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 # / Registre no	Type of Inspection / Genre d'inspection
Sep 15, 2016	2016_347197_0021	017814-16, 023545-16	Critical Incident System

Licensee/Titulaire de permis

DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST SUITE 1500 TORONTO ON M5C 3G5

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

WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH P.O. BOX 1510 PRESCOTT ON K0E 1T0

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

JESSICA PATTISON (197)

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): August 9-11, 12 (off-site), 15, 16, September 8 and 9 (off-site), 2016

Two critical incidents were inspected as part of this report related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Extendicare Regional Director, the Administrator/Director of Care, the acting Director of Care, an external Investigator, Registered Nurses, Registered Practical Nurses, Personal Support Workers (past and present), Administrative staff and residents.

The inspector also reviewed resident health care records, the home's prevention of abuse and neglect policy and internal investigation files.

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

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **0 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	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 :

The licensee has failed to protect residents #001, #005 and #007 from abuse by PSW #116 and #117.

On August 9, 2016, an inspection began for a Critical Incident related to an allegation of staff to resident abuse. Once in the home, the inspector noted that the allegations included those of verbal, emotional and physical abuse towards multiple residents.

O. Reg. 79/10, s. 2(1) defines verbal, emotional and physical abuse.

The definition of "verbal abuse" includes,
a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident

The definition of "emotional abuse" includes,
a) 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

The definition of "physical abuse" includes,
a) the use of physical force by anyone other than a resident that causes physical injury or pain

On a specified date, an email was forwarded to the Regional Director for the home by a former staff member, PSW #115. This former staff member alleged having "witnessed abuse time and time again and reported it, just to have nothing come of it". The email referenced a particular group of staff that were causing the abuse and neglect of residents. No names of staff were provided in the email.

An investigation has taken place into the alleged incidents of abuse by an external investigator hired by the home. The investigator shared his preliminary findings with the home via teleconference approximately two months after the initial allegations were made.

At that point, the following acts of staff to resident abuse were alleged to have been committed by PSWs #116 and #117:

1 - Former employee PSW #113 stated to the investigator that late in a particular year, PSW #117 completed his/her orientation and they were working with resident #013. PSW #113 told the investigator that the resident was cognitively well and could understand.

PSW #113 stated that he/she and PSW #117 were toileting the resident and PSW #117 made an emotionally abusive remark to the resident. PSW #113 indicated being shocked, but didn't report anything at the time. PSW #113 told the investigator that the resident looked like he/she was going to cry but did not say anything.

Former PSW #113 indicated to the investigator that the following day, he/she and PSW #117 were working with another resident (#016) and that they had to use a sling. PSW #117 was putting the sling strap on the resident and hit the resident with the strap. Former PSW #113 was unsure exactly how it happened but felt it was done on purpose because there was no apology from PSW #117. PSW #113 reported that the resident did not say anything at the time but that the resident did not like PSW #117. He/she said they knew the resident did not like PSW #117 because he/she would lose his/her smile when PSW #117 walked into the room. Former PSW #113 did not tell the investigator if this incident was reported immediately, but said later in the interview that he/she did tell management and would not work with PSW #117 anymore because of the way he/she is and the way he/she treats residents.

2 - Former PSW #115 told both the inspector and investigator that around a particular date, he/she was working with PSW #116 and witnessed him/her make an emotionally abusive comment while providing care to resident #006. Former PSW #115 was unsure if the resident heard the comment due to his/her hearing impairment. Former PSW #115 indicated to the inspector that he/she did report this incident to management at the time.

3 – Former PSW #115 stated to both the inspector and private investigator that around a particular date at the end of a shift, staff were standing around when PSW #117 grabbed a baby doll from resident #003, who loved the doll and thought it was a real baby. PSW #115 said that PSW #117 grabbed the doll, hit it on a table a few times and threatened to drown the doll. PSW #115 also said that PSW #117 was in the resident's face and yelled at them with hands in the air. Former PSW #115 told the inspector that the resident appeared scared. Former PSW #115 told the inspector and investigator that he/she waited about one week and then reported this incident to the Administrator at the time, #120. This former PSW told the inspector that he/she reported resident abuse regularly to Administrator #120, who no longer works in the home. He/she said they now know that this former Administrator did not report the incidents of alleged abuse to the Director (Ministry of Health and Long-Term Care) or to Head Office. Former PSW #115 said he/she gained a reputation for reporting and staff disliked him/her because of it. PSW #115 also told the inspector that the primary reason he/she quit working at the home was because of PSWs #116 and #117 and how they treated residents. Former PSW #115

stated at one point he/she stopped reporting resident abuse because nothing was being done.

4 – On a particular date, PSW #114 told the investigator that about 1.5 months ago, resident #005 requested that PSW #114 not do the resident's care. PSW #117 found out that the resident requested this and would allegedly get resident #005 upset by saying "I'm going to send PSW #114 in to do your care". PSW #114 said he/she knew this because resident #005 told him/her. PSW #114 told the investigator that he/she reported this to the Administrator/Director of Care a couple of weeks after the incident occurred.

5 - PSW #105 told the inspector and investigator that he/she has heard PSW #117 makes fun of residents. Specifically, PSW #105 stated that PSW #117 has in the past made fun of resident #002 who no longer lives in the home. PSW #105 said that PSW #117 has also allegedly been verbally and emotionally abusive towards residents #004 and #005. PSW #105 also said that PSW #117 is rough with resident #009 and does not follow procedure when moving the resident. PSW #105 said that another resident, #013, was hard to care for and told the investigator that PSW #117 would be sarcastic with the resident and make the resident angry. PSW #105 told the inspector that these incidents were not reported to management.

6 - PSW #107 reported to the inspector and investigator that PSW #117 is rough with residents. He/she said when PSW #117 rolls residents over, their legs bang on the bars and PSW #117 just doesn't care. Specifically, PSW #107 alleged witnessing an incident of physical abuse towards resident #008. PSW #107 told the investigator that he/she was new and should have reported the incident but did not. PSW #107 then recalled another time, the same resident was refusing care and PSW #117 was forceful with the resident. PSW #107 states he/she heard PSW #117 tell the story in a bragging manner to other staff, but did not actually witness the incident. PSW #107 also told the inspector that a student PSW (#122) was with PSW #117 during this incident and also told him/her about PSW #117 being forceful with the resident during care.

PSW #107 further stated to the investigator and inspector that PSW #117 is rude when talking about resident #005, calling the resident names and making emotionally abusive remarks. PSW #107 stated that PSW #117 makes these remarks loudly in the hall in front of other staff and residents. Due to where the resident's room is, he/she feels it's possible that resident #005 has heard the comments. PSW #107 told the inspector that he/she could not recall if this was reported to management. PSW #107 told the inspector that he/she had reported incidents of resident abuse to the past Administrator #120, but

that he/she felt intimidated by PSW #117 and so there were other incidents he/she heard and saw that were not reported.

6 - PSW #104 stated to the inspector and investigator that he/she has heard PSW #117 make fun of residents. Specifically, PSW #117 has called resident #005 names and allegedly does this right outside of the resident's room and he/she feels the resident could probably hear what PSW #117 has said. PSW #104 reports that another time, he/she witnessed PSW #117 take resident #002's doll and play with the doll in front of the resident. PSW #104 stated it was very upsetting to watch. PSW #104 told the inspector that he/she did not report either of these incidents when they occurred.

7 - PSW #102 told the inspector and the investigator that he/she had heard PSW #117 talk about a time when he/she had provided care to resident #008 in a forceful manner. The resident was resistant to care and PSW #117 got mad and was forceful with the resident. PSW #102 then noted that PSW #117 shared this story with other staff as if he/she was proud of what was done. PSW #102 also recalled a time that he/she witnessed PSW #117 take resident #003's clothes off in an aggressive manner. PSW #102 told the inspector that he/she reported the incident with resident #003 to Administrator #120 at the time.

8 - PSW #108 stated to the inspector that on a specified date, they had a new admission, resident #014. He/she states that at shift change, PSW #117 allegedly made emotionally abusive remarks to three or four staff in the hallway about the resident while the resident was sitting there. PSW #108 states he/she did not feel the resident would have had the cognitive ability to understand what PSW #117 was saying. The PSW said he/she didn't report this incident because they had just started working in the home and was scared for their job.

PSW #108 also indicated to the inspector that on a particular date that could not be recalled, resident #015 sustained an injury and when the resident returned from the hospital, reported to him/her that it was a staff member who was physically abusive and caused the injury. PSW #108 says he/she researched when the injury occurred and PSW #117 was caring for the resident on that shift. PSW #108 stated that after this incident, PSW #117 would transfer the resident in a rough and forceful manner. PSW #108 stated that PSW #117 would transfer other residents this way and feels it was physically abusive towards the residents.

PSW #108 states he/she did not report these incidents of alleged abuse at the time since

he/she did not trust the Administrator (#120) that was in place, but states they would report immediately now.

During a phone interview with the Administrator/Director of Care, she was asked about the above incident alleging that resident #015 was physically abused by PSW #117 and sustained an injury. The Administrator/DOC indicated being made aware of this alleged physical abuse through the investigation, but had not yet looked further into the allegation. The inspector placed a telephone call to PSW #108 to get further information about this incident but was unable to reach the staff member.

9- In addition to the investigation notes seen by the inspector, PSW #102 reported to the inspector and to the DOC, the day after the incident occurred, that on a specified date while the investigation was being conducted, resident #007 was resisting care and he/she alleges witnessing PSW #117 being emotionally abusive towards the resident. PSW #102 states he/she did not report the incident immediately, but waited until the following business day when the Administrator/DOC was back in the home.

The inspector conducted interviews with residents #003, #004, #005, #007, #008 and #009 who still reside in the home. Only resident #005 was interviewable and knew who PSW #117 was. Resident #005 did not confirm to the inspector if PSW #117 had ever been verbally and/or emotionally abusive.

On a specified date, the investigator hired by the home emailed the inspector indicating that he had interviewed resident #005 and the resident told him that he/she had suffered abuse from PSW #117. The email also indicated that the resident had recalled the inspector coming to speak with him/her but that the resident did not feel comfortable reporting the abuse.

The licensee failed to comply with:

1. LTCHA 2007, 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 policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. (Refer to WN #002)

2. LTCHA 2007, 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: 2. Abuse of a resident by anyone or

neglect of a resident by the licensee or staff the resulted in harm or risk of harm to the resident. (Refer to WN #003)

3. O. Reg. 79/10, 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 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.
(2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23(1) of the Act, immediately upon the completion of the investigation. (Refer to WN #005)

4. 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. (Refer to WN #006)

The home was first made aware of alleged incidents of staff to resident abuse on a specified date via email from a former employee. The Regional Director attempted to contact the former employee and spoke with them two days after the email was sent. Notes from this phone call provided by the Regional Director alleged that two staff members (PSWs #116 and 117) were "nasty to residents" and discussed an incident of emotional resident abuse by PSW #117 and incident of improper care/emotional abuse by PSW #116.

The Regional Director and the Administrator/Director of Care indicated during interviews that neither staff member was advised when the allegations were made and they both continued to work in the home.

A family member of resident #001 reported to the home that he/she witnessed an incident seven days after the allegations of abuse came from the former PSW, of PSW #116 being forceful and aggressive with his/her family member (resident #001). The family member told the home that resident #001 was scared, embarrassed and upset.

After this allegation, PSW #116 was suspended pending the outcome of an investigation into the incident and has since resigned.

As mentioned above as incident # 4, during the investigation into the allegations against PSWs #116 and #117, PSW #114 reported to the investigator that PSW #117 had emotionally abused resident #005 about 1.5 months prior, by taunting and telling the resident that he/she was going to send in a caregiver that the resident had requested not to have do his/her care. PSW #114 stated to the investigator that he/she reported this to the Administrator/Director of Care a couple of weeks after the incident.

As mentioned above as incident # 9, it was also reported to the Administrator/Director of Care and the investigator that on a specified weekend while the investigation into the alleged abuse was on-going, PSW #117 allegedly emotionally abused resident #007. PSW #102 stated that resident #007 was resisting care and PSW #117 provided improper care and taunted the resident. PSW #117 then reportedly was bragging about what he/she did to resident #007 to other staff in the activity room. PSW #102 reported this to the Administrator/Director of Care the day after it happened. Soon after, the Administrator/Director of Care and the Regional Director were made aware of further allegations of staff to resident abuse by PSW #117 and PSW #117 was notified of the allegations against him/her and was suspended with pay pending the outcome of the investigation.

Because the home did not follow their zero tolerance of abuse and neglect policy by suspending PSW #116 and #117 immediately when the first allegations came forward when the Regional Director first spoke with former PSW #115 and due to the fact that multiple incidents of staff to resident abuse have not been reported by both staff and management over a period of 6 years, residents (specifically #001, #005 and #007), were not protected from abuse by PSWs #116 and #117. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's policies RC-02-01-01, RC-02-01-02 and RC-02-01-03 related to zero tolerance of abuse and neglect of residents are dated April 2016. The home has failed to comply with the following steps within these policies:

- Step 1 states on page 2 of 4 under the section "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" that "any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time.

An investigation into multiple incidents of alleged staff to resident abuse that were stated to have occurred over a six year period was completed by an investigator hired by the home. Based on information gathered by the inspector up to a certain date, it was found that nine PSW staff, past and present, (PSWs # 102, 104, 105, 106, 107, 108, 113, 114 and 115) had witnessed or were aware of alleged verbal, emotional and/or physical abuse of residents and had not immediately reported as per the home's policy. In six of the instances, the abuse was not reported until the time of the investigation.

A telephone interview was conducted with the Administrator/Director of Care and she confirmed being unaware of all but one of the incidents of alleged staff to resident abuse now being reported through the investigation.

– Step 3 on page 2 of 5 under the section "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" states that the Administrator/Designate will ensure that reporting requirements to provincial/regulatory bodies have been completed as required.

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

As per WN #003, the licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident, that resulted in harm or risk of harm, was immediately reported to the to the Director.

- Step 4 on page 3 of 4 under the section "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" states that "disclosure of the alleged abuse will be made to the resident/Substitute Decision Maker (SDM)/Power of Attorney (POA), immediately upon becoming aware of the incident, unless the SDM/POA is the alleged perpetrator.

As per WN #005, the licensee failed to ensure that resident's SDMs, and any other person specified by the resident, were a) immediately notified upon becoming aware of alleged, suspected or witnessed incidents of abuse that resulted in physical injury or pain to the resident, or caused 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.

- Step 2 on page 3 of 4 under the section "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", states to “notify police authorities, as per jurisdictional legislative requirements if applicable".

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

A per WN #006, the licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

- Steps 1-3 on page 3 of 5 under the section titled "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" state the following:
1. "Advise the employee that there has been a report of suspected or witnessed abuse or neglect toward a resident."
2. "Immediately advise the employee that they are being removed from the work schedule, with pay, pending investigation."
3. "Following advice to the employee, immediately remove the employee from the work schedule, with pay, pending investigation."

The home was first made aware of alleged incidents of staff to resident abuse on a specified date via email from a former employee. The Regional Director attempted to contact the former employee and spoke with them two days later. Notes from this phone call provided by the Regional Director alleged that two staff members (PSWs #116 and 117) were "nasty to residents" and discussed an incident of alleged emotional resident abuse by PSW #117 and an incident of alleged improper care/emotional abuse by PSW #116.

The Regional Director and the Administrator/Director of Care indicated during interviews that neither staff member was advised when the allegations were made and they both continued to work in the home. [s. 20. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident, that resulted in harm or risk of harm, was immediately reported to the to the Director.

The licensee was first made aware of alleged incidents of staff to resident abuse on a specified date via email from a former employee. The Regional Director made contact with the former employee and spoke with them two days later. During this phone call, former PSW #115 reported to the Regional Director alleged staff to resident emotional abuse and improper care by two staff members, PSWs #116 and #117.

During an interview with the Regional Director, she stated she did not report immediately to the Director because the home did not want to alert PSW #117 of being investigated. The Regional Director said that she did believe former PSW #115 when he/she initially made the abuse allegations against the two staff members.

During telephone interviews with the Administrator/Director of Care, she stated that she had a bad feeling about the abuse allegations from the start . She states she knows she should have notified the Director at the time of the allegations. She also stated that she had contact with the investigator periodically through the investigation and he did tell her about some of his interviews with staff. She again indicated that she knows it was a mistake not to notify the Director as they found out about each alleged incident of abuse.

The Director was not notified immediately of the alleged incidents of staff to resident abuse brought forward over an approximate two month period through an investigation into the allegations. The home submited a Critical Incident Report related to the multiple allegations of staff to resident abuse the day the investigator presented his preliminary findings. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that an oxygen machine was readily available to meet the nursing and personal care needs of a resident.

According to the progress notes, on a specified date, RN #119 went to give resident #010 medication at at a certain time and found the resident to be in respiratory distress. The notes indicate that the RN rushed out to find oxygen. The progress notes indicate that the machine and nasal canula were found. The resident was noted to have stopped breathing about forty minutes later and was identified as DNR (Do not resuscitate).

During a phone interview with RN #119 on August 15, 2016, he/she indicated that at the time of the incident, he/she was unsure of where the oxygen machine was and recalls that tanks were being put in different spots and several staff were unsure of their location. The RN stated that after resident #010 passed away, there was communication to staff that oxygen machines were to be kept in a consistent place. When RN #119 was asked how long it took to find the oxygen machine, he/she was unsure.

Other staff that worked on the evening shift when resident #010 passed away (PSW # 105, PSW #115 and RPN #112) all indicated that the staff were unable to immediately locate the oxygen machine when trying to find it for the resident. PSW #105 indicated that it was he/she who finally found a spare oxygen machine in the clean utility room.

During a telephone interview with the Administrator/Director of Care, she recalled that she had just started as Director of Care at the time of the incident and was frustrated that registered staff were not putting equipment back where it was supposed to be kept. She stated that the oxygen concentrators were to be kept in the family room across from the nursing station at that time. She further stated that after the incident, a memo went out to staff related to where the oxygen concentrators should be stored.

An oxygen machine was not readily available to meet the nursing and personal care needs of resident #010 on a specified date. [s. 44.]

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).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's SDMs, and any other person specified by the resident, were a) immediately notified upon becoming aware of alleged, suspected or witnessed incidents of abuse that resulted in physical injury or pain to the resident, or caused 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.

The licensee also failed to ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

The licensee was first made aware of alleged incidents of staff to resident abuse on a specified date via email from a former employee. The Regional Director made contact with the former employee and spoke with them two days later via telephone. During this phone call, former PSW #115 reported to the Regional Director alleged staff to resident emotional abuse and improper care by two staff members, PSWs #116 and #117. The home hired an investigator to conduct an investigation into the allegations. The investigator reported to the home, approximately two months later, multiple incidents of alleged staff to resident verbal, emotional and/or physical abuse by PSWs #116 and #117.

An interview with the Administrator/Director of Care confirmed that no residents or resident SDMs/POAs have been informed of the alleged incidents of staff to resident abuse.

The investigator indicated to the inspector via email that his final investigation report was sent to the home on a specified date.

A telephone interview with the Administrator/DOC confirmed that involved residents and resident SDM's had not yet been notified of the results of the abuse investigation. [s. 97. (1) (a)]

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

Findings/Faits saillants :

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

The licensee was first made aware of alleged incidents of staff to resident abuse on a specified date via email from a former employee. The Regional Director made contact with the former employee and spoke with them two days later via telephone. During this phone call, former PSW #115 reported to the Regional Director, alleged staff to resident emotional abuse and improper care by two staff members, PSWs #116 and #117. The home hired an external investigator to conduct an investigation into the allegations, who further reported to the home approximately two months later, multiple incidents of alleged staff to resident verbal, emotional and/or physical abuse by PSWs #116 and #117.

Interviews with the investigator, the Regional Director and the Administrator/Director of Care all confirmed that they felt some of the reported incidents may constitute a criminal offence. The interviews also confirmed that as of ten days after the preliminary report from the investigator, the police had not yet been notified of any of the incidents of alleged staff to resident abuse.

The investigator stated that a copy of the final investigation report was given to the home on a specified date, approximately one month after sharing his preliminary results. This final report indicated that there was sufficient evidence to conclude that PSW #117 had committed verbal, physical and emotional abuse of residents in the home.

A phone call was later received from the Administrator/Director of Care stating that the police had been notified two days after the home received the final investigation report from the investigator. The police were not notified immediately of the alleged staff to resident abuse that the licensee suspected may constitute a criminal offence. [s. 98.]

Issued on this 16th day of September, 2016

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) :	JESSICA PATTISON (197)
Inspection No. / No de l'inspection :	2016_347197_0021
Log No. / Registre no:	017814-16, 023545-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 15, 2016
Licensee / Titulaire de permis :	DEEM MANAGEMENT LIMITED 2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5
LTC Home / Foyer de SLD :	WELLINGTON HOUSE NURSING HOME 990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Joseph Barnhartd

To DEEM MANAGEMENT LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

- All staff, including members of the management team, are re-educated on the home's prevention of abuse and neglect policies #RC-02-01-01, RC-02-01-02 and RC-02-01-03.

- All staff, including members of the management team, are re-educated on the Long-Term Care Homes Act and Regulations, specifically the following sections:
LTCHA 2007, s. 19 related to the home's duty to protect residents from abuse and neglect
LTCHA 2007, s. 20(1) related to complying with the home's abuse policy
LTCHA 2007, s. 24(1) related to immediate reporting of resident abuse and neglect
O. Reg. 79/10, s. 97 related to notifying residents and their SDMs of alleged abuse and the outcome of the investigation
O. Reg. 79/10, s. 98 related to immediate notification of the police of abuse that may constitute a criminal offence

- All staff are re-educated on how to identify resident abuse and neglect

In addition to the above order, the home shall immediately notify residents and their SDMs of any alleged incidents of abuse and the outcome of the home's investigation into these incidents. The home shall also immediately investigate further any allegations of staff to resident abuse that came to light during the investigation and take appropriate actions according to the home's abuse policy and the Long-Term Care Homes Act and Regulations.

The plan shall be submitted by September 23, 2016 to Inspection Team Lead, Lyne Duchesne, via fax at 613-569-9670.

Grounds / Motifs :

1. The licensee has failed to protect residents #001, #005 and #007 from abuse by PSW #116 and #117.

On August 9, 2016, an inspection began for a Critical Incident related to an allegation of staff to resident abuse. Once in the home, the inspector noted that the allegations included those of verbal, emotional and physical abuse towards multiple residents.

O. Reg. 79/10, s. 2(1) defines verbal, emotional and physical abuse.

The definition of "verbal abuse" includes,
a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident

The definition of "emotional abuse" includes,
a) 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

The definition of "physical abuse" includes,
a) the use of physical force by anyone other than a resident that causes physical injury or pain

On a specified date, an email was forwarded to the Regional Director for the home by a former staff member, PSW #115. This former staff member alleged having "witnessed abuse time and time again and reported it, just to have nothing come of it". The email referenced a particular group of staff that were causing the abuse and neglect of residents. No names of staff were provided in the email.

An investigation has taken place into the alleged incidents of abuse by an external investigator hired by the home. The investigator shared his preliminary findings with the home via teleconference approximately two months after the initial allegations were made.

At that point, the following acts of staff to resident abuse were alleged to have been committed by PSWs #116 and #117:

1 - Former employee PSW #113 stated to the investigator that late in a particular year, PSW #117 completed his/her orientation and they were working with resident #013. PSW #113 told the investigator that the resident was cognitively well and could understand. PSW #113 stated that he/she and PSW #117 were toileting the resident and PSW #117 made an emotionally abusive remark to the resident. PSW #113 indicated being shocked, but didn't report anything at the

time. PSW #113 told the investigator that the resident looked like he/she was going to cry but did not say anything.

Former PSW #113 indicated to the investigator that the following day, he/she and PSW #117 were working with another resident (#016) and that they had to use a sling. PSW #117 was putting the sling strap on the resident and hit the resident with the strap. Former PSW #113 was unsure exactly how it happened but felt it was done on purpose because there was no apology from PSW #117. PSW #113 reported that the resident did not say anything at the time but that the resident did not like PSW #117. He/she said they knew the resident did not like PSW #117 because he/she would lose his/her smile when PSW #117 walked into the room. Former PSW #113 did not tell the investigator if this incident was reported immediately, but said later in the interview that he/she did tell management and would not work with PSW #117 anymore because of the way he/she is and the way he/she treats residents.

2 - Former PSW #115 told both the inspector and investigator that around a particular date, he/she was working with PSW #116 and witnessed him/her make an emotionally abusive comment while providing care to resident #006. Former PSW #115 was unsure if the resident heard the comment due to his/her hearing impairment. Former PSW #115 indicated to the inspector that he/she did report this incident to management at the time.

3 – Former PSW #115 stated to both the inspector and private investigator that around a particular date at the end of a shift, staff were standing around when PSW #117 grabbed a baby doll from resident #003, who loved the doll and thought it was a real baby. PSW #115 said that PSW #117 grabbed the doll, hit it on a table a few times and threatened to drown the doll. PSW #115 also said that PSW #117 was in the resident's face and yelled at them with hands in the air. Former PSW #115 told the inspector that the resident appeared scared. Former PSW #115 told the inspector and investigator that he/she waited about one week and then reported this incident to the Administrator at the time, #120. This former PSW told the inspector that he/she reported resident abuse regularly to Administrator #120, who no longer works in the home. He/she said they now know that this former Administrator did not report the incidents of alleged abuse to the Director (Ministry of Health and Long-Term Care) or to Head Office. Former PSW #115 said he/she gained a reputation for reporting and staff disliked him/her because of it. PSW #115 also told the inspector that the primary reason he/she quit working at the home was because of PSWs #116

and #117 and how they treated residents. Former PSW #115 stated at one point he/she stopped reporting resident abuse because nothing was being done.

4 – On a particular date, PSW #114 told the investigator that about 1.5 months ago, resident #005 requested that PSW #114 not do the resident's care. PSW #117 found out that the resident requested this and would allegedly get resident #005 upset by saying "I'm going to send PSW #114 in to do your care". PSW #114 said he/she knew this because resident #005 told him/her. PSW #114 told the investigator that he/she reported this to the Administrator/Director of Care a couple of weeks after the incident occurred.

5 - PSW #105 told the inspector and investigator that he/she has heard PSW #117 makes fun of residents. Specifically, PSW #105 stated that PSW #117 has in the past made fun of resident #002 who no longer lives in the home. PSW #105 said that PSW #117 has also allegedly been verbally and emotionally abusive towards residents #004 and #005. PSW #105 also said that PSW #117 is rough with resident #009 and does not follow procedure when moving the resident. PSW #105 said that another resident, #013, was hard to care for and told the investigator that PSW #117 would be sarcastic with the resident and make the resident angry. PSW #105 told the inspector that these incidents were not reported to management.

6 - PSW #107 reported to the inspector and investigator that PSW #117 is rough with residents. He/she said when PSW #117 rolls residents over, their legs bang on the bars and PSW #117 just doesn't care. Specifically, PSW #107 alleged witnessing an incident of physical abuse towards resident #008. PSW #107 told the investigator that he/she was new and should have reported the incident but did not. PSW #107 then recalled another time, the same resident was refusing care and PSW #117 was forceful with the resident. PSW #107 states he/she heard PSW #117 tell the story in a bragging manner to other staff, but did not actually witness the incident. PSW #107 also told the inspector that a student PSW (#122) was with PSW #117 during this incident and also told him/her about PSW #117 being forceful with the resident during care.

PSW #107 further stated to the investigator and inspector that PSW #117 is rude when talking about resident #005, calling the resident names and making emotionally abusive remarks. PSW #107 stated that PSW #117 makes these remarks loudly in the hall in front of other staff and residents. Due to where the resident's room is, he/she feels it's possible that resident #005 has heard the

comments. PSW #107 told the inspector that he/she could not recall if this was reported to management. PSW #107 told the inspector that he/she had reported incidents of resident abuse to the past Administrator #120, but that he/she felt intimidated by PSW #117 and so there were other incidents he/she heard and saw that were not reported.

6 - PSW #104 stated to the inspector and investigator that he/she has heard PSW #117 make fun of residents. Specifically, PSW #117 has called resident #005 names and allegedly does this right outside of the resident's room and he/she feels the resident could probably hear what PSW #117 has said. PSW #104 reports that another time, he/she witnessed PSW #117 take resident #002's doll and play with the doll in front of the resident. PSW #104 stated it was very upsetting to watch. PSW #104 told the inspector that he/she did not report either of these incidents when they occurred.

7 - PSW #102 told the inspector and the investigator that he/she had heard PSW #117 talk about a time when he/she had provided care to resident #008 in a forceful manner. The resident was resistant to care and PSW #117 got mad and was forceful with the resident. PSW #102 then noted that PSW #117 shared this story with other staff as if he/she was proud of what was done. PSW #102 also recalled a time that he/she witnessed PSW #117 take resident #003's clothes off in an aggressive manner. PSW #102 told the inspector that he/she reported the incident with resident #003 to Administrator #120 at the time.

8 - PSW #108 stated to the inspector that on a specified date, they had a new admission, resident #014. He/she states that at shift change, PSW #117 allegedly made emotionally abusive remarks to three or four staff in the hallway about the resident while the resident was sitting there. PSW #108 states he/she did not feel the resident would have had the cognitive ability to understand what PSW #117 was saying. The PSW said he/she didn't report this incident because they had just started working in the home and was scared for their job.

PSW #108 also indicated to the inspector that on a particular date that could not be recalled, resident #015 sustained an injury and when the resident returned from the hospital, reported to him/her that it was a staff member who was physically abusive and caused the injury. PSW #108 says he/she researched when the injury occurred and PSW #117 was caring for the resident on that shift. PSW #108 stated that after this incident, PSW #117 would transfer the resident in a rough and forceful manner. PSW #108 stated that PSW #117 would transfer

other residents this way and feels it was physically abusive towards the residents.

PSW #108 states he/she did not report these incidents of alleged abuse at the time since he/she did not trust the Administrator (#120) that was in place, but states they would report immediately now.

During a phone interview with the Administrator/Director of Care, she was asked about the above incident alleging that resident #015 was physically abused by PSW #117 and sustained an injury. The Administrator/DOC indicated being made aware of this alleged physical abuse through the investigation, but had not yet looked further into the allegation. The inspector placed a telephone call to PSW #108 to get further information about this incident but was unable to reach the staff member.

9- In addition to the investigation notes seen by the inspector, PSW #102 reported to the inspector and to the DOC, the day after the incident occurred, that on a specified date while the investigation was being conducted, resident #007 was resisting care and he/she alleges witnessing PSW #117 being emotionally abusive towards the resident. PSW #102 states he/she did not report the incident immediately, but waited until the following business day when the Administrator/DOC was back in the home.

The inspector conducted interviews with residents #003, #004, #005, #007, #008 and #009 who still reside in the home. Only resident #005 was interviewable and knew who PSW #117 was. Resident #005 did not confirm to the inspector if PSW #117 had ever been verbally and/or emotionally abusive.

On a specified date, the investigator hired by the home emailed the inspector indicating that he had interviewed resident #005 and the resident told him that he/she had suffered abuse from PSW #117. The email also indicated that the resident had recalled the inspector coming to speak with him/her but that the resident did not feel comfortable reporting the abuse.

The licensee failed to comply with:

1. LTCHA 2007, 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 policy to promote zero tolerance of abuse and neglect of residents, and shall

ensure that the policy is complied with. (Refer to WN #002)

2. LTCHA 2007, 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: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff the resulted in harm or risk of harm to the resident. (Refer to WN #003)

3. O. Reg. 79/10, 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 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.
(2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23(1) of the Act, immediately upon the completion of the investigation. (Refer to WN #005)

4. 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. (Refer to WN #006)

The home was first made aware of alleged incidents of staff to resident abuse on a specified date via email from a former employee. The Regional Director attempted to contact the former employee and spoke with them two days after the email was sent. Notes from this phone call provided by the Regional Director alleged that two staff members (PSWs #116 and 117) were "nasty to residents" and discussed an incident of emotional resident abuse by PSW #117 and incident of improper care/emotional abuse by PSW #116.

The Regional Director and the Administrator/Director of Care indicated during interviews that neither staff member was advised when the allegations were made and they both continued to work in the home.

A family member of resident #001 reported to the home that he/she witnessed an incident seven days after the allegations of abuse came from the former PSW, of PSW #116 being forceful and aggressive with his/her family member (resident #001). The family member told the home that resident #001 was scared, embarrassed and upset. After this allegation, PSW #116 was suspended pending the outcome of an investigation into the incident and has since resigned.

As mentioned above as incident # 4, during the investigation into the allegations against PSWs #116 and #117, PSW #114 reported to the investigator that PSW #117 had emotionally abused resident #005 about 1.5 months prior, by taunting and telling the resident that he/she was going to send in a caregiver that the resident had requested not to have do his/her care. PSW #114 stated to the investigator that he/she reported this to the Administrator/Director of Care a couple of weeks after the incident.

As mentioned above as incident # 9, it was also reported to the Administrator/Director of Care and the investigator that on a specified weekend while the investigation into the alleged abuse was on-going, PSW #117 allegedly emotionally abused resident #007. PSW #102 stated that resident #007 was resisting care and PSW #117 provided improper care and taunted the resident. PSW #117 then reportedly was bragging about what he/she did to resident #007 to other staff in the activity room. PSW #102 reported this to the Administrator/Director of Care the day after it happened. Soon after, the Administrator/Director of Care and the Regional Director were made aware of further allegations of staff to resident abuse by PSW #117 and PSW #117 was notified of the allegations against him/her and was suspended with pay pending the outcome of the investigation.

Because the home did not follow their zero tolerance of abuse and neglect policy by suspending PSW #116 and #117 immediately when the first allegations came forward when the Regional Director first spoke with former PSW #115 and due to the fact that multiple incidents of staff to resident abuse have not been reported by both staff and management over a period of 6 years, residents (specifically #001, #005 and #007), were not protected from abuse by PSWs #116 and #117.

The home's compliance history was reviewed for the past 3 years:

In September 2016, the home was issued a Written Notification related to O.Reg 79/10, s. 97(2) in that the home did not immediately notify a resident of the outcome of an investigation into her allegations that a staff member had abused her.

In August 2015, the home was issued a Voluntary Plan of Correction for failing to comply with LTCHA 2007, s. 20(2) in that they did not ensure that their prevention of abuse and neglect policy contained a full explanation of the duty under section 24 of the Act to make mandatory reports.

In January 2015, the home was issued a Written Notification related to LTCHA 2007, s. 20(2) in that they did not ensure that their prevention of abuse and neglect policy contained a full explanation of the duty under section 24 of the Act to make mandatory reports.

The severity of harm in the incidents described above was determined to be "actual harm" and the scope was identified as "pattern" since 14 residents were allegedly verbally, emotionally and/or physically abused by PSWs #116 and #117 over a period of six years. (197)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

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

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

Issued on this 15th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jessica Pattison

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