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 prévue 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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 5, 2018	2018_643111_0018	009354-18, 020935-18, 023203-18	Critical Incident System

Licensee/Titulaire de permis

Mackenzie Health
10 Trench Street RICHMOND HILL ON L4C 4Z3

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

Mackenzie Health Long Term Care Facility
10 Trench Street RICHMOND HILL ON L4C 4Z3

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 4 & 5, 2018 and October 24, 25, 26 and 27 & 29, 2018 (off-site)

There were three critical incident inspections (CIRs) completed concurrently during this inspection related to resident to resident witnessed or suspected abuse: Log # 009354-18, #020935-18 & 023203-18).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), Social Worker (SW) and residents.

During the course of the inspection, the inspector observed two residents, reviewed the health care records of two residents, reviewed the licensee's investigations, and reviewed the following licensee policies: Zero Tolerance of Abuse and Neglect & Responsive behaviours.

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

Review of the licensee's policy "Resident Safeguards-Zero Tolerance to Resident Abuse and Neglect" (02-01-01) revised July 2017 indicated under procedures:
-on page 8 of 23, stop the abuse, if there is any concern for staff safety or safety of others in the area, immediately call 911 for police assistance.
-on page 9 of 23, the RN shall assess the victim and chart/record any and all findings. Following the initial assessment of the incident and victim, the RN should arrange for a medical examination of the victim by the attending physician.

Related to log #009354-18, #020935-18 and #023203-18:

There were three critical incidents (CIR) reported to the Director for witnessed, resident to resident abuse by resident #001 towards resident #002 that occurred and had no documented evidence resident #002 was assessed by the RN, the physician notified, or the police immediately notified. Review of the critical incidents and licensee's investigations into all three CIR's, also did not indicate which RN's were working when the incidents occurred as follows:

A.Log # 009354-18 (CIR), on a specified date and time, resident #001 was witnessed by Dietary Aide #107 engage in abuse towards resident #002 and reported the incident to RPN #109. No injuries were noted.
-Review of the progress notes indicated the resident was assessed by RPN #109 and had no injuries but there was no documented evidence the RN was notified. The physician was not made aware of the incident until the next day by RN #110.
-Review of the staffing schedule indicated RN #116 was working when the incident occurred.
-During an interview with RN #116 on a specified date, with Inspector #111, the RN confirmed being notified of the incident that occurred. The RN confirmed the RN did not assess resident #002 or notify the physician regarding the incident.

B.Log # 020935-18 (CIR), on a specified date and time, PSW #104 witnessed resident #001 enter the room of resident #002, attempting to engage in abuse with resident #002 and then left the room. Resident #001 then entered resident #002's room a second time and PSW #104 witnessed resident #001 engage in abuse towards resident #002. No injuries were sustained. The CIR indicated RPN #100 was notified of the incident.
-Review of the progress notes for both residents had no documented evidence the RN was notified or the physician was made aware.
-Review of the staffing schedule indicated RN #114 was working when the incident occurred.See interview with RN #114 below.

C.Log # 023203-18 (CIR), on a specified date and time, resident #001 had entered the room of resident #002, when PSW #101 witnessed resident #001 engage in abuse towards resident #002. No injuries were sustained. The CIR indicated RPN #100 was notified of the incident.
-Review of the progress notes for both residents had no documented evidence the RN was notified or the physician was made aware until the next shift. Review of the staffing schedule indicated RN #114 was working when the incident occurred. See interview with

RN #114 below.

In addition to these critical incidents, review of resident #001 and #002 progress notes indicated there were four additional incidents of witnessed or suspected resident to resident abuse that occurred, on specified dates and times as follows:
-the firs incident, RPN #100 documented resident #001 was witnessed engaged in abuse towards resident #002 and staff were unable to remove resident #002 away from resident #001. The RPN called security for assistance. The RPN also called the Administrator. There was no documented evidence the RN assessed resident #002 or notified the physician.
-the second incident, RPN #100 documented resident #001 was witnessed engaging in abuse towards resident #002. There was no documented evidence the RN was notified or completed an assessment of resident #002.
-the third incident, RPN #100 documented resident #001 was witnessed engaging in abuse towards #002.There was no documented evidence the RN was notified or completed an assessment of resident #002.
-the fourth incident, RPN #100 documented a suspected abuse by Resident #001 towards resident #002. There was no documented evidence the RN was notified or completed an assessment of resident #002.

During an interview with the DOC by Inspector #111, the DOC initially had no awareness which RNs should have been notified in all of the resident to resident abuse incidents that occurred but was later able to determine (after reviewing the RN staffing schedules for the identified dates) which RNs were working. The DOC identified RN # 114 as working on the first three incidents identified above and RN #115 on the last incident.

During an interview with RN #114 with Inspector #111, the RN indicated that the RPN's on other units were supposed to call the RN if there was any serious concerns with residents. The RN indicated they would usually either call the other units or go up to the other units at least once a shift to check on any serious concerns with the resident. The RN initially confirmed no awareness of any of the abuse incidents that occurred on five specified dates but later indicated awareness of one of the incidents of resident to resident abuse involving resident #001 towards resident #002. The RN indicated the RPN was directed to call security and then call the Administrator, but could not recall which date the incident occurred. The RN indicated no awareness that the RN was supposed to assess the resident, document and notify the physician for abuse incidents, or call police as per the licensee policy.

During an interview with RN #115 with Inspector #111, the RN indicated no awareness of any resident to resident abuse involving resident #001 towards resident #002 on a specified date. The RN indicated the RPN was supposed to call the RN if any concerns with residents but did not recall receiving any calls from RPN on the unit. The RN indicated no awareness that the RN was supposed to assess the resident, document and notify the physician for abuse incidents as per the licensee policy.

Review of the health care record for resident #001 and #002 indicated, none of the three critical incidents had any documented evidence that the RN was notified or completed an assessment of the resident. In addition, there were four witnessed and/or suspected incidents of resident to resident abuse from resident #001 towards resident #002 that occurred on four separate dates that had no documented evidence the RN was notified, completed an assessment resident #002, or to indicate the physician was notified.

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse ("Resident Safeguards-Zero Tolerance to Resident Abuse and Neglect") was complied with.

2. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall: (h) deal with any additional matters as may be provided in the regulations.

Review of the licensee's policy "Resident Safeguards-Zero Tolerance to Resident Abuse and Neglect" (02-01-01) revised July 2017 indicated under procedures: on page 8 & 9 of 23, the following individuals must also be notified: resident's family/significant others (within 12 hours).

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

The licensee's above policy on Zero Tolerance of Abuse and Neglect did not meet the

requirements as set out in the LTCHA and Ontario Regulations 79/10, as the policy failed to deal with matters when the abuse was to be reported immediately.

Additional Required Actions:

CO # - 001, 002 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 the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to log #009354-18:

A critical incident report (CIR) was submitted to the Director on a specified date for a witnessed resident to resident abuse, by resident #001 towards resident #002. No

injuries were sustained. The CIR was submitted to the Director the day after the incident occurred.

In addition to these critical incidents, review of resident #001 and #002 progress notes indicated there were four additional incidents of witnessed or suspected resident to resident abuse that occurred, on specified dates and times as follows that were not reported to the Director:
-the first incident, RPN #100 documented resident #001 was witnessed engaged in abuse towards resident #002 and staff were unable to remove resident #002 away from resident #001. The RPN called security for assistance. The RPN also called the Administrator.
-the second incident, RPN #100 documented resident #001 was witnessed engaging in abuse towards resident #002.
-the third incident, RPN #100 documented resident #001 was witnessed engaging in abuse towards #002.
-the fourth incident, RPN #100 documented a suspected abuse by resident #001 towards resident #002.

During an interview with RN #116 with Inspector #111, the RN confirmed being notified of the first critical incident of resident to resident abuse involving resident #001 towards resident #002 and confirmed they did not inform the Director of the incident.

During an interview with the RPN #100 with Inspector #111, the RPN confirmed working on three of the above identified dates and indicated they always informed the RN of the incidents. The RPN indicated it was usually RN #114 that was working on the identified dates. The RPN indicated on one of the specified incident above, the RPN notified the Administrator first and then called RN #114 regarding the incident. The RPN indicated no awareness that the Director was to be notified and the RPN thought because the Administrator and the RN were aware of the incidents, they would have contacted the Director.

During an interview with DOC, the DOC confirmed the Director was not notified of the first critical incident involving resident #001 towards resident #002. until the following day, when the DOC submitted the CIR. The DOC also confirmed the additional identified incidents involving resident #001 towards resident #002 should have been reported to the Director and confirmed they were not reported to the Director. The DOC indicated the Administrator was involved in one of the above incidents that occurred..

During an interview with the Administrator by Inspector #111,the Administrator indicated they could not recall whether they were notified of the alleged resident to resident abuse incidents that were documented three separate dates. The Administrator was made aware that the progress notes confirmed that the Administrator was notified of one of the incidents above. The Administrator confirmed all of the alleged abuse incidents noted above involving resident#001 towards resident #002 were not reported to the Director.

The licensee failed to ensure the Director was immediately notified of witnessed and or suspected abuse towards resident #002.

Additional Required Actions:

CO # - 003 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:(i) Abuse of a resident by anyone.

Related to log #009354-18:

A critical incident report (CIR) was submitted to the Director on a specified date for witnessed resident to resident abuse incident that occurred the day before.No injuries were sustained. The CIR was completed by the DOC.

Review of the health care record for resident #001 and #002 indicated there were additional witnessed and/or suspected incidents of resident to resident abuse that occurred on three separate dates.

During an interview with DOC confirmed that the witnessed resident to resident abuse incident that occurred on a specified date (CIR), was not investigated until the following day, when the staff were interviewed by the Administrator. The DOC confirmed there were no investigations completed for the three additional witnessed and/or suspected resident to resident abuse incidents that occurred on three separate dates, involving resident #001 towards resident #002.

During an interview with the Administrator, the Administrator confirmed that there was no investigation completed into the suspected or witnessed abuse incidents that occurred on three separate dates, involving resident #001 and resident #002.

The licensee failed to ensure that an immediate investigation was completed for four witnessed and/or suspected abuse incidents by resident #001 towards resident #002.

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 every alleged, suspected or witnessed incident of abuse by anyone, that the licensee knows of, or that is reported, is immediately investigated., to be implemented voluntarily.

WN #4: 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 resident #002 was protected from ongoing abuse by resident #001.

Related to log #009354-18, #023203-18 and #020935-18:

There were three critical incident reports (CIRs) submitted to the Director, on three separate identified dates and times, for witnessed, resident to resident abuse, by resident #001 towards resident #002.

In addition to these three critical incidents, review of resident #001 and #002 progress notes indicated resident #001 had ongoing responsive behaviours and witnessed or suspected abusive behaviours towards resident #002 during a specified time, for approximately three month period, until an identified intervention was put in place.

During an interview with the Social Worker (SW), the SW indicated they were notified of the first incident that occurred on a specified date involving resident #001 and #002. The SW spoke to resident #001 and the resident denied the incident, and had no further responsive behaviours noted after that incident. The SW indicated a referral for a psycho-geriatric assessment was submitted on a specified date (two months after the ongoing responsive behaviours by resident #001 towards resident #002 were occurring) and the psycho-geriatric centre was contacted after the last critical incident that occurred. The SW was unaware of all of the responsive behaviour and abuse incidents that had been occurring between resident #001 and resident #002.

During an interview with RN #119, the RN indicated resident #002 was not able to provide consent. The RN indicated awareness of resident #001 engaging in abuse towards resident #002 on a specified date and time, when the RN read about the incident

on the 24 hour nursing report.

During an interview with PSW #120, the PSW indicated resident #002 was unable to communicate verbally of needs and was aware of ongoing incidents between resident #001 and resident #002 during a specified time. The PSW was aware that an intervention had been put in place for resident #001, as a result of the ongoing incidents that were occurring. The PSW confirmed awareness of two separate incidents of abuse that occurred during a specified time. The PSW indicated resident #002 would not be able to consent. The PSW indicated both residents were not to be left unattended at any time.

During interviews with the DOC, the DOC confirmed there had been only three critical incidents of resident to resident abuse reported to the Director, involving resident #001 and #002. The DOC indicated the first incident reported to the Director on a specified date, resulted in an intervention put in place for a few days after the incident. The DOC indicated resident #001 only began demonstrating specified responsive behaviours during a specified time, towards resident #002, on a specified date. The DOC was not aware that resident #001 had been demonstrating the specified responsive behaviours towards resident #002's ongoing, during the specified time for approximately three month period. The DOC indicated the witnessed incident of resident to resident abuse that occurred on a specified date and time, involving resident #001 towards resident #002, and the police were called.

During an interview with the Administrator, the Administrator confirmed the Director was not notified of the first resident to resident abuse incident, involving resident #001 towards resident #002, until the day after the incident occurred and confirmed the police were not notified. The Administrator indicated the second critical incident reported to the Director for resident to resident abuse, involving resident #001 towards resident #002, they directed the RPN to call security instead of the police as the home had access to the hospitals on-site security staff and called the police after the incident occurred, but could not recall when the police were notified. The Administrator indicated the third resident to resident abuse incident involving resident #001 towards resident #002, that was reported to the Director, that they may have called the police, despite being informed that the abuse checklist they completed had no indication the police were notified. The Administrator confirmed they were the one who completed the interviews in the investigations into the abuse incidents but could not recall if they interviewed any of the RNs, who would have been working on any of the identified dates of the incidents. The administrator confirmed they had no documented investigations into the any of the four specified dates of witnessed or suspected resident to resident abuse incidents involving

resident #001 towards resident #002, and confirmed the alleged abuse incidents were also not reported to the Director.

The licensee failed to ensure resident #002 was protected from ongoing abuse by resident #001 and as the staff were aware of resident's #001 ongoing responsive behaviours towards resident #002. Appropriate actions were also not taken when the incidents occurred, until approximately three months later.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

Related to log # 009354-18:

A critical incident report (CIR) was submitted to the Director for witnessed resident to resident physical abuse, by resident #001 towards resident #002 that occurred on a specified date and time. The CIR was not submitted until the day after the incident occurred and indicated the SDM was notified. The CIR was completed by the DOC.

Review of the progress notes for resident #001 indicated the SDM was notified of the incident that occurred the day after the incident occurred, when RN #110 documented, the SDM was notified about the incident that occurred on a specified date (the day before).

In addition, review of the progress notes for resident #001 and #002 indicated there were three additional incidents of witnessed and/or suspected abuse by resident #001 towards resident #002 and there was no indication the SDMs was notified.

During an interview with DOC, the DOC confirmed the SDM of resident #001 and #002, were not immediately informed of the first suspected resident to resident abuse incident until the following day. The DOC also confirmed the SDM was not notified of the three additional incidents of witnessed and/or suspected abuse by resident #001 towards resident #002 that occurred.

The licensee failed to ensure the SDM was immediately notified of abuse by resident #001 towards resident #002.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident: (ii) names of any staff members or other persons who were present at or discovered the incident, and (iii) names of staff members who responded or are responding to the incident.

A.Related to log # 009354-18:

A critical incident report (CIR) was submitted to the Director on a specified date, for a resident to resident abuse incident involving resident #001 towards resident #002. The CIR indicated on a specified date and time, resident #002 was witnessed by a PSW and dietary staff member engaging in abusive behaviour towards resident #002. The CIR only identified one staff members name (staff #106) but no indication what the staff member's title was. The CIR was completed by the DOC.

Review of the licensee's investigation indicated the incident was witnessed by Dietary staff #107 and PSW #108 and the incident was reported to RPN #109. The CIR did not include the names of these staff members.

During separate interviews with both the Administrator and the DOC, indicated staff #106 was a PSW, could not indicate why this PSW was identified in the CIR or why the staff that were directly aware of the incident (dietary staff #107, PSW #108 and RPN #109), were not included in the CIR.

B.Related to log # 023203-18:

A critical incident report (CIR) was submitted to the Director on a specified date for a witnessed resident to resident abuse incident that occurred the same day. The CIR indicated at a specified time, resident #001 was witnessed by a PSW engage in abuse towards resident #002 and immediately notified RPN #100. The CIR identified two other PSWs who were also present during the incident.The CIR identified RPN #100 and PSW #101 and #102. The CIR was completed by the DOC.

Review of the home's investigation into this incident indicated:
-PSW #101 confirmed witnessing the incident, that PSW #103 was also working when the incident occurred and was aware of the incident. The PSW then reported the incident to RPN #100. PSW #103 confirmed they were aware of the incident but did not witness the incident. The CIR identified PSW#102 and not PSW #103, who was actually working when the incident occurred.

The licensee failed to ensure all staff (dietary staff #107, PSW #108 and RPN #109) who were present and/or who responded to the abuse incident on a specified date were indicated on the critical incident report. The licensee failed to ensure the correct staff who were present were identified on the abuse incident that occurred on a specified date.

Issued on this 7th day of December, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2018_643111_0018
Log No. / No de registre :	009354-18, 020935-18, 023203-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 5, 2018
Licensee / Titulaire de permis :	Mackenzie Health 10 Trench Street, RICHMOND HILL, ON, L4C-4Z3
LTC Home / Foyer de SLD :	Mackenzie Health Long Term Care Facility 10 Trench Street, RICHMOND HILL, ON, L4C-4Z3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michael Griffin

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall be compliant with LTCHA, 2007, s.20 (1).

Specifically, the licensee shall:
1) Retrain all registered nursing staff and managers regarding the new revised zero tolerance of abuse and neglect policy to ensure that: all witnessed, suspected or alleged abuse towards residents by anyone, that may constitute a criminal offence, is immediately reported to the police, and that the RN in charge is immediately made aware, including which RN, to ensure the resident is assessed, the physician is notified if required, and documentation is completed of all the above in the resident's health record, as per the licensee's policy.
2) Ensure a documented record is kept, indicating who completed the re-training and when the training was completed.
3) Actions to be taken when non-compliance occurs related to the above, and by whom.

Grounds / Motifs :

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

Review of the licensee's policy "Resident Safeguards-Zero Tolerance to Resident Abuse and Neglect" (02-01-01) revised July 2017 indicated under procedures:
-on page 8 of 23, stop the abuse, if there is any concern for staff safety or safety of others in the area, immediately call 911 for police assistance.
-on page 9 of 23, the RN shall assess the victim and chart/record any and all

findings. Following the initial assessment of the incident and victim, the RN should arrange for a medical examination of the victim by the attending physician.

Related to log #009354-18, #020935-18 and #023203-18:

There were three critical incidents (CIR) reported to the Director for witnessed, resident to resident abuse by resident #001 towards resident #002 that occurred and had no documented evidence resident #002 was assessed by the RN, the physician notified, or the police immediately notified. Review of the critical incidents and licensee's investigations into all three CIR's, also did not indicate which RN's were working when the incidents occurred as follows:

A.Log # 009354-18 (CIR), on a specified date and time, resident #001 was witnessed by Dietary Aide #107 engage in abuse towards resident #002 and reported the incident to RPN #109. No injuries were noted.
-Review of the progress notes indicated the resident was assessed by RPN #109 and had no injuries but there was no documented evidence the RN was notified. The physician was not made aware of the incident until the next day by RN #110.
-Review of the staffing schedule indicated RN #116 was working when the incident occurred.
-During an interview with RN #116 on a specified date, with Inspector #111, the RN confirmed being notified of the incident that occurred. The RN confirmed the RN did not assess resident #002 or notify the physician regarding the incident.

B.Log # 020935-18 (CIR), on a specified date and time, PSW #104 witnessed resident #001 enter the room of resident #002, attempting to engage in abuse with resident #002 and then left the room. Resident #001 then entered resident #002's room a second time and PSW #104 witnessed resident #001 engage in abuse towards resident #002. No injuries were sustained. The CIR indicated RPN #100 was notified of the incident.
-Review of the progress notes for both residents had no documented evidence the RN was notified or the physician was made aware.
-Review of the staffing schedule indicated RN #114 was working when the incident occurred.See interview with RN #114 below.

C.Log # 023203-18 (CIR), on a specified date and time, resident #001 had entered the room of resident #002, when PSW #101 witnessed resident #001 engage in abuse towards resident #002. No injuries were sustained. The CIR indicated RPN #100 was notified of the incident.
-Review of the progress notes for both residents had no documented evidence the RN was notified or the physician was made aware until the next shift. Review of the staffing schedule indicated RN #114 was working when the incident occurred. See interview with RN #114 below.

In addition to these critical incidents, review of resident #001 and #002 progress notes indicated there were four additional incidents of witnessed or suspected resident to resident abuse that occurred, on specified dates and times as follows:
-the firs incident, RPN #100 documented resident #001 was witnessed engaged in abuse towards resident #002 and staff were unable to remove resident #002 away from resident #001. The RPN called security for assistance. The RPN also called the Administrator. There was no documented evidence the RN assessed resident #002 or notified the physician.
-the second incident, RPN #100 documented resident #001 was witnessed engaging in abuse towards resident #002. There was no documented evidence the RN was notified or completed an assessment of resident #002.
-the third incident, RPN #100 documented resident #001 was witnessed engaging in abuse towards #002.There was no documented evidence the RN was notified or completed an assessment of resident #002.
-the fourth incident, RPN #100 documented a suspected abuse by Resident #001 towards resident #002. There was no documented evidence the RN was notified or completed an assessment of resident #002.

During an interview with the DOC by Inspector #111, the DOC initially had no awareness which RNs should have been notified in all of the resident to resident abuse incidents that occurred but was later able to determine (after reviewing the RN staffing schedules for the identified dates) which RNs were working. The DOC identified RN # 114 as working on the first three incidents identified above and RN #115 on the last incident.

During an interview with RN #114 with Inspector #111, the RN indicated that the RPN's on other units were supposed to call the RN if there was any serious

concerns with residents. The RN indicated they would usually either call the other units or go up to the other units at least once a shift to check on any serious concerns with the resident. The RN initially confirmed no awareness of any of the abuse incidents that occurred on five specified dates but later indicated awareness of one of the incidents of resident to resident abuse involving resident #001 towards resident #002. The RN indicated the RPN was directed to call security and then call the Administrator, but could not recall which date the incident occurred. The RN indicated no awareness that the RN was supposed to assess the resident, document and notify the physician for abuse incidents, or call police as per the licensee policy.

During an interview with RN #115 with Inspector #111, the RN indicated no awareness of any resident to resident abuse involving resident #001 towards resident #002 on a specified date. The RN indicated the RPN was supposed to call the RN if any concerns with residents but did not recall receiving any calls from RPN on the unit. The RN indicated no awareness that the RN was supposed to assess the resident, document and notify the physician for abuse incidents as per the licensee policy.

Review of the health care record for resident #001 and #002 indicated, none of the three critical incidents had any documented evidence that the RN was notified or completed an assessment of the resident. In addition, there were four witnessed and/or suspected incidents of resident to resident abuse from resident #001 towards resident #002 that occurred on four separate dates that had no documented evidence the RN was notified, completed an assessment resident #002, or to indicate the physician was notified.

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse ("Resident Safeguards-Zero Tolerance to Resident Abuse and Neglect") was complied with.

The scope was a level 3, widespread, as the staff were not complying with the home's zero tolerance of abuse and neglect policy affecting all residents. The severity was a level 3, potential for harm, as staff were not aware of what constitutes a specified abuse, or what their roles and responsibilities were, which may lead to further harm for residents. The compliance history was a level 4, with ongoing non-compliance: a voluntary plan of correction (VPC) was issued

for LTCHA, s. 20 (1) on May 8, 2018 during inspection # 2018_526510_001 and a written notification (WN) was issued for LTCHA, s. 20(2) on November 15, 2016 during inspection #2015_413500_0015. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2019

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

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

Order / Ordre :

The licensee shall be compliant with LTCHA, 2007, s.20 (2).

Specifically, the licensee shall:
1) Review and revise the Zero Tolerance of Abuse and Neglect policy, to ensure it meets all the legislative requirements, including, LTCHA, 2007, s.20 (2)(h) shall deal with any additional matters as may be provided for in the regulations, specifically Under O. Reg. 79/10, s. 97(1)(a).
2) Retrain all registered nursing staff and managers regarding the new revised policy to ensure that all Registered staff are aware of what constitutes all types of abuse, and including who is responsible for notifying the Substitute Decision Maker (SDM), when and documentation requirements around the same.
3) Shall keep a documented record indicating who completed the policy revision, which registered staff /managers were re-trained on the policy and when.

Grounds / Motifs :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall: (h) deal with any additional matters as may be provided in the regulations.

Review of the licensee's policy "Resident Safeguards-Zero Tolerance to Resident Abuse and Neglect" (02-01-01) revised July 2017 indicated under procedures: on page 8 & 9 of 23, the following individuals must also be notified: resident's family/significant others (within 12 hours).

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

The licensee's above policy on Zero Tolerance of Abuse and Neglect did not meet the requirements as set out in the LTCHA and Ontario Regulations 79/10, as the policy failed to deal with matters when the abuse was to be reported immediately.

The scope was a level 3, widespread, as the staff were not complying with the home's zero tolerance of abuse and neglect policy affecting all residents. The severity was a level 3, potential for harm, as staff were not aware of what constitutes a specified abuse, or what their roles and responsibilities were, which may lead to further harm for residents. The compliance history was a level 4, with ongoing non-compliance: a voluntary plan of correction (VPC) was issued for LTCHA, s. 20 (1) on May 8, 2018 during inspection # 2018_526510_001 and a written notification (WN) was issued for LTCHA, s. 20(2) on November 15, 2016 during inspection #2015_413500_0015. (111)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 31, 2018

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

Ministère 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 : 003

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 :

The licensee shall comply with LTCHA, 2007, s.24(1).

Specifically, the licensee shall:
1) Ensure all Registered staff are re-trained on reporting requirements to the Director, specifically, with alleged, suspected or witnessed resident to resident abuse, when the recipient resident is unable to consent.
2) Develop a process to ensure that all alleged, suspected or witnessed specified abuse by another resident has been reported to the Director as per the requirement.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to log #009354-18:

A critical incident report (CIR) was submitted to the Director on a specified date

for a witnessed resident to resident abuse, by resident #001 towards resident #002. No injuries were sustained. The CIR was submitted to the Director the day after the incident occurred.

In addition to these critical incidents, review of resident #001 and #002 progress notes indicated there were four additional incidents of witnessed or suspected resident to resident abuse that occurred, on specified dates and times that were not reported to the Director:
-the first incident, RPN #100 documented resident #001 was witnessed engaged in abuse towards resident #002 and staff were unable to remove resident #002 away from resident #001. The RPN called security for assistance. The RPN also called the Administrator.
-the second incident, RPN #100 documented resident #001 was witnessed engaging in abuse towards resident #002.
-the third incident, RPN #100 documented resident #001 was witnessed engaging in abuse towards #002.
-the fourth incident, RPN #100 documented a suspected abuse by resident #001 towards resident #002.

During an interview with RN #116 with Inspector #111, the RN confirmed being notified of the first critical incident of resident to resident abuse involving resident #001 towards resident #002 and confirmed they did not inform the Director of the incident.

During an interview with the RPN #100 with Inspector #111, the RPN confirmed working on three of the above identified dates and indicated they always informed the RN of the incidents. The RPN indicated it was usually RN #114 that was working on the identified dates. The RPN indicated on one of the specified incident above, the RPN notified the Administrator first and then called RN #114 regarding the incident. The RPN indicated no awareness that the Director was to be notified and the RPN thought because the Administrator and the RN were aware of the incidents, they would have contacted the Director.

During an interview with DOC, the DOC confirmed the Director was not notified of the first critical incident involving resident #001 towards resident #002. until the following day, when the DOC submitted the CIR. The DOC also confirmed the additional identified incidents involving resident #001 towards resident #002

should have been reported to the Director and confirmed they were not reported to the Director. The DOC indicated the Administrator was involved in one of the above incidents that occurred..

During an interview with the Administrator by Inspector #111,the Administrator indicated they could not recall whether they were notified of the alleged resident to resident abuse incidents that were documented three separate dates. The Administrator was made aware that the progress notes confirmed that the Administrator was notified of one of the incidents above. The Administrator confirmed all of the alleged abuse incidents noted above involving resident#001 towards resident #002 were not reported to the Director.

The licensee failed to ensure the Director was immediately notified of witnessed and or suspected abuse towards resident #002.

The scope was a level 2, a pattern, as the home had reported the witnessed abuse incidents involving both residents to the Director, but did not report any of the suspected and/or witnessed abuse incidents involving both residents. The severity was a level 3, as there was actual harm towards resident #002. The compliance history was a level 4, ongoing non-compliance: a voluntary plan of correction (VPC) was issued for LTCHA, 2007, s.24(1) on October 12, 2017 during the RQI inspection (#2017_642606_0012) and a VPC was issued for LTCHA, 2007, s.24(1) on November 16, 2015 during the RQI inspection (#2015_413500_0015). (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 5th day of December, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

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