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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 03, 2019	2019_746692_0013 (A1)	012200-18, 012606-18, 017966-18, 018529-18, 023639-18, 024193-18, 025225-18, 026864-18, 027022-18, 030258-18, 003725-19, 005323-19, 005411-19, 007715-19	Critical Incident System

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Hawthorne Place Care Centre
2045 Finch Avenue West NORTH YORK ON M3N 1M9

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

Amended by SHANNON RUSSELL (692) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

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Compliance Due Date for Compliance Orders #001 and #002 amended.

Issued on this 3 rd day of June, 2019 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

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

Amended by SHANNON RUSSELL (692) - (A1)

Amended 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): May 6-10 and May 13-17, 2019.

The Following intakes were inspected upon during this Critical Incident Inspection:

-One log related to an allegation of staff to resident sexual abuse;

-Two logs, related to resident to resident sexual abuse;

-Three logs, related to an injury that resulted in a transfer to hospital; and,

-Six logs, related to alleged resident to resident physical abuse.

A Complaint inspection #2019_746692_0012 was conducted concurrent with this inspection.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Acting Director of Care (DOC), Associate Director of Care (ADOC), Clinical Consultant Pharmacist, Manager of Quality Improvement for a Pharmacy, Recreation Therapy Aide, Quality Manager, Informatics Coordinator, Activity Aides, Nurse Consultant from an external agency, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health care records, internal investigation notes, personnel files, complaint logs, as well as numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

- **8 WN(s)**
- **3 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted to the Director by the home on an identified date, related to resident #010, who had a fall and sustained an injury with significant change in health status the previous day. A review of the CIS report, indicated that resident #010 had an unwitnessed fall that required transfer to the hospital, that resulted in an identified injury.

Inspector #736 reviewed the progress notes for resident #010 and noted that on the day the resident fell, they sustained an identified injury and was transferred to the hospital. The progress notes indicated that the resident was transferred back to the home three days after the incident. The progress notes further indicated that on the day after resident #010 returned from the hospital, they required the assistance of the specified intervention, which was included in their plan of care. Registered Practical Nurse (RPN) #129 documented that they had initiated the specified intervention, and then stopped as per the direction of Registered Nurse (RN) #141 (who was the Quality Manager at the time).

The Inspector further reviewed resident #010's health care record and identified a document, which indicated that the resident requested the use of the specified intervention.

A specific policy review was conducted by Inspector #736.

In an interview with the Inspector, RPN #129 confirmed that resident #010 required a specified intervention and they had initiated it, however RN #141 had indicated for them to stop.

In an interview with Inspector #736, the Acting Administrator indicated that staff were to provide care to residents as indicated in their plan of care. Together, Inspector #736 and the Acting Administrator reviewed the identified document included in residents' plan of care. The Acting Administrator confirmed resident #010 was not provided the care as set in their plan of care, and that they should have.

Long-Term Care Homes Act (LTCHA), 2007, S.O. 2007, c. 8, s. 107 (4) 3 v, was also issued in relation to this finding. Refer to Written Notification (WN) #5, finding #2 for details. [s. 6. (7)] (736)

2. The licensee has failed to ensure that the provision of care set out in the plan of

care was documented.

A CIS report was submitted to the Director by the home related to a resident who had fallen and sustained an injury with significant change in health status on an identified date. A review of the CIS report, indicated that resident #010 had sustained an unwitnessed fall that required them to be transferred to the hospital, and sustained an identified injury. The CIS report further indicated that resident #010 had sustained three previous falls within a period of a month.

Inspector #736 reviewed resident #010's health care records. A review of the progress notes for a three month period indicated that an identified intervention was to be initiated after resident #010 had fallen, and documented on a specified document.

a) Inspector #736 reviewed the specified documents for resident #010, which indicated that there was missing documentation of the identified intervention being completed on a number of occasions for the dates in which they fell.

b) The home submitted a CIS report to the Director related to resident #014 sustaining a fall with significant injury and change in health status on an identified date. The CIS report identified that resident #014 had an unwitnessed fall and sustained an identified injury.

Inspector #736 reviewed resident #014's health care records. A review of resident #014's progress notes, indicated that staff were to complete an identified intervention at set intervals.

Inspector #736 reviewed the specified document for resident #014, dated the day they fell. The Inspector noted that on two of intervals indicated, the identified intervention was not completed as the form was blank for these intervals.

c) Inspector #736 reviewed resident #021's health care records, including progress notes for a three month period. The progress notes identified that resident #012 had sustained three falls within the period reviewed. The progress notes further indicated that registered staff were to initiate an identified intervention after each fall.

Inspector #736 reviewed the specified document for resident #021 for the three dates the resident had fallen, which identified missing documentation on a

number of intervals.

Inspector #736 conducted a review of a specific policy regarding the identified intervention.

In an interview with the Inspector, RPN #126 indicated that the identified intervention would be initiated if a resident had an unwitnessed fall. The RPN further indicated that staff were to document the completion of the identified intervention on a specified document, which was to be completed at set intervals. Together, Inspector #736 and the RPN reviewed the specified document for resident #010 for the indicated dates when they had fallen, and noted the blank spaces on the forms. RPN #126 confirmed that the specified documents were not complete, which indicated the identified intervention was not completed.

In an interview with the Inspector, RPN #136 indicated that the identified intervention was to be started immediately on any resident who sustained a fall. Together, Inspector #736 and RPN #136 reviewed the specified document for resident #021 on the dates where they had fallen; the RPN confirmed that the identified intervention was not completed for the reviewed dates.

In an interview with the Inspector #736, RN #108 indicated that the identified intervention was to be initiated and completed for resident #014 when they had sustained a fall. Together, the Inspector and RN #108 reviewed the specified document for resident #014, and the RN confirmed that the blanks on the form would indicate that the identified intervention was not completed.

In an interview with the Inspector, the Acting Director of Care (DOC) indicated that the specified document was considered to be part of the resident's plan of care. The Acting DOC further indicated that it was the expectation of staff to complete the identified intervention and document on the specified document. Together, Inspector #736 and the Acting DOC reviewed the specified documents for resident #010, #014, and #021; they confirmed that the provisions of care were not consistently documented for the resident related to the identified intervention, and should have been. [s. 6. (9) 1.] (736)

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Sexual abuse is defined within the Ontario Regulations 79/10 of the LTCHA as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

A CIS report was submitted to the Director on an identified date, in which resident #008 was observed in a public area of the home displaying an identified responsive behaviour of a sexual nature towards resident #009. A further review of the CIS report identified that resident #008 had a history of sexual responsive behaviour towards other residents dating back to their admission.

Inspector #691 reviewed resident #008's health care records. A review of the electronic progress notes indicated that this behavior had been well managed, however in the past month, these behaviors had escalated and the resident was seeking out residents.

A further review of resident #008's electronic progress notes by Inspector #691, identified that within a six month period there were seven documented incidents of resident #008 seeking out residents and attempting to exhibit a responsive behaviour of a sexual nature.

A further review of resident #008's electronic progress notes identified that on an identified date, four months previous to the incident, resident #008 had displayed a responsive behaviour of a sexual nature towards #009.

A further review of resident #008's health care records by Inspector #691 indicated that following the incident of the sexual responsive behaviour towards resident #009 on the initial incident, resident #008 had a legal document to have an identified intervention in place 24 hours a day. As well, resident #008 was not to interact with resident #009.

During separate interviews with Inspector #691, PSW #120, PSW #131, and PSW #134 indicated that resident #008 had specific triggers and interventions indicated on their plan of care that they had a history of exhibiting an identified responsive behaviour of a sexual nature towards residents. PSW #134 confirmed that staff were required to implement the identified intervention on a 24 hour basis to ensure resident #008 would not display further sexual responsive behaviours towards residents.

In an interview with PSW #138, they indicated that resident #008 had a history of sexual responsive behaviours towards residents, as indicated in their care plan. They further indicated that the resident had a legal document for the implementation of an identified intervention. PSW #138 confirmed that they were the staff member who was to implement the identified intervention on the date of the reported incident. They indicated that they had not implemented the identified intervention for resident #008 at all times, and that during that time resident #008 was observed to be exhibiting an identified responsive behaviour of a sexual nature towards resident #009.

During an interview with RPN #135, they confirmed that resident #008 was to have the identified intervention implemented 24 hours a day, in order to prevent resident #008 from exhibiting sexual responsive behaviours towards others, especially resident #009 due to the previous incident involving them. RPN #135 confirmed that they were working on the date of the reported incident, when PSW

#138 did not implement the identified intervention for resident #008. They indicated that during that time, resident #008 sought out resident #009 and was witnessed to be displaying an identified responsive behaviour of a sexual nature towards resident #009, for the second time. RPN #135 confirmed that because of not implementing the identified intervention, the home did not protect resident #009 from resident #008.

During an interview with Associate Director of Care (ADOC) #102, they indicated that staff were to implement the identified intervention for resident #008 for 24 hours a day. ADOC #102 confirmed that the home failed to protect resident #009 from abuse by resident #008.

During separate interviews with Inspector #691, ADOC #102 and Acting DOC indicated that it was their expectation that staff follow the plan of care while caring for the residents. The Acting DOC confirmed that there had been a legal document for an identified intervention to be implemented twenty four hours a day after the initial incident with resident #008, to protect resident #009. ADOC #102 and Acting DOC #101 confirmed that the home did not follow through with the appropriate interventions, and did not protect resident #009 from abuse by resident #008. [s. 19 (1)

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 002

WN #3: 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, and that the strategy was complied with.

In accordance with O. Reg 52 (1) 4, the licensee was required to ensure that the pain management program must, at a minimum, provide for the monitoring of resident's responses to, and the effectiveness of the pain management strategies.

Specifically, staff did not comply with the Pain Evaluation summaries of the licensee's Pain Management policy, RCS G-60, last revised March 13, 2019, which was part of the licensee's Pain Management program.

A review of the policy titled "Pain Management", RCS G-60, last revised March 13, 2019, indicated that staff were to schedule a three day observation on the eMAR and on the fourth day, staff were to complete a Pain Evaluation Summary in Point Click Care (PCC). The policy further indicated that Pain Assessments were to be completed for all residents with uncontrolled pain, acute onset of pain (i.e. post fall), significant change and change in an analgesic order.

A CIS report was submitted to the Director for resident #014, who fell and sustained an injury with a significant change in health status. The CIS report indicated that the resident had fallen on an identified date, however the injury was not discovered until six days later. A further review of the CIS report indicated that the resident was complaining of increased pain.

Please see WN #1, finding 2 (b) for details.

a)Inspector #736 reviewed resident #014's health records, including progress notes, Physician's orders and electronic Medication Administration Records (eMARs). The Inspector noted that the resident was on a three day pain observation as documented in their eMAR, after having returned from the hospital with complaints of pain as a result of an identified injury. The Inspector also noted that the resident was started on an identified medication. The Inspector was unable to locate any Pain Evaluation Summaries in PCC for resident #014 related to the observation period, or the change in medication.

b)Inspector #736 reviewed resident #016's electronic health records, including progress notes, Physician orders and eMAR. The progress notes identified that the resident had sustained a fall on an identified date, and was complaining of "excruciating" pain, requiring further intervention. The Inspector noted that the resident was on a three day pain observation on eMAR. The Inspector was unable to locate any Pain Evaluation Summaries in PCC for resident #016 related to the observation period.

In separate interviews with RPN #107 and RPN #126, they both indicated to Inspector #736 that residents were to have the pain evaluation summaries completed on a monthly basis. RPN #126 stated that the pain assessments and summaries were to be completed every three months for all residents, to ensure that the strategies in place for their pain management were effective.

In separate interviews with Inspector #736, RN #108 and RN #122 indicated that residents were assessed for pain during the first four days of admission, every quarter and as necessary, if they had complaints of pain. RN #108 further indicated that a pain evaluation should have been completed if there was a change in level of care for a resident to ensure the resident's pain was monitored and managed. RN #122 confirmed that the pain evaluation from the observation period for resident #016 was incomplete.

In an interview with Inspector #736, the Acting DOC indicated that residents pain was to be monitored on a monthly basis using the Pain Summery evaluation on PCC, whether they received pain medication or not. They further indicated that a resident was to be started on a three day pain tracking through eMAR if there was a change in medication, and that after the pain tracking was complete, registered staff were to complete a Pain Evaluation Summary in PCC. Together, the Inspector and the Acting DOC reviewed the assessments for residents #014 and #016 and could not locate a Pain Evaluation summary after the three day pain

monitoring was completed on the resident's eMAR. They indicated that there should have been a corresponding Pain Evaluation summary; as there was not, the Acting DOC confirmed that the home did not evaluate the strategies implemented in order to effectively manage residents #014 and #016's pain.

O. Reg 79/10, r. 53, of the LTCHA (2007), was also issued in relation to this finding. Refer to WN #4, finding #1 for details.

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 homes pain management program must, at a minimum, provide for the monitoring of resident's responses to, and the effectiveness of the pain management strategies, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

A CIS report was submitted to the Director for alleged resident to resident abuse on an identified date. The CIS report indicated that on the identified date, resident #015 exhibited an identified responsive behaviour towards resident #016, resulting in resident #016 sustaining an identified injury.

A review of resident #015's electronic progress notes by Inspector #690, indicated that on the identified date, resident #015 told them that they had exhibited a responsive behaviour towards resident #016 causing them to sustain an injury.

Inspector #690 reviewed resident #015's electronic care plan dated the month previous to the incident and did not locate any foci or interventions for any responsive behaviours. A review of resident #015's current electronic care plan identified a focus that indicated that resident #015 had a history of identified responsive behaviours. There were no interventions identified for the responsive behaviours included in the care plan.

In an interview with PSW #145, they indicated that resident #015 did not currently display the identified responsive behaviour, but that were aware of the incident that took place involving resident #016. They further indicated that they would access the care plan on Point of Care (POC) in PCC to find information on a residents responsive behaviours and what interventions were in place to manage those behaviours. PSW #145 confirmed that they were not aware of any interventions in place to prevent another incident from occurring.

Inspector #690 interviewed RPN #124, who indicated that a residents responsive behaviours and any interventions that were in place to manage the behaviours, would be on the electronic care plan on PCC. RPN #124 further indicated that when there was an incident related to responsive behaviours, registered staff were to update the care plan by adding the incident, the date that it occurred, and add any interventions that were required to prevent another incident from happening. Together, Inspector #690 and RPN #124 reviewed resident #015's electronic care plan, which RPN #124 identified that they had updated after the incident. The RPN could not say why the incident involving resident #015 towards

#016 was not included on the care plan, and why there were no interventions on the care plan to manage the responsive behaviours. RPN #124 confirmed that they should have added the incident and updated the care plan with interventions to prevent a reoccurrence of the identified responsive behaviour from occurring.

In an interview with ADOC #102, they indicated that when a resident had exhibited the identified responsive behaviour, registered staff were to update the residents electronic care plan on PCC and to include interventions to manage the responsive behaviours. Together, Inspector #690 and ADOC #102 reviewed resident #015's electronic care plan; whereby ADOC #102 identified that all the information on resident #015's care plan related to their identified responsive behaviours was out of date. They further identified that the incident involving resident #015 towards resident #016 was not included in the care plan and that there were no interventions on the care plan to assist staff with managing the responsive behaviours, and that there should have been.

2. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessment, reassessments, and interventions, and that the resident's responses to interventions were documented.

A CIS report was submitted to the Director by the home for an incident of alleged resident to resident physical abuse that occurred on an identified date 20 days prior. The CIS report identified that resident #002 was observed to have displayed an identified responsive behaviour towards resident #003, causing resident #003 to become upset regarding the incident.

Inspector #692 reviewed resident #002's health care records. A review of the residents electronic care plan identified that the resident had exhibited a history of the identified responsive behaviours towards others, including co-residents. Resident #002's electronic care plan, at the time of the incident, indicated registered staff were to complete a specific document when the resident exhibited the identified responsive behaviour.

Inspector #692 reviewed resident #002's progress notes, in which documentation by RN #142 on the day of the incident, indicated that resident #002 exhibited an identified responsive behaviour towards resident #003, causing resident #003 to become upset. A review of PCC in resident #002's electronic health records, indicated that the specific document was not completed after the incident

involving resident #003.

A review of the homes policy titled, "Responsive Behaviour Debrief", #G-45, last reviewed April 22, 2019, indicated that registered staff were to complete the Responsive Behaviour Debriefing tool in PCC under the assessment section of the residents chart. A further review of the policy, indicated the assessment was to be completed to "understand the behaviour better, to manage it, and to mitigate the risk to that resident and others".

In an interview with Inspector #692, PSW #106 identified that resident #002 exhibited a history of identified responsive behaviours. PSW #106 further indicated that they would participate in a meeting with the staff working on the unit at the time of an incident after of the resident exhibiting the identified responsive behaviour and that the registered staff would document in PCC.

In separate interviews with Inspector #692, RPN #117 and RN #142 identified that resident #002 had exhibited an identified responsive behaviour towards resident #003. They both confirmed that the responsive behaviour debrief was to be completed after each incident. In order to prevent further incidents. RPN #117 and RN #142 both confirmed the responsive behaviour debrief was not completed after the incident involving resident #002 towards resident #003, and it should have been.

Together, the Inspector and the ADOC #102, [who was the Director of Care (DOC) at the time of the incident], reviewed resident #002's electronic health record in PCC and could not locate evidence of the responsive behaviour debrief being completed. ADOC #102 confirmed it was the expectation that registered staff completed the identified intervention after the incident, and they did not.

3. A CIS report was submitted to the Director for an allegation of resident to resident physical abuse on an identified date for an incident that occurred on three days prior. The CIS report indicated that resident #006 exhibited an identified responsive behaviour towards resident #007, which caused resident #007 to sustain an injury.

Inspector #690 reviewed resident #006's electronic health records and could not locate any documentation related to the incident on the identified date.

A review of resident #007's electronic progress notes identified a progress note

dated the day of the incident documented by RN #142 indicating the details of the incident involving resident #006 towards resident #007.

A review of resident #006's electronic progress notes identified a progress note dated six days after the incident, documented by Nurse Consultant #123. The progress note indicated that resident #006 only had one major episode of the identified responsive behaviour in the last week, and there was no evidence of the incident of resident #006 when they exhibited an identified responsive behaviour towards resident #007.

In an interview with Inspector #690, PSW #116 indicated that they were with resident #006 at the time of the incident and that they witnessed resident #006 exhibit an identified responsive behaviour towards resident #007. PSW #116 indicated that RN #142 was also present at the time of the incident.

In an interview with Inspector #690, RN #142 indicated that they had witnessed the incident between resident #006 and resident #007. RN #142 indicated that the responsive behaviour debrief was to be completed after an incident involving residents that posed a risk to them. Together, Inspector #690 and RN #142 reviewed resident #006's electronic health records, at which time RN #142 identified that there was no evidence of the completion of the responsive behaviour debrief or any progress notes related to the incident. RN #142 indicated that they should have reassessed resident #006 following the incident by completing a responsive behaviour debrief tool, and RN #142 could not indicate why the reassessment had not been done.

In an interview with Nurse Consultant #123, they indicated that they had consulted with resident #006 for several months related to on-going physical aggression towards staff and co-residents. Nurse Consultant #123 indicated that they would review resident #006's electronic health records and speak to staff to determine resident #006's response to the interventions in place. The Nurse Consultant indicated that they had not been made aware of the incident between resident #006 and #007, therefore had not included the incident in their assessment of resident #006 six days after the incident had occurred. Nurse Consultant #123 further indicated that they should have been made aware of the incident and that if they had known about the incident, it "may have" resulted in a change in treatment for resident #006.

In an interview with Inspector #690, ADOC #102 indicated that registered staff

were to complete the identified intervention after an incident involving resident to resident incidents to determine the cause of the responsive behaviour and any further interventions that were required to prevent a re-occurrence of the behaviour. ADOC #102 indicated that resident #006 was not reassessed related to their responsive behaviours, and they should have been. [s. 53. (4) (c)] (690)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessment, reassessment and interventions and that the responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written report submitted to the Director, included the outcome or current status of the individual who was involved in the incident.

A CIS report was submitted to the Director on an identified date, as a result of resident #013 falling the previous day resulting in an injury with significant change in health status and was transferred to hospital.

Two months after the initial CIS report submission, the Director requested an amendment to the CIS report to include the resident's date of return from hospital, status of resident upon return, and the resident's transfer and ambulation status prior to the incident.

Inspector #736 reviewed the records submitted to the Director by the home and could not locate an amended CIS report with the requested information.

In an interview with Inspector #736, ADOC #102 indicated that both the DOC and ADOCs were responsible for submitting and updating the CIS reports as needed. ADOC #102 indicated that they had submitted the initial CIS report when resident #013 fell and sustained an identified injury, however they were unable to recall

why the CIS report was not amended with the requested information. The ADOC confirmed that the CIS report had not been updated with the requested information.

In an interview with the Acting DOC, they indicated to the Inspector that the DOC and ADOCs were responsible for submitting and updating CIS reports as necessary. The Acting DOC was unaware if ADOC #102, or any other ADOC had updated the CIS report with the required information. Together, the Inspector and the Acting DOC reviewed the submitted CIS reports, and could not locate an amended CIS report to indicate resident #013's status.

2. A CIS report was submitted to the Director on an identified date, as a result of resident #010 falling the previous day, sustaining an injury with significant change in health status and was transferred to the hospital.

Please see WN #1, findings #1 and #2 for details.

Inspector #736 further reviewed the CIS report, which identified that the home had not amended the CIS report until two months after the incident with the status of resident #010 after the incident.

In an interview with Inspector #736, the Acting Administrator indicated that they were aware of the requirement to update the Director within 10 days of the outcome and current status of the resident involved in a CIS report. Together, the Inspector and the Acting Administrator reviewed the CIS report; the Acting Administrator confirmed that the CIS report was not updated with the outcome and current status of resident #010 within 10 days, and should have been.

3. A CIS report was submitted to the Director on an identified date, as a result of an allegation that resident #008 was displaying a reponsive behaviour of a sexual nature towards resident #009.

A review of the CIS report by Inspector #691, indicated that resident #008 was observed to be exhibiting a responsive behaviour of a sexual nature towards resident #009's. The CIS report further identified the actions taken at the time of the incident.

Please see WN #2, finding #1 for details.

Inspector #691 reviewed the reports submitted to the Director by the home and could not locate an amended CIS report providing an update on the outcome of the incident and the current status of residents #008 and #009.

In an interview with Inspector #691, ADOC #102 indicated that both the DOC and ADOCs were responsible for submitting and updating the CIS reports with the required information. ADOC #102 indicated that they had submitted the initial mandatory report through the after-hours reporting line on the day of the incident and then submitted the CIS report two days later, when resident #008 displayed a responsive behaviour of a sexual nature towards resident #009. The ADOC confirmed that the CIS report had not been updated with the outcome or current status of resident #008 and #009. ADOC #102 indicated that the home was aware of the reporting requirements and confirmed to Inspector that the report was required to be amended with updates, within 10 days of submitting report. The ADOC confirmed that the CIS report was not updated as required. [s. 107. (4) 3. v.] (691)

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 that ensures when a written report is submitted to the Director within 10 days and includes the outcome and current status of the individual or individuals who were involved in the incident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that any person who had reasonable grounds to suspect that abuse had occurred, or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to the Director for an alleged resident to resident abuse on an identified date for an incident that occurred three days prior. The CIS report indicated that resident #006 exhibited an identified responsive behaviour towards resident #007, who sustained an injury.

Please see WN #4, finding #3 for details.

A review of the home's policy titled "Abuse and Neglect Policy, #RCS P-10", last revised February 19, 2018, indicated that when a staff member had a reason to believe that a resident had suffered harm or was at risk of harm due to abuse, they must immediately report their suspicion to the Director appointed under the LTCHA, 2007.

In an interview with Inspector #690, RN #128 indicated that they recalled the incident involving resident #006 towards resident #007, yet was unable to recall if

they had reported the incident to the manager on call. They continued to state that if they had notified the manager on call, they would have documented the call in a progress note, and there was not any evidence of a documented progress note. RN #128 indicated that when there was an allegation of resident to resident abuse and a resident sustains an injury, they were to notify the Director immediately. RN #128 further indicated that at the time when the identified injury was discovered, they should have notified the manager on call and notified the Director, and that they did not.

In an interview with Inspector #690, ADOC #102 indicated that they submitted the CIS to the Director on an identified date, for the incident that occurred three days prior, when they became aware of resident #007's injury. The ADOC further indicated that it was the responsibility of registered staff that were working at the time of the incident to call the manager on call or call the after hours reporting line immediately when there was an alleged resident to resident physical abuse that resulted in an injury to a resident. ADOC #102 confirmed that the registered staff did not call the manager on call, or report the incident to the after-hours reporting line, and that they should have. [s. 24. (1)] (690)

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (2) The licensee shall comply with subsection (1) immediately upon completing the licensee's investigation into the complaint, or at an earlier date if required by the Director. O. Reg. 79/10, s. 103 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a copy of any written complaint that was received related to a matter that the licensee reported to the Director under section 24 of the Act, and a corresponding written report documenting the response the licensee made to the complainant was submitted to the Director.

A CIS report was submitted to the Director on an identified date for an incident of alleged resident to resident abuse causing injury that occurred three days prior.

Please see WN #4, finding #3 and WN #6, finding #1 for details.

Inspector #690 reviewed the above mentioned CIS report and noted that a written complaint letter related to the incident was attached to the CIS report. The letter was dated two days after the date of the incident, addressed to the homes Administrator from resident #007's Substitute Decision Maker (SDM). The letter indicated that resident #007's SDM was upset regarding the incident that had occurred towards resident #007 and wanted the home to provide the follow up that will be completed to ensure that this type of incident does not occur in the future.

A review of the home's policy titled, "Client Service Response Form", policy #LGM I-10, last reviewed June 1, 2018, indicated that a "written complaint concerning the care of a resident or the operation of the home along with a written report documenting the home's response to the complainant will be forwarded to the Director, immediately upon completion of the home's investigation into the complaint".

In an interview with Inspector #690, the Acting Administrator indicated that the home forwarded a copy of the written complaint letter, but that the home did not forward a written report documenting the response to the Director, and that they should have. [s. 103. (2)] (690)

WN #8: 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).

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the report to the Director included the names of any staff members or other persons who were present at, or discovered the incident.

A CIS report was submitted to the Director on an identified date for an allegation of staff to resident abuse. The CIS report indicated that resident #005 reported to a staff member that an "identified staff member", had exhibited an inappropriate act towards them. The CIS report did not include the name of the identified staff member.

Inspector #690 reviewed the home's internal investigation notes related to the incident, which indicated that the identified staff member was PSW #144. The investigation notes had identified that the home had determined that the allegation of abuse was unfounded after the home conducted an investigation.

In an interview with Inspector #690, the Acting Administrator indicated that a CIS report was to include the names of any staff members that were present at or that

discovered the incident. Inspector #690 and the Acting Administrator reviewed the CIS report and the Acting Administrator indicated that the CIS report did not include the name of the staff member that was present at the time of the incident, and that it should have. [s. 104. (1) 2.] (690)

2. The licensee has failed to submit a CIS report upon becoming aware of the alleged, suspected or witnessed incident of abuse to a resident the within 10 after reporting the incident to the after-hours reporting line.

A CIS report was submitted to the Director on an identified date by the home for an incident of alleged resident to resident physical abuse that had occurred 20 days prior. The CIS report identified that on an identified date, resident #002 was observed to exhibit an identified responsive behaviour towards resident #003, causing resident #003 to become upset regarding the incident. The CIS report further identified the incident occurred after hours, the licensee reported the incident using the after-hours reporting line on the day the incident occurred, and the initial CIS report was first submitted to the Director 20 days later.

Please see WN #4, finding #2 for details.

Inspector #692 reviewed resident #002's progress notes, in which documentation by RN #142 on the date of the incident, indicated that resident #002 had exhibited an identified responsive behaviour towards resident #003, causing resident #003 to become upset. RN #142 documented that they reported the incident to the Director through the after-hours reporting line, and reported the incident immediately to the on-call manager.

In an interview with Inspector #692, RPN #117 indicated they were the registered staff that responded to the incident involving resident #002 towards #003 on the identified date. The RPN further confirmed they reported the incident to the charge nurse, RN #142, immediately following the incident.

During an interview with RN #142, they recalled the incident being reported to them by RPN #117 after the incident occurred. Together, Inspector #692 and RN #142 reviewed a progress note dated the day of the incident. RN #142 confirmed that they had reported the incident of resident to resident abuse to the after-hours reporting line, and further confirmed that they contacted the manager on call, after the incident occurred.

Inspector #692 interviewed the ADOC #102, and they confirmed they completed the CIS report and submitted it to the Director 20 days after the incident occurred. ADOC #102 confirmed that when an incident of abuse occurs after hours, the licensee was to report the details to the Director using the after-hours reporting line and was to submit the initial CIS report within 10 business days. ADOC #102 confirmed that the incident occurred on the identified date and that the incident was reported immediately through the after-hours reporting line by RN #142. They were unable to recall the rationale as to why the CIS report was not first submitted until 20 days after being reported, and that it should have been submitted within 10 business days. [s. 104. (2)] (692)

Issued on this 3 rd day of June, 2019 (A1)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SHANNON RUSSELL (692) - (A1)
Inspection No. / No de l'inspection :	2019_746692_0013 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	012200-18, 012606-18, 017966-18, 018529-18, 023639-18, 024193-18, 025225-18, 026864-18, 027022-18, 030258-18, 003725-19, 005323-19, 005411-19, 007715-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 03, 2019(A1)
Licensee / Titulaire de permis :	Rykka Care Centres LP 3760 14th Avenue, Suite 402, MARKHAM, ON, L3R-3T7
LTC Home / Foyer de SLD :	Hawthorne Place Care Centre 2045 Finch Avenue West, NORTH YORK, ON, M3N-1M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Charlotte Altenburg

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Rykka Care Centres LP, 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. 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).

Order / Ordre :

The licensee must be in compliance with s. 6. (7) of the LTCHA.

Specifically the licensee must:
a) Ensure all residents' with specific interventions are followed as per the residents wishes.
b) Educate/re-educate all relevant staff on the process related to these specific interventions.
c) Maintain records, including the attendees, date(s), and material reviewed.

Grounds / Motifs :

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

A Critical Incident System (CIS) report was submitted to the Director by the home on an identified date, related to resident #010, who had a fall and sustained an injury with significant change in health status the previous day. A review of the CIS report, indicated that resident #010 had an unwitnessed fall that required transfer to the hospital, that resulted in an identified injury.

Inspector #736 reviewed the progress notes for resident #010 and noted that on the day the resident fell, they sustained an identified injury and was transferred to the hospital. The progress notes indicated that the resident was transferred back to the home three days after the incident. The progress notes further indicated that on the day after resident #010 returned from the hospital, they required the assistance of the specified intervention, which was included in their plan of care. Registered

Practical Nurse (RPN) #129 documented that they had initiated the specified intervention, and then stopped as per the direction of Registered Nurse (RN) #141 (who was the Quality Manager at the time).

The Inspector further reviewed resident #010's health care record and identified a document, which indicated that the resident requested the use of the specified intervention.

A specific policy review was conducted by Inspector #736.

In an interview with the Inspector, RPN #129 confirmed that resident #010 required a specified intervention and they had initiated it, however RN #141 had indicated for them to stop.

In an interview with Inspector #736, the Acting Administrator indicated that staff were to provide care to residents as indicated in their plan of care. Together, Inspector #736 and the Acting Administrator reviewed the identified document included in residents' plan of care. The Acting Administrator confirmed resident #010 was not provided the care as set in their plan of care, and that they should have.

Long-Term Care Homes Act (LTCHA), 2007, S.O. 2007, c. 8, s. 107 (4) 3 v, was also issued in relation to this finding. Refer to Written Notification (WN) #5, finding #2 for details. [s. 6. (7)] (736).

The severity of this issue was determined to be a level three, as there was actual harm/actual risk. The scope of the issue was a level one, as the plan of care not being complied with was isolated. The home had a level three compliance history with one or more related non-compliance in the last 36 months with this section of the Ontario Regulation 79/10 that included:
-Compliance Order (CO) issued November 29, 2017, (2017_644507_0016);
-Written Notice (WN) issued September 11, 2017, (2017_527665_0004);
-Voluntary Plan of Correction (VPC) issued August 11, 2017, (2017_653648_0007); and
-VPC issued August 4, 2017, (2017_595604_0011).
(736)

Aug 06, 2019(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Order / Ordre :

The licensee must be in compliance with s. 19 (1) of the LTCHA.

Specifically the licensee must:
a) Protect all residents from abuse from anyone.
b) Ensure all relevant staff are educated/re-educated on the purpose, process and expectations required when implementing a specified intervention.
c) Maintain records, including attendees, date(s) and the material reviewed.

Grounds / Motifs :

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

Sexual abuse is defined within the Ontario Regulations 79/10 of the LTCHA as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

A CIS report was submitted to the Director on an identified date, in which resident #008 was observed in a public area of the home displaying an identified responsive behaviour of a sexual nature towards resident #009. A further review of the CIS report identified that resident #008 had a history of sexual responsive behaviour towards other residents dating back to their admission.

Inspector #691 reviewed resident #008's health care records. A review of the

electronic progress notes indicated that this behavior had been well managed, however in the past month, these behaviors had escalated and the resident was seeking out residents.

A further review of resident #008's electronic progress notes by Inspector #691, identified that within a six month period there were seven documented incidents of resident #008 seeking out residents and attempting to exhibit a responsive behaviour of a sexual nature.

A further review of resident #008's electronic progress notes identified that on an identified date, four months previous to the incident, resident #008 had displayed a responsive behaviour of a sexual nature towards #009.

A further review of resident #008's health care records by Inspector #691 indicated that following the incident of the sexual responsive behaviour towards resident #009 on the initial incident, resident #008 had a legal document to have an identified intervention in place 24 hours a day. As well, resident #008 was not to interact with resident #009.

During separate interviews with Inspector #691, PSW #120, PSW #131, and PSW #134 indicated that resident #008 had specific triggers and interventions indicated on their plan of care that they had a history of exhibiting an identified responsive behaviour of a sexual nature towards residents. PSW #134 confirmed that staff were required to implement the identified intervention on a 24 hour basis to ensure resident #008 would not display further sexual responsive behaviours towards residents.

In an interview with PSW #138, they indicated that resident #008 had a history of sexual responsive behaviours towards residents, as indicated in their care plan. They further indicated that the resident had a legal document for the implementation of an identified intervention. PSW #138 confirmed that they were the staff member who was to implement the identified intervention on the date of the reported incident. They indicated that they had not implemented the identified intervention for resident #008 at all times, and that during that time resident #008 was observed to be exhibiting an identified responsive behaviour of a sexual nature towards resident #009.

During an interview with RPN #135, they confirmed that resident #008 was to have the identified intervention implemented 24 hours a day, in order to prevent resident #008 from exhibiting sexual responsive behaviours towards others, especially resident #009 due to the previous incident involving them. RPN #135 confirmed that they were working on the date of the reported incident, when PSW #138 did not implement the identified intervention for resident #008. They indicated that during that time, resident #008 sought out resident #009 and was witnessed to be displaying an identified responsive behaviour of a sexual nature towards resident #009, for the second time. RPN #135 confirmed that because of not implementing the identified intervention, the home did not protect resident #009 from resident #008.

During an interview with Associate Director of Care (ADOC) #102, they indicated that staff were to implement the identified intervention for resident #008 for 24 hours a day. ADOC #102 confirmed that the home failed to protect resident #009 from abuse by resident #008.

During separate interviews with Inspector #691, ADOC #102 and Acting DOC indicated that it was their expectation that staff follow the plan of care while caring for the residents. The Acting DOC confirmed that there had been a legal document for an identified intervention to be implemented twenty four hours a day after the initial incident with resident #008, to protect resident #009. ADOC #102 and Acting DOC #101 confirmed that the home did not follow through with the appropriate interventions, and did not protect resident #009 from abuse by resident #008. [s. 19 (1).

The severity of this issue was determined to be a level three, as there was actual harm/actual risk. The scope of the issue was a level one, as the incident was isolated. The home had a level three compliance history with one or more related non-compliance in the last 36 months with this section of the Ontario Regulation 79/10 that included:
-Compliance Order (CO) issued November 29, 2017, (2017_644507_0016);
-Voluntary Plan of Correction (VPC) issued August 4, 2017, (2017_595604_0011); and
-Written Notice (WN) issued May 26, 2016, 2016_365618_0013.

(691)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Aug 06, 2019(A1)

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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 3 rd day of June, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by SHANNON RUSSELL (692) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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