specified date and time, the SDM of resident #005 reported a complaint to RPN #107 and RN #108, alleging that PSW #109 was abusive and the resident was refusing their baths. There was no after hours call received for the alleged abuse complaint when it was received.

During an interview with RPN #107, they indicated on a specified date and time, they received a complaint from the SDM of resident #005 alleging the resident was abused by PSW #109 and refusing their baths as a result. The RPN indicated they notified RN #108 (agency) of the allegation. The RPN confirmed they did not report the allegation to the Ministry as they thought it was the RNs responsibility.

During an interview with RN #108, they confirmed that they worked for an agency and

worked regular part-time hours in the home for the last two months. The RN indicated if they receive a report or complaint of an alleged, suspected or witnessed incident of abuse of a resident by anyone, they are supposed to call the on-call manager in order to get further direction on who will be notifying the Ministry. The RN confirmed they were working on a specified date and on a specified shift, when they were notified by RPN #107 of an alleged staff to resident abuse incident. The RN indicated that RPN #107 reported the allegation was received by the SDM resident #005 and the SDM alleged that PSW #109 was abusive towards the resident during bathing, resulting in the resident refusing their baths. The RN indicated they did not call the on-call manager or report the allegation to the Ministry and only reported the allegation to the RN #106 on the next shift.

During an interview with the DOC, they confirmed that the allegation of staff to resident abuse that was reported on September 17, 2019 was not immediately reported to the Director and should have been. The DOC indicted the allegation was reported the following day when they received the email from RN #106 regarding the allegation.

The licensee had failed to ensure that when RPN #107 and RN #108 had reasonable grounds to suspect that improper care of resident #005, that resulted in a risk of harm had occurred, they immediately reported the suspicion and the information upon which it was based to the Director.

2. A critical incident report was submitted to the Director on a specified date for alleged staff to resident abuse incidents that occurred on a specified date and time. The CIR indicated the incidents of abuse involved PSW #110 towards resident #003 and #004. The allegations were reported by RN #105.

A review of the home's investigation indicated there were five staff (RN #105, RN #111, PSW #112, #113 and #114) who either witnessed, suspected or who had reported alleged staff to resident abuse by PSW #110 towards six residents (#003, #004, #005, #006, #007 and #010) that occurred on two separate dates. Resident #006 and #007 were deceased by the time the allegations were reported. Resident #003, #004, #005 and #010 were unable to recall the incidents.

During an interview with RN #111, they confirmed that they were aware of staff to resident abuse incidents involving PSW #110 towards resident #003, #004 and #010. The RN indicated the incidents occurred during on a specified shift and a specified date. The RN confirmed that they did not report the alleged or witnessed staff to resident

verbal and/or emotional abuse to the Director.

During an interview with RN #105, they indicated they became aware of allegations of staff to resident abuse by PSW #110 towards resident #003 and #004, on a specified date and time. The RN indicated the allegations were reported by PSW #112 and #113, both PSWs reported the incidents had been occurring for a long time and they had previously reported their concerns to RN #111. The RN confirmed they did not immediately report the allegations to the Director via the after hours line when the allegations were received and emailed the allegations to the ADOC.

During an interview with ADOC #102, they indicated they received the email from RN #105 regarding the allegations of staff to resident abuse by PSW #110 towards resident #003 and #004 on a specified date. The ADOC indicated the Director was notified of the allegations at that time.

During an interview with the DOC, they indicated the investigation was concluded and they confirmed that RN #105, RN #111, PSW #112, PSW #113 and PSW #114, all had either received allegations, suspected or witnessed, staff to resident abuse by PSW #110 towards six residents (#003, #004, #005, #006, #007 and #010) on specified dates. The DOC confirmed both RNs should have immediately notified the Director regarding the allegations when they became aware. The DOC confirmed that the Director was not notified until the ADOC and the DOC became aware, a number of months later.

The licensee had failed to ensure the Director was immediately notified of alleged, suspected or witnessed incidents of staff to resident abuse or improper care by PSW #110 towards six residents (#003, #004, #005, #006, #007 and #010), as they were not made aware of incidents that had occurred on identified dates, until a number of months later.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A critical incident report was submitted to the Director on a specified date, for alleged staff to resident abuse incidents that occurred on a specified date and time. The CIR indicated the incidents of abuse involved PSW #110 towards resident #003 and #004 and were reported by RN #105 on a specified date.

A review of the home's investigation indicated there were five staff (RN #105, RN #111, PSW #112, PSW #113 and PSW #114) who either witnessed, suspected, or who were made aware of alleged, staff to resident abuse by PSW #110 towards six residents (#003, #004, #005, #006, #007 and #010). Resident #006 and #007 were deceased by the time the allegations were reported.

During an interview with RN #111, they confirmed that they were aware of staff to resident abuse incidents involving PSW #110 towards resident #003, #004 and #010, that occurred on a specified shift, on specified dates and times. The RN confirmed that they did not report the witnessed or suspected staff to resident abuse to any of the resident's SDMs at that time.

During an interview with RN #105, they indicated on a specified date and time, PSW # 112 and #113 had reported that they had been witnessing PSW #110 being abusive

towards resident #003 and #004, had previously reported their concerns to RN #111 and were concerned that no actions were being taken. The RN confirmed they did not inform any of the resident's SDMs of the allegations at that time.

During an interview with ADOC #102, they indicated they received the email on a specified date, from RN #105 regarding allegations of staff to resident abuse by PSW #110 towards residents on a specified unit. The ADOC indicated the allegations were indicated in the email to have occurred on specified dates, the previous week and a number of months prior. The ADOC indicated the SDMs for residents #003, #004, #005 and #010 were notified of the allegations on a specified date, when they became aware, a number of months later. The ADOC indicated resident #006 and #007 were deceased by the time the allegations were reported so those SDMs were never informed of the alleged incidents.

The licensee had failed to ensure the SDMs of resident #003, #004, #005, #006, #007 and #010 were notified within 12 hours of becoming aware of alleged or witnessed incidents of staff to resident abuse by PSW #110.

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

Findings/Faits saillants :

The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incidents of abuse and/or improper care of a resident, that the licensee suspected may constitute a criminal offence.

A critical incident report was submitted to the Director on a specified date, for alleged staff to resident abuse incidents that occurred on a specified date. The CIR indicated the incidents of abuse involved PSW #110 towards resident #003 and #004. The allegations were reported by RN #105.

A review of the home's investigation indicated there were five staff (RN #105, RN #111, PSW #112, #113 and #114) who either witnessed, suspected or who had reported alleged staff to resident abuse and/or improper care by PSW #110 towards six residents (#003, #004, #005, #006, #007 and #010) that occurred on specified dates. Resident #006 and #007 were deceased by the time the allegations were reported. Resident #003, #004, #005 and #010 were unable to recall the incidents.

During an interview with RN #111, they confirmed that they were aware of staff to resident abuse incidents involving PSW #110 and occurred on a specified shift and a specified date and time. The RN confirmed they witnessed PSW #110 being abusive towards the resident. The RN indicated during the same specified shift, PSW #113 reported to them, that they had witnessed PSW #110 being abusive towards resident #010. The RN confirmed that they did not immediately report either of the staff to resident abuse incidents to the police.

During an interview with RN #105, they indicated they received allegations of staff to resident improper care and/or abuse on a specified date and time by PSW #112 and #113. The RN indicated that the alleged incidents had occurred during a specified shift, on a specified date and involved PSW #110 towards resident #003 and #004. The RN indicated both PSWs also reported that PSW #110 had been witnessed being abusive to the residents "for a long time" and that both PSWs had been reporting their concerns to RN #111. The RN confirmed they did not immediately report the allegations to the police but sent an email to the ADOC and DOC.

During separate interviews with the DOC and ADOC #102, they both confirmed they received the email from RN #105 on a specified date regarding the allegations of staff to resident abuse and/or improper care, by PSW #110 towards six residents. They both confirmed that the police should have been immediately notified as per the home's prevention of abuse policy and that the police were notified of the allegations when they became aware of the allegations.

The licensee had failed to ensure the police were immediately notified of alleged, suspected or witnessed incidents of staff to resident abuse and/or improper care, by PSW #110 towards six residents, that had occurred during a specified shift and on specified dates, as the police were not notified until a number of weeks later, when the DOC and ADOC were notified.

Issued on this 23rd day of December, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l’inspection :	2019_643111_0022
Log No. / No de registre :	017280-19, 017379-19, 018096-19, 018100-19, 019756-19, 020207-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 9, 2019
Licensee / Titulaire de permis :	The Corporation of the City of Kawartha Lakes 26 Francis Streeet, P.O. Box 9000, LINDSAY, ON, K9V-5R8
LTC Home / Foyer de SLD :	Victoria Manor Home for the Aged 220 Angeline Street South, LINDSAY, ON, K9V-4R2
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Pamela Kulas

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To The Corporation of the City of Kawartha Lakes, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall comply with LTCHA, 2007, s.19(1).

Specifically,

1. The licensee shall develop a monitoring process to ensure that:
- Any staff who alleged, suspect or witness staff to resident verbal and/or emotional abuse, are complying with the home's Prevention of Abuse and Neglect policy by immediately intervening, immediately assessing the residents involved for any emotional response or injury and documenting the incident and the assessment; ensuring that those residents and their SDMs are offered emotional support; ensuring that staff are aware of what the definitions of abuse, specifically verbal and emotional abuse, and what their responsibilities are related to any abuse.
- The resident's SDM is immediately notified of every incident of alleged, suspected or witnessed incident of staff to resident verbal and/or emotional abuse and this information is documented.
- The Director is immediately notified if there are reasonable grounds to suspect abuse of a resident by a staff member, that resulted in harm or risk of harm to a resident.
-all nursing staff are to be retrained on the home's policy and to include, the definitions of abuse and reporting requirements. A documented record is to be kept of the training.
- The appropriate police force have been immediately notified of all alleged, suspected, or witnessed incidents of staff to resident verbal and/or emotional abuse that the licensee suspects may constitute a criminal offense.

2. A documented record shall be kept of this monitoring process.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone, by the licensee or staff in the home.

A critical incident report was submitted to the Director on a specified date, for alleged staff to resident abuse incidents that occurred on a specified date. The CIR indicated the incidents of abuse involved PSW #110 towards resident #003 and #004. The allegations were received by the ADOC by RN #105 a week after the incidents had occurred.

A review of the home's investigation indicated there were five staff (RN #105, RN #111, PSW #112, #113 and #114) who either alleged, suspected or witnessed, staff to resident abuse or improper care PSW #110 towards six residents (#003, #004, #005, #006, #007 and #010) and occurred on specified dates, during a specified shift. The alleged abuse was reported by email to the ADOC a week after the last incident had occurred but was not received by the ADOC until the following day.
-PSW #114 reported they witnessed PSW #110 being abusive towards with resident #006 and the resident complained of pain during care due to improper care and occurred a week earlier.
-PSW #112 reported hearing PSW #110 being abusive to resident #006 while provide care approximately a week earlier and the incident was also witnessed by PSW #114.
-PSW #113 reported that they witnessed PSW #110 being abusive towards resident #003 and the incident was witnessed by RN #111. PSW #113 also indicated resident #007 would refuse care by PSW #110 as they thought the PSW was abusive towards them.
-RN #111 reported that approximately two months earlier, at a specified time, they witnessed PSW #110 being abusive towards resident #003 and also witnessed PSW #110 being abusive towards another residents when they were asking for assistance with toileting and the toileting assistance was not provided.

-Resident #006 and #007 were deceased by the time the allegations were reported.

Review of the progress notes for resident #003, #004, #005, #006, #007 and #010 for a specified period, indicated there was no documentation regarding the

incidents or to indicate any of the residents were assessed for injury or emotional response as a result of the incidents, or to indicate what emotional support was provided to the residents regarding the allegations, as per the home's prevention of abuse and neglect policy.

Resident #003, #004, #005 and #010 were interviewed by the Inspector on a specified date and none of the residents were able to recall the allegations. Resident #006 and #007 were no longer in the home.

During an interview with RN #111 by the Inspector, they indicated that for any alleged, suspected or witnessed incidents of staff to resident abuse, they would initiate the investigation by speaking to all the staff involved or aware regarding the allegations and including the residents involved (where possible) and then immediately report to their manager on call. The RN indicated they would document the incident and the assessment of the resident in the progress notes. The RN indicated during a specified shift on a specified date and time, they overheard resident #003 yelling and when they went to check on the resident, they witnessed PSW #110 being abusive towards the resident. The RN indicated on the same date, but later in the shift, they were notified by PSW #113 that they had witnessed PSW #110 being abusive towards resident #010. The RN confirmed that they did not intervene, the did not assess the residents, did not document the incidents and assessments or notify the manager on call, as per the home's prevention of abuse policy. The RN confirmed they did not inform the SDMs of resident #003 or #010 of the incidents, or notify the police and the Ministry of Long Term Care (MLTC) after hours.

During an interview with RN #105, they indicated on a specified date and time, PSW #112 and #113 had reported that they had been witnessing ongoing abuse by PSW #110 towards residents and they were concerned that no actions were being taken. The RN indicated that both PSWs confirmed they had been reporting their concerns to RN #111. The RN indicated that PSW #113 reported witnessing PSW #110 being abusive towards resident #003 and witnessing PSW #110 being abusive and providing improper care towards resident #004 resulting in pain to the resident. The RN indicated they sent the ADOC and DOC an email regarding the allegations. The RN confirmed they did not assess the residents at that time, did not document the incidents in the residents health record, they did not immediately report the allegations to the manager on call,

did not inform the SDMs of either resident or notify the police and MLTC, regarding the allegations.

During an interview with ADOC #102, they indicated they received an email on a specified date, from RN #105 reporting allegations of PSW #110 being abusive towards residents on a specified unit. The ADOC indicated the email did not provide specific dates regarding when the incidents occurred but indicated that RN #111 was also aware of abusive incidents that occurred approximately two months prior, involving PSW #110. The ADOC indicated the email stated that the previous week, PSW #114 witnessed PSW #110 being abusive towards resident #003 and #004. The ADOC confirmed they did not document an assessment of resident #003, #004 or #010 in their health records related to the allegations but reported the allegations to the DOC, the SDMs, the police and the MLTC at that time. The ADOC indicated during their investigation, they discovered that there were additional allegations of abuse and improper care by PSW #110 towards resident #005, #006 and #007 that were either witness or suspected by other staff who did not immediately intervene, assess the residents involved or immediately reported the incidents.

During an interview with the DOC, they indicated the investigation into the alleged staff to resident abuse incidents was concluded and confirmed that RN #105, RN #111, PSW #112, PSW #113 and PSW #114 all had either witnessed, suspected or received allegations of either staff to resident abuse or improper care by PSW #110 towards a number of residents. The DOC confirmed that both RNs failed to follow the home's prevention of abuse and neglect policy, as they did not immediately assess the residents involved for any injury or emotional distress, did not document the incidents in the resident's health records when they occurred or when they became aware. The DOC indicated both RNs also did not immediately report the allegations to their on call manager as per the home's policy. The DOC confirmed the RNs did not inform any of the resident's SDMs of the alleged incidents, did not immediately notify the police or the MLTC of the allegations, as per their policy. The DOC indicated resident #006 and #007 were no longer in the home and confirmed that none of the remaining residents involved, were capable of recalling the incidents. The DOC indicated they instructed the registered staff the day after the allegations was received and a week to two months after the incidents had occurred, to monitor and document on resident #003, #004 and #005 for any injuries or emotional responses related

to the allegations.

The licensee failed to protect six residents (#003, #004, #005, #006, #007 and #010) from abuse by PSW #110 as follows:
-When the home's policy on prevention of abuse and neglect was not complied with, as three PSWs (#112, #113 and #114) either suspected or witnessed staff to resident abuse and/or improper care of six residents (#003, #004, #005, #006, #007 and #010) by PSW #110 and did not immediately intervene or report the allegations to their charge nurse. RN #111 and #105 were either notified, suspected or witnessed, incidents of staff to resident verbal/emotional abuse by PSW #110 and did not assess the residents or document the incidents as per the home's policy as identified under LTCHA, 2007, s.20 (1) under WN #3.
- When the Director was not immediately notified of alleged, suspected or witnessed incidents of staff to resident abuse and/or improper care by PSW #110 towards six residents (#003, #004, #005, #006, #007 and #010) as the Director was not made of the incidents that had occurred on specified dates, until approximately two months later, as identified under LTCHA, 2007, s.24(1) under WN #4.
-When the SDMs of resident #003, #004, #005, #006, #007 and #010 were not notified within 12 hours of becoming aware of alleged or witnessed incidents of staff to resident abuse and/or improper care by PSW #110. The SDM of resident #006 and #007 were not notified of the allegations as identified under O.Reg. 79/10, s.97(1)(b) under WN #5.
-When the police were not immediately notified of alleged, suspected or witnessed incidents of staff to resident abuse and/or improper care by PSW #110 towards residents, until the ADOC and DOC were made aware of the incidents, approximately two months after the incidents occurred, as identified under O.Reg. 79/10, s.98 under WN #6.

The severity is a level 3 as there was actual risk and actual harm towards the residents involved. The scope was a level 3, as although there was only one incident, there were six residents affected by the one staff member. Although the home did not have LTCHA, s.19(1) issued, the compliance history was a level 3, as there was previous non-compliance to the same identified subsections as follows:
-A voluntary plan of correction (VPC) was issued for LTCHA, 2007, s.20(1) and s.24(1) on March 27, 2017 during inspection #2017_594624_0003.

-A VPC was issued for LTCHA, s.24(1) and O.Reg.79/10, s.97 and s.98 on June 7, 2018 during inspection #2018_716554_0004.

(111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 28, 2020

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 Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

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

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

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

Issued on this 9th day of December, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Central East Service Area Office