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**

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 18, 2016 | 2016_268604_0007 | 005484-16 | Resident Quality Inspection |

## Licensee/Titulaire de permis

WOODS PARK CARE CENTRE INC.
110 LILLIAN CRESCENT BARRIE ON L4N 5H7

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

WOODS PARK CARE CENTRE
110 LILLIAN CRESCENT BARRIE ON L4N 5H7

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

SHIHANA RUMZI (604), DIANE BROWN (110), VALERIE JOHNSTON (202), VALERIE PIMENTEL (557)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): February 24, 25, 26, and 29, March 1, 2, 3, 4, 7, 8, 9, and 10, 2016.**

**The following intakes were inspected concurrently with the Resident Quality Inspection:**
**Log #003186-14, Log #0031630-14, Log #06869-14, Log # 008510-14, Log #005080-14, Log #010211-14, Log #009843-15, Log #007565-15, Log #007681-15, Log # 030107-15, Log #023215-15, Log #034345-15 and Log #000685-16.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Practical Nurse Special Projects (RPNSP), Life Skills Coordinator (LSC), St. Elizabeth College Preceptor, Recreation Assistant (RA), Recreational Therapist (RT), Maintenance Manager (MM), Physiotherapist (PT), Registered Dietitian (RD), Food Service Manager (FSM), Director of Dietary Services, Nutritional Aide (NA), Director of Resident/Family Services (DRFS), Residents, Substitute Decision Makers (SDMs), and Presidents of Residents' and Family Council.**

**During the course of the inspection, the inspectors conducted a tour of the home, made observations of: meal service, medication administration, staff and resident interactions, provision of care, conducted reviews of: health records, complaints and critical incident logs, employee files, staff training records, meeting minutes of Residents' and Family Council meetings, and relevant home policies and procedures.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Snack Observation**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**

- **16 WN(s)**
- **9 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 all residents are protected from abuse by anyone.

The home has been subject to a previous non-compliance under section 19 (1) of the Act, where by compliance order #001 was issued to the home April 22, 2015, under inspection report #2015_414110_0004.

The home was required to be in compliance by July 31, 2015.

On an identified date, a follow up inspection for compliance order #001 was conducted.

Staff were interviewed throughout the home and questioned as to whether they had witnessed abuse in the home or if a resident had reported that they had been abused by staff. The following statements were obtained:

RPN #110 revealed that sometime on an identified date, he/she noticed that PSW #148 had been providing care to an identified resident in an inappropriate manner. The RPN indicated that around the same time, a number of PSWs and two Nutritional Aide (NA) also noticed that PSW #148 was providing inappropriate care to residents.

RPN #110 further stated that at around this same time, an identified resident had complained to him/her while in an identified area one day that he/she did not favour the staff, referring to PSW #148 and could sense that the resident was fearful of PSW #148.

RPN #110 also revealed that on an identified month, PSW #101 and NA#139 had reported that an identified resident had been brought to an area of the home and was found to be fearful. RPN #110 indicated that he/she did not work that day but did recall reading documentation to support PSW #101 and NA #139's concerns. RPN #110 further indicated that upon a discussion with other PSWs working on the identified home area, it had been identified by the team that an identified resident had become more fearful, and that fear had been making them uncomfortable. The staff decided that it was the right time to report the suspected alleged abuse to the DOC.

RPN #110 indicated that after the conversation with the PSW's, he/she reported to the DOC and reported the same incident again on an identified day, after an identified residents' family member reported that the resident had reported to him/her that he/she had been physically harmed.

PSW #101 revealed that an identified resident had reported to him/her that PSW #148 was mistreating him/her and that he/she was unkind to the resident. PSW #101 further revealed that when PSW #148 would walk near the identified resident, the resident would

shake and that he/she could tell that he/she was fearful of PSW #148.

An interview with LSC #142 revealed that an identified resident had been visibly upset on an identified time period. LSC #142 further revealed that on an identified date, the resident became upset and pointed to PSW #148, and stated the staff member had physically harmed him/her.

NA #139 revealed that several months ago, he/she witnessed PSW #148 attempting to get an identified resident to come for a meal. The NA revealed that the resident had refused; however, once the PSW got the resident into an identified location of the home, the resident was visibly upset and would not eat.

PSW #105, indicated that he/she had been concerned about PSW #148's task orientated behaviours, and had witnessed PSW #148 make an identified resident do an activity by force and had grabbed the identified resident by his/her body pulling the resident up to a perform an activity beyond residents capabilities. PSW #105 indicated that after the witnessed incident and as time passed, the identified resident was notably more fearful and had made statement that he/she was "scared". PSW #105 further indicated that the resident also reported that he/she had been physically harmed by PSW #148, which was not of an identified resident's character. PSW #105 indicated that after a discussion with his/her colleagues it was decided that PSW #148 be reported to the DOC.

RA #144 revealed that on an identified date, an identified resident reported to him/her that a staff member physically harmed him/her. The RA indicated that he/she reported the concern to his/her supervisor RT #145 and documented the statement on the following day in a progress note as late entry on an identified date.

RT #145 revealed no awareness of the concerns raised by an identified resident from staff. The RT indicated that he/she did recall discussing PSW #148 among the recreational staff acknowledging that PSW #148 had been rough with residents and that the PSW did not have the skill set to handle cognitively impaired residents. The RT indicated that after the discussion with the team, he/she directed the recreational staff to document everything and report to the charge nurse with any concerns.

A review of the above mentioned identified resident's progress notes of an identified three month period, revealed the following:

-On an identified date: RPN #113 documented that an identified resident began shaking

and verbalized being physically harmed.

-On an identified date: LSC #142 documented that an identified resident indicated he/she was being physically harmed and disliked this staff member.

- On an identified date RA #144 documented that an identified resident stated the resident was physically harmed and that a staff member was mean to him/her.

- On an identified date: RPN #110 documented that an identified resident's family member reported that resident had reported to him/her that he/she had been physically harmed.

An interview with the DOC confirmed receipt of the above mentioned allegations of abuse late on an identified month. The DOC indicated that the home began an investigation once the home was aware of the alleged abuse, and PSW #148's actions were found to be a complete disregard to the resident's feelings and abusive in nature. PSW #148 received a three day suspension and was re-assigned to another home area.

RPN #110, NA#139, PSW #105, PSW #101, all indicated in interviews that after PSW #148 had been reassigned to another home area within the home, the identified resident has not expressed fear at any time after PSW #148 had been reassigned.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual. The scope of the non-compliance is isolated.

A review of the home's compliance history revealed that LTCHA, 2007, c.8, s.19 (1), has been the subject of previous non-compliance, identified in Resident Quality Inspection #2015_414_110_0004, whereby order #001 was issued to the home on April 22, 2015.

***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. 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 a person who has reasonable grounds to suspect that any
of the following has occurred or may occur 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.

On an identified date, a follow up inspection was conducted, which revealed the following. Staff were interviewed throughout the home and questioned as to whether they had witnessed abuse in the home or if a resident had reported that they had been abused by staff. The following statements were obtained:

RPN #110 revealed in an interview that sometime in an identified period of 2015, he/she noticed that PSW #148 had been rough with residents. The RPN indicated that around the same time, a number of PSWs and two NA's also noticed that PSW #148 had been rough. The RPN further indicated that at the time it was difficult to determine if it was abuse, as the PSW may not have known he/she was visibly rough with residents.

RPN #110 stated that at around this same time, resident #001 complained to him/her about PSW #148 and indicating dislike towards a PSW staff member. The RPN indicated that he/she could sense the resident was fearful of PSW #148, but was not sure as to why.

RPN #110 revealed on an identified date, PSW #101, and NA #139, had reported to him/her that resident #001 had been observed to be fearful. RPN #110 indicated that upon further discussions with other PSWs working on the identified home area, it was confirmed that resident #001 had become more fearful, and that the resident's increased fear had been making them uncomfortable. RPN #110 indicated on an identified date, when he/she reported to the DOC and again on a second identified date, after receiving the same concern from the resident's family member.

An interview with LSC #142 revealed that resident #001 was visibly upset last year. LSC #142 further revealed that on an identified date, while walking in an identified area of the home with resident #001, the resident became upset and pointed to PSW #148, and stated the staff member harmed the resident. When asked of the LSC if the resident's statement had been reported, the LSC confirmed that he/she documented a behavioural note in the progress notes and did not report the statement further. The LSC indicated that with any abuse, he/she had been directed by management that "if you do not see it, then just document it". The LSC confirmed that this is what he/she did.

When asked of PSW #105, whether he/she had witnessed abuse, the PSW indicated that he/she had been concerned about PSW #148's task orientated behaviours, but was unsure if his/her actions were actual abuse. PSW #105 described a time when he/she witnessed PSW #148 make resident #001 perform an activity beyond his/her will by taking resident #001 and forcing resident to perform the activity. PSW #105 indicated that he/she did not report the incident at the time, however, as time passed, resident #001 was notably more fearful and would often state that he/she was "scared". After the resident had reported to PSW #105 that he/she had been harmed by PSW #148, which PSW #105 indicated was not of resident #001's character, PSW #105 had decided to discuss the issue with other PSWs and the decision was made to report to the charge nurse at this time, which the PSW indicated time period.

An interview with RA #144 revealed that while taking resident #001 to an activity on a specified date, the resident reported to him/her that a staff member had harmed the resident. The RA indicated that he/she reported the concern to his/her supervisor RT

#145 and documented the statement on the following day in a progress note.

An interview with RT #145 revealed no awareness of the concerns raised by resident #001 from staff. The RT indicated that he/she did recall discussing PSW #148 among the recreational staff acknowledging that PSW #148 had been rough with residents and that the PSW did not have the skill set to handle cognitively impaired residents. The RT indicated that at that time he/she had directed the recreational staff to document everything and report to the charge nurse with any concerns.

An interview with the DOC confirmed receipt of the above mentioned allegations of abuse was identified last year, but was unable to verify the exact date. The DOC indicated that the home began an investigation on an identified date, and PSW #148's actions were found to be a complete disregard to the resident's in the home and abusive in nature. PSW #148 received a three day suspension and was re-assigned to another home area.

The DOC confirmed that the MOHLTC Director had not been notified at any time regarding the
suspected improper or incompetent treatment or care or physical abuse by PSW #148 toward
resident #001.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

The scope of the non-compliance is widespread.

A review of the home's compliance history revealed that LTCHA, 2007, c.8. s. 24 (1), has been thesubject of previous non-compliance, identified in Resident Quality Inspection #2015_414_110_0004, issued April 22, 2015. [s. 24. (1)] (202)

***Additional Required Actions:***

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

**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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).**

**s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

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

**s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,**
**(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).**
**(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was a written plan of care for each resident, which set out clear directions to staff and others who provided direct care to the resident.

Record review of the written plan of care for resident #006 identified specific care which is to be provided to the resident by the home's staff.

An interview conducted with PSW #107, identified that the PSW reviewed and referred to the resident's written plan of care and was aware of the care that is to be provided. The kardex and written plan of care were reviewed with the PSW, the kardex indicated to provide specific care at specified intervals for resident #006.

An interview with Registered Practical Nurse (RPN) #103 confirmed the resident #006 should be provided with the specific care at different specified intervals for resident #006.

An interview with the Associate Director of Cares (ADOC) revealed residents receiving the specified care should receive it at the different specified intervals and confirmed the written plan of care and did not set out clear direction to the direct care providers. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

The inspector observed resident #019 utilizing a mobility device and was positioned as directed by the manufacturer on eight identified dates. On two identified dates, resident #019 was observed to be in the mobility device in two different positions.

Documentation review of the written plan of care revealed the following:
-resident #019 was dependent on a mobility device.
-An assessment section identified that resident #019 was high risk for falls.

On an identified date, the PT assessment was completed and the resident was recommended to use a different mobility device. Resident #019's kardex identified that a personal alarm is to be used at all times when resident is using his/her mobility device and when in bed.

Interviews conducted with PSW #117 and #120, confirmed resident #019 had a change in mobility device for the resident's safety. PSW #117 indicated that he/she does not like to the change in mobility device as resident #019 cannot mobilize themselves.

An interview with PT and RPN #119 confirmed that neither the physiotherapy department

nor the nursing department collaborated with each other in the development and implementation of the plan of care so that the information regarding the changes to the care were integrated, consistent and complement each other for resident #019 in regards to his/her mobility needs. [s. 6. (4) (a)]

3. On an identified date and home area, the PM snack service was observed, PSW#134 offered resident #031 a specific snacks.

PSW #134 indicated resident #031 has requested the specific snack since he/she moved to the unit and staff have been serving resident #031 as per resident's request.

Review of resident #031's written plan of care identified resident's diagnosis with no indication for the requested snack by the resident during the PM snack.

An interview with the Registered Dietitian (RD) revealed the specific snacks was a lot to give resident #031. The RD was unaware resident #031 was requesting and that staff were regularly providing the resident with their requested PM snack. The RD confirmed he/she was not informed by nursing of resident #031 receiving a requested snack during evening snack. [s. 6. (4) (b)]

4. The licensee has failed to ensure that different approaches were considered in the revision of the plan of care if the plan of care was being revised because the care set out in the plan had not been effective.

Record review of resident #008's progress notes, on an identified date, revealed the RD's annual assessment identified resident #008 experienced weight loss over the past year and the past quarter, and placed resident below his/her goal weight range.

The written plan of care was revised to change the goal weight range from its current range to a range 4kg less, as a realistic goal with no further changes to achieve the original goal. Resident #008's weight continued to decrease by 5kg. A referral was sent to the RD on January 26, 2016, to address this additional weight loss.

Interviews with PSW #017 and Nutritional Aide (NA)#127 revealed that the resident often requests less than full servings at meals.

An interview with resident #008 revealed that he/she had lost weight since coming to the home. The resident revealed a preference to weigh within the original goal weight range.

An interview with the RD revealed that different approaches were not considered when reviewing and revising resident #008's nutritional plan of care when resident's goal weight was not achieved in May 2015.

5. Documentation review revealed resident #019 had 124 documented responsive behavioral notes between an identified time period in 2016. The responsive behavioral notes described numerous behaviors in identified locations of the home.

Record review of resident #019's written plan of care revealed the following focuses, goals and interventions:
- On an identified date, the written plan of care described the resident's temperament. Goals were set to ensure resident will experience a better mood with identified interventions for the behaviors.
- On a different identified date, the written plan of care described the resident as having ineffective coping mechanism. Goals were set to ensure safety of residents and staff, and for staff to recognize and avoid behaviors which would provoke the resident. Interventions for these behaviors were identified at that time, as well as, some revisions were made on three identified dates.

An interview with RPN #124 confirmed the plan of care is reviewed but not always revised.

Interviews with the Director of Care (DOC) and Administrator confirmed they were not aware of the number of responsive behaviors displayed by resident #019 within a set date range. The DOC further confirmed that different approaches should have been considered in the revision of the plan of care. [s. 6. (11) (b)]

6. Record review of resident #007's written plan of care revealed quarterly assessment documentation on an identified date, by the RD which identified resident #007's weight. The resident's weight was assessed as a significant loss in the past quarter, an underweight Body Mass Index (BMI) was identified and a statement the resident was now below his/her goal weight range.

The written plan of care was revised to introduce feeding aides and to change the goal weight range from his/her previous set goal weight range to a range 2-5kg leass as a realistic goal with no further changes or nutrition interventions to achieve the original goal weight range.

Record review revealed on an identified date, during the RD quarterly assessment it identified resident #007's weight which remained at low body weight with a low BMI and is below the new goal range.

The plan of care was to continue with the current interventions. The RD lowered the resident's goal weight range once again to reflect a realistic goal.

Observations made over the course of this inspection identified that resident #007 was served undersized portions of minced steak and mushroom pie at lunch on an identified date, and was not offered a PM snack on an identified date, all contrary to resident #007's written plan of care.

An interview with the RD revealed that different approaches were not considered when reviewing and revising resident #007's nutritional plan of care when resident's weight goal was not achieved. [s. 6. (11) (b)]

7. Record review of resident #009's progress notes revealed the RD documentation on an identified date related to a weight loss assessment in response to a referral. Resident #009's weight was identified at the time of the assessment.

The RD assessed resident #009's current weight stating the goal weight range had not been achieved.

The written plan of care was revised to lower the resident's goal weight range to a realistic goal with no further changes to achieve the original set goal weight range.

Record review revealed that resident #009 had not maintained or regain weight since an identified date, when no different approaches were considered. Resident #009's weight on an identified date indicated a loss of 1.8kg.

Interview with resident #009, revealed that his/her weight had always been between a set weight. The resident also revealed that he/she wasn't always able to eat a lot as he/she had a medical procedure which impacts resident's intake.

An interview with the RD revealed that different approaches were not considered when reviewing and revising the resident #009's nutritional plan of care for an identified date, when resident's goal weight was not achieved. [s. 6. (11) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that;***
***-There is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.***

***-Staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other.***

***-Different approaches are considered in the revision of the plan of care if the care is being revised because the care set out in the plan has not been effective, to be implemented voluntarily.***

---

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place
(b) was complied with.

During the initial tour of the home conducted on an identified date, resident #043, #044, #051, #071, and #072 on two identified floors were identified with similar health concern.

Documentation review for resident #043, #044, #051, #071, and #072 revealed health assessments were not carried out as per home's policy for the above-identified residents.

Home's identified policy directed staff as to when health assessments where to be carried out for specified health concerns.

Observation and interview conducted with the ADOC, confirmed the home had identified the above residents to have similar health concerns and did not follow the home's identified interventions in conducting health assessments. ADOC identified the home would carry out the health assessments as identified in the home's policy immediately for the residents identified above. [s. 8. (1)]

2. Staff interviews revealed resident #010 had a fall on an identified date and time. Resident was found on the floor sitting between the bed and wheelchair after having attempted to self-transfer.

Home's policy directed staff to completed an identified assessment for the incident.

Documentation review for resident #010, revealed no assessment was carried out for the incident which occurred on an identified date.

Interview conducted with RPN #110 and the DOC revealed an assessment should have been completed for resident #010's incident and confirmed there was no assessment completed on Point Click Care (PCC) as per home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

3. Review of log #030107-15, revealed missing identified narcotics, on an identified floor and date, which was identified during day shift count.

Interview conducted with RPN #116 stated he/she worked on the identified date, they worked night shift on an identified floor. RPN #116 indicated when he/she arrived on the unit RPN #119 handed he/she the medication cart keys, indicated they had carried out the narcotic count and left the unit. RPN #116 stated the unit got busy and he/she did not conduct a narcotic count during their night shift with the off going RPN.

Home's policy "Controlled Substance & Narcotic Count", policy # VII-F-10.50, current revision done January 2015; under procedure directs Registered Nurse (RN)/RPN staff to conduct a controlled and narcotic shift count in the Resident Home Area (RHA) at each shift change. Verification is done with the nurse coming on duty and the nurse going off duty.

Interview conducted with the DOC confirmed narcotic counts are to be conducted with two nurses, one oncoming and off going and on an identified , RPN #116 had not conducted a narcotic shift count till the next morning when the day RN arrived on the unit. DOC confirmed RPN #116 and RPN #119 did not follow home's policy of carrying out a narcotic shift count on their shift. [s. 8. (1) (b)]

4. The home's policy in the LTC Resident Care Manual, titled "Responsive Behavior Management", Policy #VI-F-10.20, current revision date January 2015, identified the registered staff will complete a "Responsive Behavior" assessment or referral whenever there is a change in the residents behaviors and to evaluate the effectiveness of the planned interventions on the care plan.

Record review of resident #019's plan of care revealed in the assessment section of the resident's chart that no responsive behavior referral was completed in the assessment section of PCC. It was also noted the effectiveness of the planned interventions identified were not evaluated, as a result, resident #019 continued to display responsive behaviors as he/she was noted to have approximately 124 documented responsive behaviors notes with in a set time period.

An interview with DOC confirmed the home did not follow the policy in regards to responsive behaviors by evaluating the interventions that were developed for resident #019. [s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.***

---

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

**Specifically failed to comply with the following:**

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**

**1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,**

**i. kept closed and locked,**

**ii.equipped with a door access control system that is kept on at all times, and**

**iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,**

**A. is connected to the resident-staff communication and response system, or**

**B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.**

**O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.**

**4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg.**

**363/11, s. 1 (1, 2).**

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,**
**i. kept closed and locked,**
**ii.equipped with a door access control system that is kept on at all times, and**
**iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,**
**A. is connected to the resident-staff communication and response system, or**
**B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.**
**O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

On an identified date, time, and floor, the inspector observed two non-residential area doors to be opened and unlocked. The rooms consisted of care carts with topical medicated creams for five residents left on top of the care carts.

Observation and interview conducted with RN #100 confirmed that the rooms should have been locked and the RN proceeded to lock the doors.

On another identified date, time, and floor, the inspector observed in an non-residential area a door to be opened and unlocked. The room consisted of the following items: blue razors left on the shower ledge and three ED disinfectant bottles.

An interview conducted with Recreation Assistant (RA) #102 confirmed that the room doors should have been locked and the razors and disinfectant should be kept in the cupboard. The RA proceeded to lock the room door and indicated she/he would get a nursing staff to remove the items found in the room.

An interview conducted with the DOC confirmed all doors which are non-resident areas should be locked at all times when not in use or supervised to ensure safety of residents. [s. 9. (1)]

2. On an identified date, time, and floor, the inspector observed the soiled utility room door to be unlocked with accessibility to disinfectants.

The ADOC present confirmed the door was open and should have been locked. [s. 9. (1) 1.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.***

---

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,**
**(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).**
**(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the registered dietitian who is a member of the staff of the home assessed the resident's nutritional status, including weight and any risks related to nutrition care.

A review of resident #009's written plan of care identified the resident is at high nutritional risk related to low body weight, BMI and slow weight loss of 11 per cent loss over the past year.

Interview with the RD revealed food intake is a component of a nutritional assessment. It was further shared if a resident consistently requests small portions, the RD should be notified and that an intervention would be put in place.

Interview with resident #009, revealed he/she is not a big eater and always requests half portions at lunch and supper.

Interviews conducted with PSW #109 , PSW #130, and Nutritional Aide (NA) #128 confirmed that resident #009 requests half portions at lunch and supper.

An interview with the RD revealed he/she was not aware that resident #009 was regularly requesting small portions and confirmed this nutritional risk was not considered in his/her nutritional assessments of resident #009. [s. 26. (4) (a),s. 26. (4) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the registered dietitian who is a member of the staff of the home assess the resident's nutritional status, including weight and any risks related to nutrition care, to be implemented voluntarily.***

---

**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:**
**1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).**
**2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).**
**3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).**
**4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the following are developed to meet the needs of residents with responsive behaviours, written approaches to care, including screening protocols.

Documentation review for resident #019 revealed 124 documented responsive behavioral notes for a set period of time.

Record review of resident #019's written plan of care revealed identified focus, goals and interventions for behaviors, however, there was no written interventions identified to complete Dementia Observation System (DOS) a screening protocol for behaviors the home uses. DOS was being completed periodically by the PSW staff as observed through documentation review between a set period of time. Previous DOS documentation was found for a set period of time as well.

Interviews with PSW #117 and #120 confirmed they had completed DOS documentation on occasion.

Interviews with the DOC and Administrator confirmed they were unaware that there were 124 responsive behavioral notes documented and staff should have completed the DOS screening tool. [s. 53. (1) 3.]

***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 following were developed to meet the needs of residents with responsive behaviours, written approaches to care, including screening protocols, to be implemented voluntarily.***

---

**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).**

**s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident was offered a minimum of a snack in the afternoon and evening.

Afternoon snack service observation was conducted on an identified date and floor of the home. The snacks were delivered by PSW #134, inspector observed resident #007 was not offered an afternoon snack.

Interview with PSW #134, confirmed an afternoon snack was not offered to resident #007 as the resident required an identified diet and they do not usually offer a snack to resident #007 as there is nothing on the snack cart appropriate for the resident.

Record review of the electronic POC history response, where staff document the amount of snack taken revealed coding the "Resident Refused" the afternoon snack on an identified date. The response was documented by PSW #135.

An interview with the DOC and RD confirmed that the resident should have been offered a snack. Further interview with the DOC and FSM confirmed no awareness that staff

were concerned with the lack of appropriate minced snacks on the snack cart. [s. 71. (3) (c)]

2. The licensee has failed to ensure that planned menu items were offered and available at each meal and snack.

Lunch service was observed on an identified floor and date. The inspector observed the portions sizes of menu items posted and served.

At the end of the lunch meal, the portion sizes served were compared to the required portion size identified on the planned menu with DA #127. NA #127 confirmed the serving sizes used were incorrect and was not according to the planned menu.

Pureed omelette on toast, was served using a #10 scoop (90mls) and not a #12 scoop (80mls) omelette plus 2 x #16 scoop pureed toast (2x 60mls) as planned.

Minced steak and mushroom pie was served using a #8 scoop (125mls) and not a #6 scoop (240mls) as planned.

Pureed beef pie was served using a #10 scoop (90mls) and not a #6 scoop (180mls) as planned.

An interview with the Director of Dietary Services (DDS) revealed that portion sizes are part of the planned menu and staff are required to follow the menu when serving meals and snacks.

The DDS confirmed staff did not follow the planned menu portions and provided smaller portions than required. [s. 71. (4)]

3. On an identified date, the inspector conducted a snack service observation carried out by PSW #134 on an identified location of the home. Observations revealed a PM snack was not offered to resident #007.

On an identified date, a review of the snack menu revealed arrowroot cookies were identified as a PM snack for those residents requiring a specified diet. Observations identified that arrowroot cookies were not available on the PM snack cart.

An interview conducted with PSW #134 confirmed a snack was not offered to resident

#007 and that there was no suitable snack for the resident as resident was on an identified diet.

PSW #134 indicated he/she was unaware of the menu binder on the snack cart which identified arrowroot cookies as the suitable snack choice for those on an identified diet.

PSW #137 was observed serving the PM snacks on an identified location of the home. PSW #137 revealed he/she did not have enough snacks for those residents on an identified diet identifying the two containers of pureed snack returned on the cart as the suitable snack choice.

An interview with the DOC confirmed that PSW staff is expected to follow the snack menu provided and to request items that are not available ensuring that all residents are offered a snack. [s. 71. (4)]

***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 resident is offered a minimum of a snack in the afternoon and evening.***
***-Planned menu items offered and available at each meal and snack, to be implemented voluntarily.***

---

**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:**
**9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Record review of the diet information sheets, available to staff at meal service, and resident #009's written plan of care identified the resident’s need for a special drinking aid for fluids.

On an identified date, resident #009 was observed at breakfast. Three fluids were served and the required drinking aid were not offered or provided for any fluids.

An interview with PSW #130, confirmed that resident #009 was not provided with the required drinking aid for fluids according to his/her plan of care. [s. 73. (1) 9.]

2. Resident #007's plan of care, including the diet type report, for reference by staff serving snacks, identified resident #007's need for a drinking aid for fluids.

Observations of the snack service on an identified date, on an identified floor, revealed a drinking aid was not offered when resident #007 was served a drink.

An interview with PSW #134 revealed he/she was unaware of the need for a drinking aid resident #007’s fluids.

An interview with the DOC confirmed that staff is expected to follow the diet type report, attached to the snack cart, which identifies the special needs of residents. [s. 73. (1) 9.]

***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 residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.***

---

**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff receive training in the area of mandatory reporting under section 24 of the Act, prior to performing their responsibilities.

On an identified date, an order was issued to the home, under section 19 (1) of the LTCHA, 2007, within the inspection report #2015_414110_0004. The order directed the home to amend the licensee's policy to promote zero tolerance of abuse and neglect of residents such that it shall contain an explanation of the duty under section 24 to make mandatory reports and to provide training to all staff, volunteers and students within the home on any changes made to the licensee's policy.

The home was required to be in compliance by July 31, 2015.

On February 27, 2016, a follow up inspection was conducted.

Ten staff were interviewed throughout the home and questioned of their understanding of mandatory reporting under section 24 of the LTCHA. Ten out of ten staff responded in a manner not consistent with the legislative requirement.

The following statements were obtained:

-RPN #100 indicated that he/she did not know the above mentioned section in the legislation and that any and all abuse would be reported to the managers and would trust that the managers do something with the information.

-LFC #101 stated that if he/she witnessed abuse, he/she would document in Point Click Care (PCC), write a note and then call the manager. The LFC indicated that if he/she felt the managers did not deal with the situation, he/she would then call the Ministry.

-RPN #103 indicated that mandatory reporting of abuse means to report any and all abuse to a manager and a letter would be written to the manager. RPN #103 further indicated that she may report to the Ministry only if he/she felt it was abuse, but would definitely report to the manager first.

-NA #104 revealed that any witnessed abuse would be reported immediately to the manager and if he/she felt it was not going anywhere, would call the Ministry at that time.

-PSW #105 indicated in an interview that mandatory reporting of abuse is reporting to the manager and would assume that they take further steps. When asked if education had been provided regarding mandatory reporting of abuse under section 24 of the Act, PSW

#105 responded that it had and that mandatory reporting under section 24 of the Act, means to report to the managers and they are to take the next steps.

-RA #106 stated that mandatory reporting of abuse is, "if we witness it, we have to report it". RA#106 further stated that he/she would report to a manager.

-RT #107 indicated that mandatory reporting under section 24 of the Act, is that abuse is not to be tolerated and you need to take the information directly to the charge nurse, or manager. When asked if the Director would be informed, RT #107 stated that "the manager would have to call the Ministry. The managers would need to determine what happened and decide to investigate and call the Ministry once they determine what it is.

-PSW #111 revealed an understanding that mandatory reporting of abuse under section 24 of the Act, is to report to the nurse and that they would look into it more.

The interviews with the above mentioned staff revealed knowledge of documenting and reporting of abuse to their manager, however, the staff had no knowledge of mandatory reporting under section 24 of the Act, which states, "a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006, 2007, c.8. 24 (1), 195 (2).

The administrator indicated that in response to the order issued to the home on April 22, 2015, all staff in the home received an e-learning session on abuse and neglect and all staff were required to read both of the home's revised abuse policies and sign a declaration which would indicate that the policies had been read and understood. The staff education records and the Administrator confirmed that all staff in the home had received training on abuse and neglect and the revised abuse policies throughout September and October 2015.

A review of the abuse and neglect e-learning module provided to staff and an interview

with the DOC confirmed that the e-learning module did not include training on mandatory reporting of abuse under section 24 of the Act. [s. 76. (2) 4.]

***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 staff receive training in the area of mandatory reporting under section 24 of the Act, prior to performing their responsibilities, to be implemented voluntarily.***

---

**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that is (i) used exclusively for drug and drug-related supplies and (ii) that is secure and locked.

On an identified date and location of the home, the inspector observed two non-residential area doors to be opened and unlocked. Inside the two rooms, the inspector found resident #001, #002, #003, #004, and #005's prescribed medication to be sitting on top of the care carts.

Interview and observation conducted with RN # 100 indicated prescription medications are carried out in the morning to residents by PSW staff and the PSW staff is to return the prescription medication back to the nursing station after use, the RN confirmed the prescription medications were accessible to anyone as both room doors were open and unlocked. The RN proceeded to lock the two room doors, and took the prescription medications to the nursing station.

Interview with the DOC confirmed all prescription medications are to be kept in the nursing station locked when not in use, leaving the medication in non-residential areas with the room door unlocked posed a risk of ingestion or administration of the medication by a resident. [s. 129. (1) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs were stored in an area or medication cart that is (i) used exclusively for drug and drug-related supplies and (ii) that is secure and locked, to be implemented voluntarily.***

---

**WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted, every resident has the right to be properly clothed and cared for in a manner consistent with his or her needs.

On an identified date and floor, the inspector observed resident #015 wearing identified clothing in disrepair.

On an identified date, the inspector and PSW #101 observed the same clothing, as well as, other clothing to be in disrepair hanging in the resident's closet.

Record review of resident #015's intervention task record and an interview with PSW #101 confirmed he/she did assist the resident with dressing on an identified date.

An interview with PSW #101 and RPN #108 confirmed the resident was dressed inappropriately and the PSW did not promote the resident to be properly dressed in order to maintain his/her dignity and respect.

An interview with the ADOC confirmed it is the home's expectation that resident #015 be dressed appropriately. [s. 3. (1) 4.]

2. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On an identified date and time, the inspector observed an unattended medication cart to be stored on an identified location of the home. The Electronic Medication Administration Record (E-MAR) screen was left open to resident #042's personal medication administration records, which was visible to the public.

Observation and interview conducted with RPN #103 confirmed that the E-MAR screen is to be kept locked at all times when the cart is left unattended and confirmed resident #042's medication information was visible to the public. The RPN proceeded to lock the E-MAR screen.

Interview with the DOC confirmed the home's expectation is to lock the E-MAR screen when the nurse is not administering medication and resident #042's medication record would be visible to the public when the E-MAR screen is left open. [s. 3. (1) 11.]

---

**WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

An interview with the DOC on February 26, 2016, regarding a complaint received by the MOHLTC about 24 hour nursing care during the time frame of July 01, to September 31, 2014, confirmed the following:

There was no registered nurse on duty at the home during the following times:
-July 23, 2014, between 1730 hours to 2230 hours and
-September 12, 2014, between 0230 hours and 0630 hours.

The DOC indicated that in the event that a scheduled RN is not able to commit to his/her shift, the home attempts to replace the RN with an RN from the home's staffing list and/or agency staff. The DOC further indicated that on the above mentioned dates, there had been no RN available from the home's staffing plan. [s. 8. (3)]

---

**WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration**

**Specifically failed to comply with the following:**

**s. 11. (1) Every licensee of a long-term care home shall ensure that there is,**
**(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and 2007, c. 8, s. 11. (1).**
**(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there is an organized hydration program to meet the hydration needs of residents by failing to consistently document residents' fluid intake, and accurately monitor residents' hydration status.

A laminated sheet of paper entitled "Hydration" was observed posted on the bulletin boards in each home area dining rooms. The paper identified pictures of cups and mugs with an associated number for documentation.

The paper stated "the cups that have a number 1 in front of them are ½ = 125mls servings = 1 serving" and "the cups that have a number 1.5 in front of them are 1 cup = 188mls = 1.5 servings."

Interviews with PSW #109 and PSW #132 revealed that they were not recording fluids as directed by the chart leading to an over and under estimation of a resident's fluid intake.

DOC interview confirmed that PSW's were responsible to record residents' daily fluid intake in an electronic documentation program. The DOC was unable to provide a policy and procedure directing PSW staff on how to record residents' fluid intake.

Interviews conducted with the DFS and RD stated each full, large glass consumed should be recorded as two servings and is equivalent to 250 mls. The response of both the DFS and RD were not in keeping with the laminated sheet of paper entitled "hydration". [s. 11. (1) (b)]

---

**WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council**

**Specifically failed to comply with the following:**

**s. 59. (7) If there is no Family Council, the licensee shall,**
**(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).**
**(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).**

**Findings/Faits saillants :**

1. The licensee has failed to convene semi-annual meetings to advise such persons of the right to establish a Family Council.

Review of the "Family Meeting" minutes for April, May, and June 2015, identified no families attended the meetings and in September, October and November, one family member attended the meeting. In the posted minutes, there was no notation of the right to establish a Family Council. The home's Administrator did not attend any of these meetings.

An interview with the Administrator confirmed that he/she had not had a semi-annual meeting in three to four years as no families attend the meetings. The Administrator further revealed the home puts a notice in the "The View from Here" newsletter.

During an interview conducted with the Director of Resident Family Services (DRFS) the newsletters were reviewed for the following months: January, March, April, May, June, August, September, October and November 2015. A notice was found in the programs section of the newsletter identifying when the family meetings occur and that it is a Family Council. The DRFS and the Administrator confirmed that they do not have a Family Council.

Interview with the Administrator confirmed that he/she did not hold a semi-annual meeting to advise such persons of the right to establish a Family Council. [s. 59. (7) (b)]

---

**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production**

**Specifically failed to comply with the following:**

**s. 72. (2) The food production system must, at a minimum, provide for,**
**(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the food production system provided documentation on the production sheet of any menu substitutions.

On February 29, 2016, on an identified floor, the posted lunch menu board identified raspberry sherbet and mandarin oranges for dessert.

Lunch observations identified PSW #133 offering peachy peach yogurt and mandarin oranges to residents.

Interview conducted with NA #127 confirmed they did not have raspberry sherbet and the menu board had not been changed to reflect the change in dessert.

An interview with the DFS revealed an unawareness of the menu change. The DFS reviewed the production sheets for February 29, 2016, revealing no documentation of the menu substitution.

The home's policy entitled "Menu Substitutions", policy # XI-E-10.40, dated January 2015, stated the cook/dietary staff will obtain approval from the director of dietary services before implementing change and that the director of dietary services will document the new food items being served on all current "week at a glance menus, therapeutic menus, production sheets and daily menus".

The DFS confirmed the menu change on February 29, 2016, at lunch was not documented on the production sheets as required. [s. 72. (2) (g)]

**Issued on this 27th day of June, 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) :** | SHIHANA RUMZI (604), DIANE BROWN (110), VALERIE JOHNSTON (202), VALERIE PIMENTEL (557) |
| **Inspection No. / No de l'inspection :** | 2016_268604_0007 |
| **Log No. / Registre no:** | 005484-16 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | May 18, 2016 |
| **Licensee / Titulaire de permis :** | WOODS PARK CARE CENTRE INC.<br>110 LILLIAN CRESCENT, BARRIE, ON, L4N-5H7 |
| **LTC Home / Foyer de SLD :** | WOODS PARK CARE CENTRE<br>110 LILLIAN CRESCENT, BARRIE, ON, L4N-5H7 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | CATHY COTTON |

To WOODS PARK CARE CENTRE INC., 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

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) (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 :**

Upon receipt of this order the licensee shall:

1. Within one week of receipt of this order, provide a plan to the inspector, identifying when all staff will receive education on abuse and neglect of residents. The education shall include staff recognition of all forms of abuse defined under the legislation, and the immediate reporting of such.

2. The plan shall also include education to staff on how to assist, report and identify when a colleague who may be exhibiting inappropriate behaviours that may pose a risk to residents in the home.

3. The plan shall include the above two requirements, the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to valerie.johnston@ontario.ca within one week of receipt of the order.

**Grounds / Motifs :**

1. The licensee has failed to ensure that all residents are protected from abuse by anyone.

The home has been subject to a previous non-compliance under section 19 (1) of the Act, where by compliance order #001 was issued to the home April 22, 2015, under inspection report #2015_414110_0004.

The home was required to be in compliance by July 31, 2015.

On an identified date, a follow up inspection for compliance order #001 was conducted.

Staff were interviewed throughout the home and questioned as to whether they had witnessed abuse in the home or if a resident had reported that they had been abused by staff. The following statements were obtained:

RPN #110 revealed that sometime on an identified date, he/she noticed that PSW #148 had been providing care to an identified resident in an inappropriate manner. The RPN indicated that around the same time, a number of PSWs and two Nutritional Aide (NA) also noticed that PSW #148 was providing inappropriate care to residents.

RPN #110 further stated that at around this same time, an identified resident had complained to him/her while in an identified area one day that he/she did not favour the staff, referring to PSW #148 and could sense that the resident was fearful of PSW #148.

RPN #110 also revealed that on an identified month, PSW #101 and NA#139 had reported that an identified resident had been brought to an area of the home and was found to be fearful. RPN #110 indicated that he/she did not work that day but did recall reading documentation to support PSW #101 and NA #139's concerns. RPN #110 further indicated that upon a discussion with other PSWs working on the identified home area, it had been identified by the team that an identified resident had become more fearful, and that fear had been making them uncomfortable. The staff decided that it was the right time to report the suspected alleged abuse to the DOC.

RPN #110 indicated that after the conversation with the PSW's, he/she reported to the DOC and reported the same incident again on an identified day, after an identified residents' family member reported that the resident had reported to him/her that he/she had been physically harmed.

PSW #101 revealed that an identified resident had reported to him/her that PSW #148 was mistreating him/her and that he/she was unkind to the resident. PSW #101 further revealed that when PSW #148 would walk near the identified resident, the resident would shake and that he/she could tell that he/she was fearful of PSW #148.

An interview with LSC #142 revealed that an identified resident had been visibly upset on an identified time period. LSC #142 further revealed that on an

identified date, the resident became upset and pointed to PSW #148, and stated the staff member had physically harmed him/her.

NA #139 revealed several months ago, he/she witnessed PSW #148 attempting to get an identified resident to come for a meal. The NA further revealed that the resident had refused; however, once the PSW got the resident into an identified location of the home, the resident was visibly upset and would not eat.

PSW #105, indicated that he/she had been concerned about PSW #148's task orientated behaviours, and had witnessed PSW #148 make an identified resident do an activity by force and had grabbed the identified resident by his/her body pulling the resident up to a perform an activity beyond residents capabilities. PSW #105 indicated that after the witnessed incident and as time passed, the identified resident was notably more fearful and had made statement that he/she was "scared". PSW #105 further indicated that the resident also reported that he/she had been physically harmed by PSW #148, which was not of an identified resident's character. PSW #105 indicated that after a discussion with his/her colleagues it was decided that PSW #148 be reported to the DOC.

RA #144 revealed that on an identified date, an identified resident reported to him/her that a staff member physically harmed him/her. The RA indicated that he/she reported the concern to his/her supervisor RT #145 and documented the statement on the following day in a progress note as late entry on an identified date.

RT #145 revealed no awareness of the concerns raised by an identified resident from staff. The RT indicated that he/she did recall discussing PSW #148 among the recreational staff acknowledging that PSW #148 had been rough with residents and that the PSW did not have the skill set to handle cognitively impaired residents. The RT indicated that after the discussion with the team, he/she directed the recreational staff to document everything and report to the charge nurse with any concerns.

A review of the above mentioned identified resident's progress notes of an identified three month period, revealed the following:

-On an identified date: RPN #113 documented that an identified resident began shaking and verbalized being physically harmed.

-On an identified date: LSC #142 documented that an identified resident indicated he/she was being physically harmed and disliked this staff member.

- On an identified date: RA #144 documented that an identified resident stated the resident was physically harmed and that a staff member was mean to him/her.

- On an identified date: RPN #110 documented that an identified resident's family member reported that resident had reported to him/her that he/she had been physically harmed.

An interview with the DOC confirmed receipt of the above mentioned allegations of abuse late on an identified month. The DOC indicated that the home began an investigation on once the home was aware of the alleged abuse, and PSW #148's actions were found to be a complete disregard to the resident's feelings and abusive in nature. PSW #148 received a three day suspension and was re-assigned to another home area.

RPN #110, NA#139, PSW #105, PSW #101, all indicated in interviews that after PSW #148 had been reassigned to another home area within the home, the identified resident has not expressed fear at any time after PSW #148 had been reassigned.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual. The scope of the non-compliance is isolated.

A review of the home's compliance history revealed that LTCHA, 2007, c.8, s.19 (1), has been the subject of previous non-compliance, identified in Resident Quality Inspection #2015_414_110_0004, whereby order #001 was issued to the home on April 22, 2015.
(202)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 29, 2016

**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

Upon receipt of this order the licensee shall:

1. Within one week of receipt of this order, provide a plan to the inspector, identifying when all staff, students, and volunteers within the home will receive training of the duty under section 24 to make mandatory reports.

2. The plan shall include educational material designed to support and ensure staff understanding of the duty under section 24 to make mandatory reports.

3. The plan shall ensure that all staff, managers, students and volunteers understand all of the requirements under section 24 of the Act to make mandatory reports. The plan shall include, the person(s) responsible for completing the tasks and the time lines for completion. The plan is to be submitted to valerie.johnston@ontario.ca.

**Grounds / Motifs :**

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any
of the following has occurred or may occur 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.

On an identified date, a follow up inspection was conducted, which revealed the following. Staff were interviewed throughout the home and questioned as to whether they had witnessed abuse in the home or if a resident had reported that they had been abused by staff. The following statements were obtained:

RPN #110 revealed in an interview that sometime in an identified time period in 2015, he/she noticed that PSW
#148 had been rough with residents. The RPN indicated that around the same time, a number of PSWs and two NA's also noticed that PSW #148 had been rough. The RPN further indicated that at the time it was difficult to determine if it was abuse, as the PSW may not have known he/she was visibly rough with residents.

RPN #110 stated that at around this same time, resident #001 complained to him/her about PSW #148 and indicating dislike towards a PSW staff member. The RPN indicated that he/she could sense the resident was fearful of PSW #148, but was not sure as to why.

RPN #110 revealed on an identified date, PSW #101, and NA #139, had reported to him/her that resident #001 had been observed to be fearful. RPN #110 indicated that upon further discussions with other PSWs working on the identified home area, it was confirmed that resident #001 had become more fearful, and that the resident's increased fear had been making them uncomfortable. RPN #110 indicated on an identified date, when he/she reported to the DOC and again on a second identified date, after receiving the same concern from the resident's family member.

An interview with LSC #142 revealed that resident #001 was visibly upset last year. LSC #142 further revealed that on an identified date, while walking in an identified area of the home with resident #001, the resident became upset and pointed to PSW #148, and stated the staff member harmed the resident. When asked of the LSC if the resident's statement had been reported, the LSC

confirmed that he/she documented a behavioural note in the progress notes and did not report the statement further. The LSC indicated that with any abuse, he/she had been directed by management that "if you do not see it, then just document it". The LSC confirmed that this is what he/she did.

When asked of PSW #105, whether he/she had witnessed abuse, the PSW indicated that he/she had been concerned about PSW #148's task orientated behaviours, but was unsure if his/her actions were actual abuse. PSW #105 described a time when he/she witnessed PSW #148 make resident #001 perform an activity beyond his/her will by taking resident #001 and forcing resident to perform the activity. PSW #105 indicated that he/she did not report the incident at the time, however, as time passed, resident #001 was notably more fearful and would often state that he/she was "scared". After the resident had reported to PSW #105 that he/she had been harmed by PSW #148, which PSW #105 indicated was not of resident #001's character, PSW #105 had decided to discuss the issue with other PSWs and the decision was made to report to the charge nurse at this time, which the PSW indicated time period.

An interview with RA #144 revealed that while taking resident #001 to an activity on a specified date, the resident reported to him/her that a staff member had harmed the resident. The RA indicated that he/she reported the concern to his/her supervisor RT #145 and documented the statement on the following day in a progress note.

An interview with RT #145 revealed no awareness of the concerns raised by resident #001 from
staff. The RT indicated that he/she did recall discussing PSW #148 among the recreational staff
acknowledging that PSW #148 had been rough with residents and that the PSW did not have the
skill set to handle cognitively impaired residents. The RT indicated that at that time he/she had
directed the recreational staff to document everything and report to the charge nurse with any
concerns.

An interview with the DOC confirmed receipt of the above mentioned allegations of abuse was identified last year, but was unable to verify the exact date. The DOC indicated that the home began an investigation on an identified date, and

PSW #148's actions were found to be a complete disregard to the resident's in the home and abusive in nature. PSW #148 received a three day suspension and was re-assigned to another home area.

The DOC confirmed that the MOHLTC Director had not been notified at any time regarding the
suspected improper or incompetent treatment or care or physical abuse by PSW #148 toward
resident #001.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual.

The scope of the non-compliance is widespread.

A review of the home's compliance history revealed that LTCHA, 2007, c.8. s. 24 (1), has been the subject of previous non-compliance, identified in Resident Quality Inspection #2015_414_110_0004, issued April 22, 2015. [s. 24. (1)] (202)

(202)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 29, 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 18th day of May, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Shihana Rumzi

**Service Area Office /**
**Bureau régional de services :** Toronto Service Area Office